

Ethiopia

Situation Analysis on Population, Reproductive Health and Gender



UNFPA Country Technical Services Team
Addis Ababa, Ethiopia



ETHIOPIA

SITUATION ANALYSIS ON POPULATION, REPRODUCTIVE HEALTH AND GENDER

by

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UNFPA CST Addis Ababa

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ABBREVIATIONS

ARH	Adolescent Reproductive Health
AIDS	Acquired Immuno Deficiency Syndrome
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CMR	Child Mortality Rate
CPR	Contraceptive Prevalence Rate
CSA	Central Statistical Authority
CSTAA	Country Technical Services Team, Addis Ababa
DHS	Demographic and Health Survey
EPLF	Eritrean People's Liberation Front
EPRDF	Ethiopian People's Revolutionary Democratic Front
ESPD	Educational Sector Programme
ETP	Education and Training Policy
FDRE	Federal Democratic Republic of Ethiopia
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GDP	Gross Domestic Product
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
HIV	Human Immuno Deficiency Virus
IEC	Information, Education and Communication
KM	Kilometres
MDG	Millennium Development Goals
MEFF	Macro Economic Fiscal Framework
MMR	Maternal Mortality Rate
MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
NGO	Non-Governmental Organization
ODA	Official Development Assistance
OLF	Oromo Liberation Front
PHCCC	Population and Housing Census Commission
PRSP	Poverty Reduction Strategy Plan
RH	Reproductive Health
SDPRP	Sustainable Development Poverty Reduction Programme
SNNPR	Southern Nation Nationalities Peoples Region
STI	Sexually Transmitted Infections
TB	Tuberculosis
TFR	Total Fertility Rate
TPLF	Tigrayan People's Liberation Front
UDHR	Universal Declaration of Human Rights
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WFP	World Food Programme
WHO	World Health Organization

INTRODUCTION

The United Nations Population Fund (UNFPA) seeks to improve the quality of life of all people through expanding reproductive health choices; assisting countries in collecting and analyzing population data; and in addressing gender issues. Furthermore, the Fund helps governments, upon their own request, to formulate policies and develop programmes that address poverty reduction among other issues. Over the years, there is evidence that proper implementation of UNFPA policies and programmes have contributed positively to the quality of life of individuals and couples.

An important strategy used by the Fund for policy formulation and programme implementation is the establishment of Country Support Teams (CST) that provide technical assistance directly to countries. There are nine such Teams globally, three of which are based in Africa in Addis Ababa, Harare and Dakar. Among the many technical functions of the Teams include undertaking regional analysis that contribute to the availability of national and regional information on demographic and socio-economic information for informed programming. During the period 2004-05, the Team in Addis Ababa undertook analyses in all the countries that they serve. The analyses focused on demographic and socio-economic characteristics, identifying population evolving needs and emerging issues.

The focal person for the Federal Democratic Republic of Ethiopia undertook the country's Situation Analysis of the Population, Reproductive Health and Gender. The author relied heavily on literature review methodology in collating existing information on all the pertinent issues. Some of reports and documents reviewed include:

- The 1994 Population and Housing Census;
- The Health Sector Development Programme (1997 - 2001);
- State of the World Population Report (all years);
- Human Development Index (all years);
- Sustainable Development and Poverty Reduction Programme (SDPRP);
- Millennium Development Goals Report;
- Report of the 1997 Swaziland Population and Housing Census;
- Census Summary,
- US Census Bureau;
- Common Country Assessment,
- UNCT 1999;
- Health and Health Related Indicators,
- 2002-2003 (MOH);
- Demographic and Health Survey 2000;
- Humanitarian Appeal for Ethiopia;
- The State of World's Children;
- World Health Organization; and,
- Reproductive Health Indicators.

The situation analysis covers the following issues and areas:

- **Development context:** Geographical locations, culture, history and politics, socio-economic situation, macro-economic situation, development framework, environment and data for development.
- **Populations:** Population characteristics, population dynamics and implications.
- **Reproductive health:** General health situation, knowledge attitudes and practices, reproductive rights, maternal health, family planning, adolescent sexual reproductive health, STIs/HIV/AIDS, other reproductive health conditions, reproductive health commodity security, quality services and health information systems.
- **Gender equality, equity and women empowerment:** Domestication of international and regional frameworks related to gender - harmful practices, gender equality, gender equity, women empowerment and gender mainstreaming.
- **Conflict, emergencies and humanitarian response:** Nature of conflict and emergencies, consequences and overall response to consequences; and;
- **Critical issues in population, reproductive health, gender and data needs.**

It is expected that government officials and all development partners working in Ethiopia will find this document particularly useful in addressing population issues.

Note that based on the analysis undertaken, some conclusion remarks were made. I wish to state that these are purely the ideas of the author and not of the organization.

I wish to acknowledge the contribution and assistance provided by the UNFPA County Office, Ms. Meron Tewfik (while she was working with CST), Ms. Shewaye Lulu and Ms. Meskerem Teklemariam.

CHAPTER 1

DEVELOPMENT CONTEXT

1.1 Geography, Culture, History and Politics

1.1.1 *The Geography, Location and Rain Patterns*

The Federal Democratic Republic of Ethiopia is situated in the north-eastern part of Africa. It is bordered on the south by Kenya, on the west and southwest by Sudan, on the east by Djibouti and Somalia, and on the north and north-east by Eritrea.

The country occupies a land area of approximately 1.1 million sq. kilometres or 472,000 square miles, making it one of the largest countries in Africa. Since the secession of Eritrea in 1993, Ethiopia is a landlocked country that currently depends on the port of Djibouti for its imports and exports

There are a number of small lakes in Ethiopia. Lake Tana is the largest lake. Other lakes include Lake Turkana, which it shares with Kenya, Lake Langano and Lake Awasha among others. The Great Rift Valley, which runs into Kenya, has its origin in Ethiopia.

There is a high central plateau which rises up to 3,000 metres above sea level. Some mountains rise up to approximately 4,600 metres above sea level. The plateau slopes to the lowlands of the Sudan on the west and to Somali in the southeast. Ethiopia is also home to several major rivers including the Blue Nile which flows from Lake Tana.

The country experiences a temperate climate in the highlands. It is hot in the lowlands with maximum temperatures of 26^o C (80^oF) and minimum temperatures of 4^oC (40^oF). For most of the year, the weather is sunny and dry with short rains coming in February to April, while the long rains come between June and September.

1.1.2 *The People, Religion and Culture*

Ethiopia is home to 77 ethnic groups each with their own distinct languages. The most predominant groups are the Oromo (35 percent), Amharas (35 percent), Tigreans (6.3 percent) and Somali (6 percent). These groups make up more than three-fourths of the population (*CSA, 1994 Census*).

Major languages are Amharic, Oromo, Tigrinya and Somali. Amharic is the official Government language and main teaching language in primary schools. This, however, has recently been replaced with local languages. English is the most popular foreign language and it is taught in all secondary schools and tertiary levels of education. In addition, Arabic and Italian are used in commerce.

Ethiopia has a long history of religion which started with the introduction of Christianity in the fourth Century A.D by missionaries from Egypt and Syria. Currently, there are three major religions including Ethiopian Orthodox Christians (45 percent), Sunni Muslim (45 percent), Protestant (5 percent) and the indigenous beliefs (5 percent) (*US Department of State, Ethiopia*).

1.1.3 The Political History

Ethiopia is the only African country that was never colonised. According to the legends, Menelik I, the son of King Solomon and the Queen of Sheba, founded the Ethiopian Empire. Religious conflicts and wars contributed greatly to shaping the history of Ethiopia. Missionaries from Egypt and Syria brought Christianity to Ethiopia. However, the rise of Islam in the seventh Century alienated Ethiopia from Europe for many years. Later, the Portuguese arrived in 1493 and converted a number of Ethiopians into Catholics, but this brought bitter wars between pro- and anti-Catholics, resulting in the expulsion of all missionaries in the 1630s.

Under Emperor Theodre II (1855-68), Emperor Johannes IV (1872–89) and Emperor Menelik II (1889–1913), the country was consolidated into a strong Kingdom. Emperor Lij Lyasu succeeded Menelik II, followed by Empress Zewdtu (Menelik's daughter). In 1990, Haile Sellasie was crowned emperor and he reigned Ethiopia until September 1974 when he was overthrown by a self-proclaimed military junta.

Following the assassinations of several leaders, Lt. Colonel Mengistu assumed power and introduced a totalitarian style of government, creating the largest military in this part of Africa with substantial support from the Soviet Union and other countries from the Eastern Bloc. Communism was officially adopted in the late 1970s with the promulgation of a soviet style constitution and the creation of the Workers Party of Ethiopia.

In 1989, the Tigrayan People's Liberation Front (TPLF) merged with other opposition movements in the country to form the Ethiopian People's Revolutionary Democratic Front (EPRDF) that eventually deposed the Derg Regime in 1991.

1.1.4 The Political System

The constitution establishing the Government structures of the Federal Democratic Republic of Ethiopia (RDRE) was ratified in 1994. In June 1995, the Transitional Government of Ethiopia presided over the first ever democratic elections that ushered in 547 constituent assembly members and several regional legislature assembly members.

The Constitution spells out three branches of the Government: the Executive, Legislature and Judiciary. The Executive consists of the President, Council of State and Council of Ministers. The Legislature has a bicameral Parliament while the Judiciary is divided into Federal and Regional Courts.

Administratively, the country is divided into two special city administrations (Addis Ababa and Dire Dawa) and nine administrative regions, namely: Tigray, Afar, Amhara, Benishangul, Oromiya, Gambella, Southern Nation Nationalities Peoples (SNNP).

Political parties include the ruling Ethiopian Revolutionary Democratic Front (EPRDF) and 50 other registered parties, most of them quite small and ethnically based.

1.1.5 Socio-Economic Situation

(a) Poverty

The Ministry of Finance and Economic Development (MOFED) estimates Ethiopia's per capita income as US\$ 167, which places Ethiopia among the most poverty stricken countries on the globe. Comparatively, the per capita income of the neighbouring countries is much higher. For example, in 2002, the per capita income for Kenya and Uganda was estimated at US\$ 393 and US\$ 236 respectively.

A high number of Ethiopia's population lives below the poverty line. Specifically, in 1995-96, 45.5 percent of the population was below poverty line. Also, in the period 1990-2000, 82 percent of the population lived on less than US\$ 1 a day (MOFED, 2003).

There are significant disparities in poverty levels between urban and rural populations. For example, in 1995-96, rural and urban populations living below the poverty line was given as 47.5 percent and 33.2 percent respectively. Also, there are high variations in poverty levels among the regions: Tigray region has the highest level of absolute poverty, followed by Amhara and the southern regions. Other indicators of poverty (literacy and population without access to safe water) are all extremely high.

Due to its association with a high standard of living, literacy status is considered as one of the major indicators of the extent and level of poverty. Since the 1990s, the adult literacy rate for persons aged 15 years and above has shown minimal increase. The rate increased from 28.6 percent in 1990 to 41.5 percent in 2002, which is still very low compared to other African countries. There are major differences in literacy rates between male and female. In 2002, for example, female and male literacy was found to be 49.2 percent and 33.8 percent respectively. Again, this emphasizes the differences in gender equality in education.

There are also major differences in illiteracy between urban and rural populations as well as among regions. The illiteracy rate in Affar region (rural) was 93 percent while Addis Ababa city had only 8 percent.¹

Limited access to safe water shows that a large proportion of Ethiopians are exposed to water borne diseases including diarrhoea. According to the 1994 Census analysis², 76 percent of all households in Ethiopia had no access to safe water. The urban rural gap was found noteworthy - 85 percent rural and 19 percent urban.

Population without access to sanitation facilities is another measure of the extent of poverty in Ethiopia and, indeed, elsewhere in the world. Nationally, 87 percent of all households have no access to sanitation facility³. Also, variations are high between urban and rural populations. About 43 percent have no access to sanitation in urban areas while the same applies to 94 percent in rural areas. Differences among regions are also significant. According to the Health Sector Development Programme report (1997-2001), the percentage population with no access to sanitation is 93 in Tigrey, 92 in Affar and 26 in Addis Ababa.

(b) Education

The gross and net enrolment in primary and secondary schools are good indicators of progress made in the education sector. The definition of gross enrolment ratio as used in Ethiopia is the number of students enrolled in a level of education, whether or not they belong to that age group, as a percentage of the population in the relevant age group. It is observed that due to effective government efforts, the gross enrolment ratio rose from 27 in 1996 to 76 in 2003⁴. With regard to girls, the ratio rose from 9 to 52, a very significant improvement.

There are also differences between girls and boys in net enrolment ratio (defined as the number of students enrolled in a level of education that belongs to a relevant age group, as a percentage of the population in the age group). The net enrolment for boys in the period

¹ Human Development Index, 2004

² 1994 Census in which safe water and sanitation were reported by households

³ Federal Democratic Republic of Ethiopia, Ministry of Health (1996) Health Sector Development Programme (1997-2001), October 1996, Addis Ababa

⁴ State of World Population report, 1996

1995-1999 and 1997-2000 are 34 and 53 respectively. The net ratio for girls for the same period was 28 and 41 respectively.

In 1996 and 2003, the gross secondary enrolment for boys was 12 and 22 respectively. The gross enrolment ratio for girls for the same period was 11 and 14 respectively.

Differences in both gross and net enrolment for boys and girls are more pronounced at tertiary level. In 2000-01, tertiary enrolment ratio for females was only one. The dramatic drop in the value of the ratio of both gross enrolment and net enrolment from primary to tertiary level is a major concern for the Government.

There are also differences in gross and net enrolment of males and females between rural and urban populations. Specifically, gross enrolment ratio (in 1994) for rural and urban males was given as 9.23 and 90.23 respectively.

The rising trend in enrolment and net ratio at primary and secondary levels may be due to the implementation of the new Education and Training Policy (ETP) that was adopted in 1994. Among other things, the policy focuses on increasing access to educational opportunities with enhanced equity, quality and relevance. As a follow up to ETP, a multi-year Educational Sector Programme (ESPD) with the long-term goal of achieving universal primary education by 2015, started its operations in 1997-98. Indeed, the implementation of ETP through the ESPD has enabled the Ethiopian education sector to undergo changes in its structure, content and quality during the past few years

(c) The Human Development Index

The Human Development Index (HDI) ranking shows the position of a country relative to other countries in the world, and is good measure of development performance. Ethiopia's HDI ranking was 172 in 1997 and 170 in 2002.

On the other hand, the lowest and highest HDI value was 0.298 in 1997 and 0.359 in 2002. It is important to note that the Index has been increasing over the years. Compared to other countries in the region, however, it is still very low and, therefore, calls for appropriate development policies and strategies.

(d) Agriculture

Agricultural growth provides important basis for general economic growth as well as employment creation. Ethiopia is one of the countries in the continent that was in the past, affected by food shortages due to high population growth; too much dependency on the agricultural sector; erratic patterns of rain; and poor policies among others. Despite its dominant role in the national economy, the agricultural sector continues to experience several structural problems including:

- Poor road infrastructure which could link food surplus areas with food deficit areas
- Inadequate local marketing arrangements
- Poor purchasing powers of the local population
- Backward production techniques; and
- Recurring natural disasters like lack of rains

Table 1.1 provides trends in the production of cereals (teff, maize, barley, wheat and sorghum) for the period 1994-7. Teff production is shown as 18.6 million quintals in 1994-95 and 20 million quintals in 1996-97, an increase of only 1.4 million quintals. Yet, it is the basic food for most Ethiopians.

Table 1.1: Trends in Production of Cereals (Teff, Maize, Barley, Wheat and Sorghum) for the period 1994-97

Indicator	Year	Value (Million Quintals)
Cereals	1994-95	58.5
	1995-96	107.4
	1996-97	86.3
Teff	1994-95	18.6
	1995-96	31.1
	1996-97	20.0
Maize	1994-95	13.6
	1995-96	17.2
	1996-97	25.3
Barley	1994-95	9.4
	1995-96	18.1
	1996-97	7.4
Wheat	1994-95	7.3
	1995-96	11.2
	1996-97	10.0
Sorghum	1994-95	7.0
	1995-96	17.9
	1996-97	20.1
Pulse	1994-95	7.9
	1995-96	8.7
	1996-97	3.3

Source: OPHCC (1994 Census)

Table 1.2 provides percentage contribution of agriculture to GDP. It appeared to have stabilised at about 50 percent over the period 1985-86 to 1996-97. This is a worrisome trend given that agriculture is the mainstay of the economy. A constant contribution to GDP growth also indicates a slow down of the general economic growth.

Table 1.2: Percentage Contribution of Agriculture to GDP (1985-86 to 1996-97)

Agricultural Year	Percentage Contribution of Agriculture to GDP
1985-86	50.0
1986-87	51.4
1987-88	50.5
1988-89	50.0
1989-90	50.9
1990-91	56.0
1991-92	56.4
1992-93	53.4
1993-94	50.6
1994-95	50.0
1995-96	51.5
1996-97	50.4

Source: MOFED

Table 1.3 gives the annual growth rate of agricultural production for the period 1987-88 to 1996-97. It is interesting to note that negative growth was observed over a number of years. For example, the negative growth of 21.0 in 1991-92 coincided with a period when there was an acute food shortfall in the county. On the other hand, in 1995-96, there was a positive growth of 31.8.

Table 1.3: Annual Growth Rate of Agricultural Production (1987-88 to 1996-97)

Agricultural Year	Annual Growth Rate of Agricultural Production
1987/88	-4.3
1988/89	-2.3
1989/90	8.1
1990/91	-1.0
1991/92	-21.6
1992/93	9.1
1993/94	3.9
1994/95	16.0
1995/96	31.8
1996/97	3.2

Source: CSA (computed)

1.2 Macro-Economic Situation

1.2.1 Production (GDP, Economic Growth, Policies)

Ethiopia remains one of Africa's poorest countries with very low income per capita and a population that is almost two thirds illiterate. The growth rate of real total GDP was 3.0 percent between the period 1980-81 and 2000-01. However, during the same period, annual population growth was 2.9 percent, implying a 0.1 percent annual growth per capita income.

Agriculture accounted for 45 percent of GDP and more than 80 percent of the exports, and employed 85 percent of the population. The major export crop is coffee which provides 35 percent of foreign exchange earnings. Other traditional major agricultural exports are pulses, oilseeds, khat, meat, hides and skins and sugar. Industry, on the other hand, accounted for about 11 percent of the GDP where the main products included textiles, processed food, construction, cement and hydroelectric power. Thus, Ethiopia is dependent on few vulnerable crops for foreign exchange earnings, a situation which the government is trying to address by introducing stringent import controls.

Trade from the 2002 figures indicate that exports brought US\$ 451 million into the economy while imports consumed about US\$ 1.8 billion. Remittances were estimated at US\$ 400 million⁵. Thus, there is a huge gap which should be addressed. This implies that the largely subsistence economy is unable to meet the budget requirements for drought relief, an ambitious government development plan and the indispensable imports such as fuel.

⁵ Bureau of Africa Affairs, US Department of State

Since the fall of the Derg regime in 1991, the government has embarked on serious economic reforms including the privatisation of state enterprises and the rationalization of government regulations. Specific notable changes include the elimination of price controls, removal of private sector restrictions and the reduction of tax rates. Other reforms include the introduction of the value added tax in January 2003; reforming the import tariff regime; increasing the tax base and revenues collected; introduction of flexible interest and exchange rates that are market oriented; redirecting national spending from military to social sectors such as health, education, sanitation and poverty reduction. In 2002, Ethiopia suffered a terrible drought that resulted in a significant increase of the food crises. The effects of the drought were so severe that the country had to rely on food aid from international donors. The permanent solution to perennial drought in the country is yet to be addressed.

Table 1.4 gives the trend of GDP annual growth rate for the period 1975-2002. It is noted that for the period 1990-2001, a constant growth rate of 2.4 percent was realised. There was, on the other hand, a negative growth rate of 0.4 percent in the period 1975-1998. It is useful to note that the negative growth occurred when Ethiopia was following socialist policies.

Table 1.4: Gross Domestic Product (GDP) Annual Growth Rate (Percentage); 1975-2002

Year	Value
1975-1997	-0.4
1975-1998	-0.4
1975-1999	-0.3
1975-2000	0.1
1975-2001	0.2
1990-1999	2.4
1990-2000	2.4
1990-2001	2.4
1990-2002	2.3

Sources: Human Development Report (HDR) 1999, 2000, 2001, 2002, 2003, 2004

1.2.2 Communication

Ethiopia has a network of internal telephones and is also linked to international telecommunications. With the recent liberation of mobile telephone technology, communication has become very efficient and reliable. However, there are still a number of controls which, if removed, will make communication even more efficient. The state still controls the radio and television. However, since the adoption of free market policies, the print media has undergone significant changes..

1.2.3 Infrastructure/Transport (Roads)

Ethiopia is a landlocked country that currently relies on Djibouti for almost all of its international trade. The main capital city, Addis Ababa, and other towns are connected to Djibouti by rail and road. In 2000, the road network was estimated at 31,571 kilometres, with only 12 percent (3,789 km) paved while the balance - 27,782 km - remains unpaved (*The World Fact Book*).

Compared to the neighbouring countries of Sudan and Somali, Ethiopia is mountainous and therefore, is quite expensive to develop an extensive road network. With regard to air transport, the Ethiopian Airlines is one of the oldest airlines in Africa and has currently 38 domestic airfields and 42 international destinations.

1.2.4 Development Assistance

Table 1.5 below shows medium term resources envelop for the financial years 2002-03 to 2004-05.

Table 1.5: Forecast of Revenue and Grants; 2002-03, 2003-04 to 2004-05 (in Million Birr)

Item	2002/03	2003/04	2004/05
	Budget	Forecast	Forecast
Total Revenue	15,189.0	16,795.5	18,790.5
Domestic Revenue	12,441.0	14,095.7	16,193.8
Grants	2,748.0	2,699.8	2,596.7

Source: SDPRP, July 2002

The Government uses the Macro-Economic Fiscal Framework (MEFF) tool to identify resources required for developmental purpose. The projections for the MEFF are estimated on the basis of assumptions about domestic resource mobilization and inflow of external resources. In the financial years 2002-03 for example, total revenue was 15,189 million Birr of which 12,441 million Birr was expected from domestic sources, most it from tax revenue. Thus, the balance of 2,748 million Birr was expected from external resources in terms of grant-in-kind or earmarked and counterpart fund grant.

Analysis of the MEFF indicates that revenue from domestic resources is expected to rise over the period and is estimated at 16,790 million Birr in the financial year 2004-05. However, external support is estimated to decline slightly to 2,596.7 million Birr in the same period, which indicates improvements in tax collection and picking up of the economy.

Tables 1.6 and 1.7 give the external development assistance provided to Ethiopia since 1996. Total development assistance in 1996 was US\$ 9.3 million and by 2003, the amount had risen to US\$ 31.5 million. The expectations and demands contained in the SDPRP suggest that development assistance is likely to increase.

Table 1.6: External Development Assistance provided to Ethiopia (US\$,000)

Year	Value
1996	9,269
1997	9,269
1998	20,284
1999	29,130
2000	29,130
2001	22,209
2002	24,731
2003	31,512

Sources: The State of World Population 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003

Table 1.7: Net ODA Disbursement in Million US\$

Year	Value
1991	1,097.0
1992	11,77.4
1997	637.0
1998	647.5
1999	633.4
2000	693.0
2001	1,079.8
2002	13,06.7
2000	693.0

*Source: Human Development Report (HDR) 1999, 2000, 2001, 2002, 2003, 2004
The State of the World's Children 2003*

Net disbursement from Official Development Assistance has shown an upward trend since 1991 of approximately US\$ 1,097 million. However, the amount was lowest in 2000 - approximately US\$ 693 million. The per capita of ODA was also lowest in 2000 at US\$ 11, while the amount in 1992 was US\$ 23.4, which is particularly significant because that is about the time the new government took over from the previous communist regime.

1.2.5 Debt Burden

High servicing of debt slows down the economy of any developing country. In Ethiopia, the total debt service as a percentage of GDP has been high over the years. Table 1.8 gives total debt service as a percentage of the GDP for the period 1986-87 to 1996-97. The debt burden for example, stood at 92 percent, 82.3 percent and 71.6 percent in the financial years 1993-94, 1994-95 and 1995-96 respectively.

Ethiopia is currently seeking debt relief from Paris Club Creditors and from other bilateral and commercial creditors. Hence, there are efforts within the SDPRP (the equivalent of PRSP) to enable the country qualify for relief through the HIPC initiatives.

Table 1.8: Total Debt Service as Percentage of GDP

Year	Value
1986-87	37.7
1990-91	39.4
1991-92	31.8
1992-93	71.9
1993-94	92.0
1994-95	82.3
1995-96	71.6
1996-97	64.4
Note: the above values are External Debts as Percent of GDP	
1990	2.7
1999	2.5
2000	2.2
2001	2.9
2002	1.8

*Sources: Common Country Assessment (CCA)
Human Development Report (HDR) 2004*

1.3 Development Frameworks

The Federal Democratic Republic of Ethiopia is using a number of development frameworks including the SDPRSP, the MDGs and CCA/UNDAF.

1.3.1 Sustainable Development and Poverty Reduction Programme (SDPRP)

The fundamental development objective of the Government is to reduce poverty and build a free-market economic system that can ensure the following:

- Rapid economic development
- Less dependence on food aid
- That poor people become the main beneficiaries of economic growth

The SDPRP provides a broad picture of the on-going strategies for addressing poverty issues. It also identifies major development challenges. The principal objective of the SDPRP is to reduce poverty by ensuring macro-economic stability. The specific targets and objectives are to ensure⁶ the following:

- Poverty head count ratio declines by about 10 percent by 2004-05 from its 1999-2000 level of 44 percent
- Achieve an average of 7 percent growth rate of GDP during the period
- Achieve adequate commitment by the government to work towards meeting the Millennium Development Goals by 2015
- Improvements in institutional efficiency, ensuring poverty rights, maintaining peace and stability, and improving the function of public services
- Reduction of the deficit, by use of fiscal policy, to a sustainable level while at the same time re-orienting investment and current spending towards key sectors such as agriculture
- Commitment to enhancing efficiency and effectiveness in the financial sector
- An average growth rate of 7.7 percent in agricultural sectors, though giving more emphasis to the transformation of the rural economy

The main strategies during the sustainable development programme include the following:

- Focus on agriculture, which is a source of livelihood for 85 percent of the population
- Strengthen private sector growth and development, especially in industry as a means of achieving off-farm employment and output growth
- Rapid export growth through production of high value agricultural products and increased support to export oriented manufacturing sectors particularly intensified processing of high quality skins, leather and textile garments
- Undertake major investment in education and strengthen the on-going effort on capacity building to overcome critical constraints to implementation of development programmes
- Deepen and strengthen the decentralization process by shifting decision-making closer to the grass root population to improve responsiveness and service delivery
- Improvements in governance to move forward in the transformation of society, improve empowerment of the poor and set frameworks that provide an enabling environment for private sector growth and development

⁶ SDPRP, (MOPED, 2002)

1.3.2 United Nations Development Assistance Programme (UNDAF)⁷

The UNDAF document is a reflection of the consensus reached through discussions among all stakeholders who include UNCT, government, donors, non-governmental organizations, as well as non-resident UN agencies. It is a key instrument in implementing the Secretary General's reform programme, and an advocacy tool for the UN agencies in their operations with the Government of Ethiopia.

The programme circle for the current UNDAF is three years and is expected to end in 2005. The UNDAF goal is "Contributing Towards Reducing Absolute Poverty in Ethiopia" (the UNDAF document). The six thematic areas include:

- Sustained economic growth
- Productive employment
- Food security and sustainable agricultural development
- Access to basic social services
- Good governance; and
- HIV/AIDS

Besides the six thematic areas, a number of crosscutting issues include:

- Promoting gender equality and equity, and the advancement of women
- Encouraging globalisation through faster integration of the Ethiopian economy into the global economy
- Reducing the digital divide through information and communication technology; and
- Mainstreaming human rights perspectives in their broader context to encompass economic, social, civil, cultural and political dimensions

The UNDAF strategic framework has joint monitoring and evaluation mechanisms that aim at ensuring success in the objectives set out. The framework ensures that the UN system in Ethiopia strengthens its collaborative efforts towards achieving the MDGs. The framework provides the direction and greater convergence.

1.3.3 Millennium Development Goals (MDGs)

Among the primary development challenges of the Millennium Declaration - which was adopted by heads of state and governments in September 2000 - is the achievement of its eight major goals referred to as Millennium Development Goals, and its eighteen specific targets. Ethiopia is one of the countries that embraced the principles of MDGs as reflected in its Sustainable Development and Poverty Reduction Program (SDPRP) as seen in the table below.

⁷ UNDAF (UNCT) October, 2001

Table 1.9: Relationship: SDPRP Indicators and MDG Targets⁸

Welfare Component	Outcome/Indicator	National SDPRP Target and Indicators		MDG Targets
		Current Level	Target by 2004/05	
Poverty and Inequality	Poverty Headcount	P ₀ = 44.2 by 1999-2000	P ₀ = 40 by 2004-05	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day
Health	Under-five Mortality Rate	CMR = 167/1000	CMR = 160/1000 by 2005	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
	MMR	MMR = 500700/100,000 by 2000-01	MMR = 500-450/100,000 by 2004-05 and 300/100,000 by 2017	Reduce MMR by three-quarters between 1990 and 2015
Education	Gross Enrolment Ratio	GER (primary) = 57.4% by 2000-01	GER (primary) = 65% by 2004-05	Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
	Girls/boys ratio	Ratio of girls to boys students = 40.65% by 2000-01	Ratio of girls to boys students = 45% by 2004-05	Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education no later than 2015
HIV/AIDS	Transmission			
	Prevalence	7.3% by 2000-01	Contain prevalence at 7.3% by 2004-05	Halve by 2015 and began to reverse the spread of HIV/AIDS

* Only relevant welfare component issues reflected

Source: SDPRP document

Assessment of progress made in achieving the goals is monitored through the MDG Task Force composed of the Government and UN Country Team members. Due to the fact that MDGs are global and too general to fit into any country, the Task Force has translated these goals and targets into local context. The adoption of the MDGs in Ethiopia meant the following:

- Examining MDG indicators based on available data
- Ensuring consistency of the goals, policy context and time line
- Examining the government structure
- Determining the feasibility of targets in light of observed trends

The Task Force recently completed preparing its first MDG report. Among other things, the report reviews the basic issues and challenges facing the achievements of the goals and the targets. Specifically, the report examines how MDGs fit into the socio-economic conditions prevailing in Ethiopia; baseline information on MDGs focusing mainly on recent trends in key goals stipulated in generic MDGs; and preliminary costing of MDGs. It also addresses issues related to harmonization with existing policies, strategies and programmes; and identifying the MDG targets that are inconsistent with the SDPRP.

The SDPRP uses some MDG targets as benchmarks and indicators to monitor progress towards achieving the goals. Table 1.9 above shows relationships of some MGD targets and some selected welfare component issues in the SDPRSP document.

⁸ Millennium Development Goals Report, March 2004

By adopting the MDGs in the SDPRP document, the government has shown its full commitment in the achievement of the MDGs. Given the massive poverty in Ethiopia, the MDGs are indeed timely and relevant to the Ethiopian situation. Whether the MDG targets will be met is a question that depends on ensuring that national targets are implemented on the datelines set by government ministries and departments.

1.4 Environment

The current environmental policy in Ethiopia states as follows; “The overall goal is to improve and enhance the health and quality of life of all Ethiopians and to promote sustainable social and economic development as a whole so as to meet and use of natural resources, human made and cultural resources and the environment as well as to meet the needs of the present generation without compromising the ability of the future generations to meet their own needs”⁹

The extent of forest cover determines the amount of rainfall received in an area. The assumption is that African governments are striving to achieve at least more than 10 percent of forest cover. In 1990 and 2000, of the total land area, forested area in Ethiopia was 4.5 percent and 4.2 percent respectively (see table 1.10). Unless stringent measures are taken to halt the trend, the decline in forested land is likely to accelerate. In response to the challenge, the Government has identified three priority areas. These are to strengthen:

- On-going efforts to address the critical problem of land degradation with its attendant problems of deforestation, overgrazing, soil erosion, loss of soil structure and hydrological cycle disruption
- Regulatory and institutional capacity
- Measures to preserve, develop, manage, sustain and able use of biodiversity

Table 1.10: The Proportion of Land in Ethiopia Covered by Forest

Year	Proportion
1990	4.5
2000	4.2

Source: Millennium Development Goals (MDG Indicators)

The government is aware of the multi-sectoral nature of the environment and it has therefore made it very clear that all stakeholders have to be very sensitive to all issues pertaining to environment. For that, the Environmental Pollution Protections Authority (EPA) is expected to play a regulatory role and ensure that non-governmental and government departments comply with Environment Pollution Control proclamations.

The UNDP in Ethiopia supports the Government of Ethiopia in its environmental conservation efforts especially through the integration of conservation concerns in development initiatives. Specifically, it supports governmental efforts in Biodiversity Strategy and Action plans and the establishment of regional community-based banks that assist farmers to grow major crops as well as combat desertification.

⁹ SDPRP, (MOPED, 2002)

1.4.1 Water and Sanitation

Table 1.11 gives the proportion of population with access to safe water. There was an increase from 18 percent in 1996 to 23 percent in 2003, a dismal increase of 4 percent over a seven-year period. Large differences are observed between urban and rural populations. For example, in 1990, the percentage of rural population with access to water was 17 percent compared to 80 percent in urban areas (CCA). Such huge differences appear to be maintained over the years.

Table 1.11: Proportion of Population with Access to Safe Water

Year	Value (%)
1996	18
1999	26
2000	26
2001	24
2002	24
2003	23

Source: The State of World Population, 1996, 1999, 2000, 2001, 2002, 2003

The government policy is to promote efforts for efficient and equitable distribution of the existing water. To realize the overall goal, the Government has put forward a number of water management policy objectives. The most important of these include conserving, protecting and enhancing water resources and aquatic environment on sustainable basis; and to develop the country's water resources for economic and social benefits for its people.

The proportion of population in rural areas with sustainable access to improved sanitation was 5.7 percent in 1998-2000 compared to 55 percent in urban areas. Except for Addis Ababa and a few other urban centres, sanitation facilities are almost non-existence in Ethiopia. Concerned with this grave situation, the government formulated a water resources management policy and put forward specific goals, strategies and targets.

There are also a number of water strategy components that include water resource development; water resource management; and creating an enabling environment for financing and the participation of stakeholders; etc.

To specifically address water related problem, Ethiopia recently finalized a water sector development programme which consists of projects related to water supply and sanitation, irrigation and hydropower.

1.4.2 Data for Development

Ethiopia's data for development may be divided into three major categories: nationwide official data, independent quantitative sources and qualitative data collection and analysis. The major sources of population and socio-economic data are:

- Population and housing census
- Demographic and health surveys
- Welfare monitoring surveys
- Household income and expenditure surveys
- Labour surveys
- Health information system
- Agricultural census

Data from all sources has been harnessed to assess achievement of SDPRP, MDGs, NEPAD and other national frameworks. The required data, however, is limited both in scope and coverage

and is subject to many missing values. It should be mentioned that monitoring and analyses of MDG targets are only as good as the data available. To address the problem of data limitation, the Government has produced the document "The Medium Term National Statistical Programme for Ethiopia, 2003-04 to 2007-08". The objective of preparing the document is to take stock of the existing data and prepare plans for generating relevant and reliable data for monitoring progress in SDPRP and MDGs.

The main concerns for data include: human resource development and utilization; capacity building for population programme management; basic data collection, analysis and dissemination, research and policy studies; monitoring and evaluation of population programmes.

Selected SDPRP welfare monitoring data are given below:

Source	Survey/Type	Ref. Year	Coverage	Reporting Levels	Institutions Responsible
A: Nationwide Official Data					
Welfare Monitoring Survey	Cross-section household data	1995-96, 1997, 1998, 2000-01	Nationally representative	National, Regional, Zonal, Urban/Rural	CSA, WMU
Household Income Expenditure Survey	Cross-section household data	1995-96, 2000-01	Nationally representative	National, Regional, Zonal, Urban/Rural	CSA, WMU
Demographic and Health Survey	Cross-section household data	2000	Nationally representative	National, Regional, Zonal, Urban/Rural	CSA
Census	Household and individual data	1994	National	National, Woreda, down to enumeration areas	CSA
Data from Health Sector Development Programme	Administrative reporting	Yearly	National	National and Regional	Ministry of Health
Data from Education Sector Development Programme	Administrative reporting	Yearly	National	National and Regional	Ministry of Education
Agricultural Sample Census	Household and individual data	2001-02	National	National, Regional and Woreda	CSA
National Labour Force Survey	Cross-section household data	1999	National	National, Regional, Urban/Rural	CSA
Independent Quantitative Sources					
Ethiopian Rural Household Survey-Sub-Sample	Panel household data	1994, 1995, 1997, 1999, 2000	15 villages	Selected villages (reflecting livelihood diversity)	Economic Department, AAU with Oxford University
Ethiopian Urban Household Survey – Sub Sample	Panel household data	1994, 1995, 1997, 1999	10 major towns	Main towns	Economic Department, AAU with Oxford University
Quantitative Data Collection and Analysis					
Participatory Poverty Assessment	Multiple qualitative methods	1997	10 specific communities (6 rural and 4 urban)	Diverse communities, but not statistically representative	World Bank in collaboration with Government
Consultation with the Poor	Multiple qualitative methods	2000	10 specific communities, (drawn from Addis Ababa and two regional Woreda)	Diverse communities, but not statistically representative	Forum for Social Studies/World Bank

Source: SDPRP document

CHAPTER 2

POPULATION

2.1 Population Characteristics (Distribution by Sex, Age, Density, etc)

(a) Population Size and Distribution:

The 1994 Population and Housing Census gave Ethiopia's total population as 53.1 million. Table 2.1 gives the estimated 1997 population distribution by sex, region, urban and rural. It is observed that there is almost equal proportion of males and females.

Table 2.1: Total Estimated Population (1997) and its Distribution by Sex

Region	Urban			Rural			Total			Population Density
	Male	Female	Total	Male	Female	Total	Male	Female	Total	
Tigray	214,066	254,412	468,478	1,328,099	1,339,690	2,667,789	1,542,165	1,594,102	3,136,267	62.6
Affar	41,708	38,160	79,868	559,297	421,408	980,705	601,005	459,568	1,060,573	-
Amara	577,192	688,123	1,265,315	6,370,354	6,198,628	12,568,982	6,947,546	6,886,751	13,834,297	86.9
Oromiya	953,435	1,016,653	1,970,088	8,417,793	8,344,644	16,762,437	9,371,228	9,361,297	18,732,525	53.1
Somali	231,462	205,573	437,035	1,513,302	1,248,177	2,761,479	1,744,764	1,453,750	3,198,514	-
Benishangul-Gumuz	17,938	18,089	36,027	215,075	209,357	424,432	233,013	227,446	460,459	9.3
S.N.N.P.	351,579	353,239	704,818	4,810,208	4,862,002	9,672,210	5,161,787	5,215,241	10,377,028	92.4
Gambella	14,629	12,795	27,424	78,273	76,165	154,438	92,902	88,960	181,862	7
Harari	37,449	38,929	76,378	28,101	26,660	54,761	65,550	65,589	131,139	421.3
Addis Ababa	1,008,928	1,075,660	2,084,588	14,524	13,625	28,149	1,023,452	1,089,285	2,112,737	3985.2
Dire Dawa	86,419	86,769	173,188	40,867	37,809	78,676	127,286	124,578	251,864	207.6
Total	3,534,805	3,788,402	7,323,207	23,375,893	22,778,165	46,154,058	26,910,698	26,566,567	53,477,265	

Source: OPHCC (1994 Census)

In terms of population size in 2004, Ethiopia was third in the African Continent behind Nigeria (137 million) and Egypt (76 million).

There are large differences among regions. Table 2.2 shows the 2000 population projections and gives the most populous region as Oromiya which had a population of about 22.4 million (or 35 percent). The smallest region, Benishangui-Gumuz, had a population of 0.5 million (0.86 percent).

**Table 2.2: Total Population of Ethiopia by Sex, Region, Urban, Rural, July 2000
(in Thousands)**

Region	Urban			Rural			Total Country		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Tigary	306	316	622	1,511	1,561	3,072	1,817	1,817	3694
Affar	56	43	99	626	491	1,117	682	534	1216
Amara	841	839	1,680	7,316	7,299	14,615	8,157	8,138	1,6295
Oromiya	1,322	1,326	2,648	9,838	9,868	19,706	11,160	11,194	2,2354
Somali	303	257	560	1,698	1,440	3,138	2,001	1,697	3,698
Benishangul-Gumuz	24	23	47	247	243	490	271	266	537
S. N.N.P	476	482	958	5,743	5,814	11,557	6,219	6,296	12,515
Gambela	18	18	36	89	86	175	107	104	211
Harari	49	48	97	32	31	63	81	79	160
Addis Ababa	1,202	1,293	2,495	0	0	0	1,202	1,293	2,495
Dire Dawa	115	114	229	45	44	89	160	158	318
Total	4,712	4,759	9,471	27,145	26,877	54,022	31,857	31,636	63,493

Source: OPHCC (1994 Census)

Ethiopia is relatively less urbanized compared to other countries in the region. Table 2.3 gives the percentage of the urban population over a number of years. The urban population in 2002 was estimated at only 15.4 percent and a high rural population of about 85 percent. The annual urban growth was estimated at 4.8 percent and is projected to reach 19.8 percent by 2015.

Table 2.3: Percentage Urban Population

Year	Value
1975	9.5
1997	16.3
1998	16.7
1999	17.2
2000	15.5
2001	15.9
2002	15.4
2015	19.8
Note: The above population data for 2015 is projected medium variant population	
2000	15.5
2001	16.22
2001	16.0

Sources: Human Development Report (HDR) 1999, 2000, 2001, 2002, 2003, 2004
World Health Organization (WHO) Reproductive Health Indicators
United Nations Fund for Population Activities (UNFPA) Country Profile
The State of the World's Children 2003

The annual population recorded in 1994 dropped from 2.9 percent to about 2.7 percent in 2001 (CSA) Table 2.4 gives projected population for the periods 1995 - 2020 by sex. It is significant that Ethiopia's population is expected to hit the 100 million mark by the year 2018.

Table 2.4: Projected Total Population Size (in Thousands) by Sex and Year

Year	Total	Male	Female
1995	54,649	27,499	27,150
1996	56,372	28,344	28,028
1997	58,117	29,202	28,915
1998	59,882	30,071	29,811
1999	61,672	30,956	30,716
2000	63,495	31,858	31,637
2001	65,344	32,775	32,569
2002	67,220	33,707	33,513
2003	69,127	34,653	34,474
2004	71,066	35,618	35,448
2005	73,044	36,604	36,440
2006	75,067	37,615	37,452
2007	77,127	38,644	38,483
2008	79,221	39,691	39,530
2009	81,343	40,753	40,590
2010	83,483	41,826	41,657
2011	85,647	42,911	42,736
2012	87,839	44,009	43,830
2013	90,050	45,119	44,931
2014	92,283	46,239	46,044
2015	94,526	47,367	47,159
2016	96,795	48,508	48,287
2017	99,083	49,659	49,424
2018	101,382	50,817	50,565
2019	103,695	51,983	51,712
2020	106,003	53,145	52,858

Source: OPHCC (1994 Census)

Population density in 1990 and 2004 was given as 44 and 76 persons per sq.km respectively. Although there has been a steady increase, the density is still quite low compared to most countries in the region.

(b) Analysis of Age Structure and Dependency Ratio

Broad age groups referred to as young (0-14 years), middle (15-64 years) and old (65 and above) are given in Table 2.5 below and compared with similar age structures in Swaziland (from 1997 census) and USA (from the 2000 census).

Table 2.5: The 2002 Age Structure of Ethiopia, Swaziland (1997) and United States of America (2000) (Percent)

Category	Age Group	Ethiopia 1998	Swaziland 1997	USA 2000
Young	0-14	45.10	44.57	21.41
Middle	15-64	52.0	52.27	66.16
Old	65+	2.90	3.16	12.43
Dependency Ratio		96.0%	91.32%	51.16%

Sources: 1. Central Statistical Authority, Addis Ababa, Ethiopia
 2. Report on the 1997 Swaziland Population and Housing Census, Central Statistical Office.
 3. U.S. Census Bureau, Census 2000 Summary File 1:
<http://factfinder.census.gov/home/en/datanotes/expsf1u.htm>

From the table, it is clear that Ethiopia has a young age structure: broad at the base with 45.1 percent for those below 15 years and 52.0 for those aged 15-64 years, traditionally referred to as economically active population. The old age group (65 years and above) constitutes only 2.9 percent of the total population. As expected, this compares very well with the age structure in Swaziland. In contrast, we find typical old age structure in the USA, where only 21.41 percent of the population is below 15 years, 66.16 percent of the population aged 15-64 years and 12.43 percent aged 65 years and above.

The explanation for young age structures in Ethiopia and Swaziland and an old age structure in USA is given by Kamuzora (1988)¹⁰ - that Ethiopia and Swaziland have a broad base age structure of young ages because of they had a long past of periods of high fertility while USA has a broad base age structure of old age not because people live longer in the USA, but because of a fertility decline in the last hundred years.

The table also shows dependency ratios - the number of people supported by one hundred in the economically active age group (15-64 years). The dependency ratio for Ethiopia is rather high, about 96 compared to USA with only 51. On the other hand, the dependency ratio for Swaziland is somewhat similar to that of Ethiopia, which is about 91. This must, however, be treated with caution because in developing countries like Ethiopia, children cannot entirely be regarded as dependants since their contribution to economic and domestic activities cannot be ignored. It is important to note that dependency ratio affects the poverty status of the population. If the ratio increases by one unit, the probability of a household falling into the poverty trap is increased by almost 31 percent at mean values¹¹. Those households with more children and older people are particularly vulnerable to falling into poverty.

(c) Household Size and Other Characteristics

The use of the household as a unit of enquiry permits aggregation of household information such as the size of the household. In the 1994 Population and Housing Census, a household was defined as consisting of one or more persons, related or unrelated, who made common provisions for food or other upkeeps of the household. The number of people living in a household determines the household size. Thus, average household size is calculated by dividing the number of persons by the total number of households in a particular area.

Given the high fertility patterns in the country, population household size in Ethiopia in 1994 was given as 4.8, up from 4.5 indicated in the 1984 census. The figure is comparable to other countries in the region which average about five persons per household. It should be mentioned that size has an effect on poverty at the household level. Research indicates that an additional household member increases the probability of being poor by about 3.2 percent at mean value. Furthermore, female-headed households face 8.9 percent higher probability of being poor in rural areas (*SDPRP, page 16*).

2.2 Population Dynamics (Trends)

One has to look at population growth in Ethiopia as the outcome of interplay between current and future fertility, mortality and migration on one hand, and population age structure on the other.

¹⁰ C.L Kamuzora (1988): Evaluation, Smoothing and Analysis of Age Structure: 1988 Census Analytical Report.

¹¹ Common Country Assessment, UNCT, 1999

2.2.1 Fertility

In the first half of the 21st century, the Ethiopia fertility level will be the key to understanding its long-term potential and the way age composition will evolve. However, like many other countries in sub-Saharan Africa, Ethiopia does not have a complete, reliable and accurate vital registration system. This problem has necessitated the use of demographic surveys and population censuses to collect data on lifetime and current fertility. The indices of fertility levels and trends used in Ethiopia are: average parities; total fertility rate (TFR); age-specific fertility rate (ASFR); age-specific birth order rate; relative age-specific fertility rate and crude birth rate (CBR). Although available estimates of the future course of fertility suggest a declining trend, the high levels of fertility are likely to be sustained until 2015 and beyond. The situation may, however, change if population programmes intensify their efforts in increasing contraceptive adoption among all the sexually active population.

The crude birth rate (CBR) is normally the first step towards estimating the fertility of a nation. It is defined as the ratio of the total births in a population for a specified period to the total number of person-years lived by the population during that period, with the assumption that the population is closed to migration and is experiencing constant age specific fertility and mortality rates. However, when mortality gradually declines without any change in fertility, the population loses its stability and becomes what is known as a 'quasi-stable' population. Table 2.6 gives CBR for the whole country based on the 1984 and 1994 population and housing census. In the period 1995–2000, CBR was calculated as 45.6 per 1,000. In 2000-05, the CBR was 46.7. Based on the 1994 census, the CBR was estimated to decline from 39.90 in 2000–05 to about 30.58 in 2015–20.

Table 2.6: Crude Birth Rate per 100,000 Population (1984 and 1994 Censuses)

Year	Value
Projected CBR (1984)	
1985-90	46.1
1990-95	45.5
1995-2000	45.6
2000-05	46.7
2005-10	45.5
2010-15	43.2
2015-20	40.4
Projected CBR (1994)	
1995-2000	44.17
2000-05	39.90
2005-10	36.89
2010-15	33.62
2015-20	30.58
2020-25	27.51
2025-30	24.63

Source: OPHCC (1984 and 1994 Censuses)

Like other African countries, Ethiopia has experienced high fertility rates in the past.

The total fertility rate (TFR) is defined as the number of children a woman would have by the end of her child bearing years if she were to pass through those years bearing children at the observed age-specific fertility rates. This measure has an advantage that it is not affected by the age structure of the population like CBR. Table 2.7a gives the TFR trends for the period 1978–2002, for which several indirect techniques were used to calculate the values. It is noted that for the whole period, TFR for the whole country remained at more than 6.2, and therefore

fertility in Ethiopia remains the dominant factor dictating the future size, growth and composition of the population in the country.

Table 2.7a: Total Fertility Rate (1978-2002)

Year	Value
1978	6.8
1998	6.3
1990	6.9
2000	6.8
1991	6.9
2001	6.8
1992	6.8
2002	6.2

Source: Total World Health Report (1999, 2001, 2002, 2003 reports)

Table 2.7b: Demographic Characteristics by Main Regions

	Infant Mortality Total per 1,000 live births	Life Expectancy M/F	Births per 1,000 women aged 15-19	Contraceptive Prevalence any method	Modern Methods	Total Population (millions) 2004	Projected Population (millions) 2004	Average Population Growth Rate (%) (2000-2005)	% Urban 2003	Urban Growth Rate (2000-2005)	Total Fertility Rate (2000-2005)
World Total	56	63.3/67.6	50	61	54	6,377.6	8,918.7	1.2	48	2.1	2.69
More Developed Regions	8	72.1/79.4	27	69	55	1,206.1	1,219.7	0.2	75	0.5	1.56
Less Developed Regions	61	61.7/65.1	53	59	54	5,171.5	7,699.1	1.5	42	2.8	2.92
Less Developed Countries	97	48.8/50.5	124			735.6	1,674.5	2.4	27	4.3	5.13
Africa	89	47.9/50.0	107	27	20	869.2	1,803.3	2.2	39	3.6	4.91
Eastern Africa	97	42.4/43.8	117	22	17	276.2	614.5	2.2	26	4.3	5.61
Middle Africa	116	41.6/43.8	200	23	5	103.4	266.3	2.7	37	4.1	6.28
Northern Africa	49	64.5/68.2	36	47	42	187	306	1.9	50	2.7	3.21
Southern Africa	52	43.9/49.1	66	53	51	51.9	46.6	0.6	54	1.5	2.79
Western Africa	90	49.0/50.3	119	15	8	250.6	569.9	2.6	42	4.2	5.56

Source: State of World Population 2004

The projections however, indicate significant drops. For example, TFR estimates for 2025–30 are given as 3.32. Compared to the estimated value of 6.8 in 2001, the drop is significant and if achieved, it may greatly impact on general economic growth. In general, the high fertility levels are major detriments of fast growth of any country and, therefore, the expected significant declines during the later part of this century are encouraging.

Comparisons with other countries indicate that more efforts have to be taken to reduce the fertility levels in Ethiopia. Global TFR is given as 2.69 as compared to 4.91 for Africa in the period 2000–05. On the other hand, TFR for the countries of Eastern Africa (where Ethiopia is situated) is given as 5.61 (see Table 2.7b). The differences are significant and hence the need for developing countries, including Ethiopia, is to review past policies with the aim of reducing the high fertility levels.

The macro-economic impact of high fertility is that it impedes development. Studies have indicated that fertility impact on a family's poverty in several ways.

- Smaller families share income among fewer people, and average income per capita increases
- Fewer pregnancies lead to lower maternal morbidity and mortality, and also to better education of children
- Families with lower fertility are better able to invest in the health of children

Place of Residence and Fertility

Urbanization is significantly correlated with fertility. In general, low levels of fertility are often associated with high levels of urbanization and vice versa.

There are major differences in TFR between urban and rural areas in the country. For example, in 1994, the TFR in urban and rural areas was given as 4.50 and 7.19 respectively (*OPHCC, 1991*). Furthermore, there are huge variations among regions with Oromiya having the highest TFR of 7, and Addis Ababa with a TFR of 2. Table 2.8 below gives the 1994 Age Specific Fertility Rates (ASFR). The ASFR determines the overall TFR.

Age Group	ASFR		
	Urban	Rural	Total
15-19	0.022	0.053	0.047
20-24	0.095	0.172	0.157
25-29	0.136	0.203	0.192
30-34	0.132	0.183	0.176
35-39	0.097	0.157	0.148
40-44	0.046	0.088	0.082
45-49	0.031	0.066	0.061

Source: OPHCC (1994 Census)

2.2.2 Mortality Levels and Trends

Mortality contributes to population change by affecting the number of people who exit a population. Put simply, if the number of deaths is greater than the number of births, the size of Ethiopia's population will decrease (this obviously assumes no migration effects). Measures for

mortality include Crude Death Rate (CDR) and Age Specific Death Rate (ASDR). Other measures include Infant Mortality Rate (IMR) and Under-five Mortality (U5MR).

The Crude Death Rate (CDR) is a crude measure of overall level of mortality in a given population usually obtained by dividing the number of reported deaths occurring in a calendar year by the mid-year population. The calculated value is the level of mortality per 1,000 persons. Table 2.9 gives Ethiopia's CDR projected trends (based on 1984 and 1994 census) for the periods 1995- 2000 to 2025-30). It is important to note that there is a significant drop in CDR projected for the period 2010-15, which is given as 10.10 compared to the 16.20 projected for the period 1995-2000.

Table 2.9: Projected Crude Death Rate 1995-2000 to 2025-30

Year	Value
1995-00	16.20
2000-05	13.70
2005-10	11.80
2010-15	10.10
2015-20	8.70
2020-25	7.50
2025-30	6.50

Source: OPHCC (1994 and 1999 Censuses)

There are also major differences in CDR between rural and urban areas. The 1984 census gives 9.2 as CDR in urban areas while it is given as 5.7 in rural areas.

Age Specific Death Rates (ASDRs) are obtained by dividing the number of deaths by age to the total population of that particular age and 1,000 multiply the result. As observed in other countries, mortality trends in Ethiopia are quite high in the first years of life, declines rapidly as age increases reaching its lowest levels between ages 10 and 19 before it starts to increase.

Based on the different approaches that have been applied, and taking into account the fact that reported deaths are grossly misreported, it is evident that levels of mortality for Ethiopia have declined slightly though they are still high.

Tables 2.10 and 2.11 give the trends of infant and under-five child mortality rates. There has been a decline in IMR from 128 observed in 1990 to 100 projected for 2003. For the under-five mortality, the decline was from 193 in 1990 to 171 in 2002. The decline of infant and child mortality is quite significant and may be attributed to the improved provision of health services and expanded coverage of the immunization programme.

Table 2.10: Infant Mortality Rate per 1,000 Live Births

Year	Value
1995-2000	110
1990	128
1996	107
1997	107
1998	107
1999	116
2000	116
2001	116
2002	106
2003	100

*Sources: Common Country Assessment (CCA)
Millennium Development Goals (MDG) Indicators
The State of World Population 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003
World Health Organization (WHO) Reproductive Health Indicators*

Table 2.11: Under Five Mortality Rate per 1,000 Live Births

Year	Value
1995-2000	161.1
1990	193.0
1997	175.0
1998	173.0
1999	176.0
2000	174.0
2001	172.0
2002	171.0

*Sources: Common Country Assessment (CCA)
Millennium Development Goals (MDG) Indicators
Human Development Report (HDR) 1999, 2000, 2001, 2002, 2003, 2004*

Life Expectancy

Life expectancy at birth is defined as the average number of years a group of people born in the same year can be expected to live if mortality at each age remains constant in the future.

Table 2.12 shows life expectancy for the period 1997 to 2005. Life expectancy recorded slow rise from 43.3 years in 1997 to 45.5 years in 2002. Although there are improvements in quality of life and a decline in major diseases, the high HIV/AIDS prevalence rate may have been the main cause for the slow increase of life expectancy in Ethiopia. The Age Specific Deaths Rates pattern for females especially among those in the age group 15-44 tends to suggest that HIV/AIDS may have been the cause for the slight fall in life expectancy.

Table 2.12: Life Expectancy at Birth

Year	Value
1997	43.3
1998	43.4
1999	44.1
1995-2000	44.5
2000	43.9
2001	45.7
2002	45.5
2000-2005	45.5

*Sources: Human Development Report (HDR) 1999, 2000, 2001, 2002, 2003, 2004
World Health Report 2002, 2003
United Nations Fund for Population Activities (UNFPA) Country Profile*

Table 2.13 provides trends of projected life expectancy based on the 1994 census figures. Full implementation of current population programmes and the expected achievements of the main MDGs, including reduction of HIV/AIDS incidences, will contribute to a steady increase of life expectancy over the coming years. As indicated on the table, life expectancy in the period 2005–10, is projected to be 57.93 years and is expected to rise even further to 67.65 years in the period 2025–30.

Table 2.13: Projected Life Expectancy at Birth (2005-30)

Year	Value	
	Male	Female
1995-00	50.92	52.96
2000-05	53.42	55.43
2005-10	55.91	57.93
2010-15	58.37	60.42
2015-20	60.83	62.89
2020-25	63.13	65.34
2025-30	65.13	67.65

Sources: OPHCC (1994 and 1999 Censuses)

Regional and Sex Differentials in life expectancy

There are significant differences in life expectancy at birth between males and females. In 1997, life expectancy at birth was given as 42.4 for males and 44.3 for females (HDR, 2002). As expected, mortality rates are slightly lower among females than for males. Comparatively, life expectancy for Africa in 1990 and 2002 was given as 51 and 52 respectively. On the other hand, life expectancy in Sub-Sahara Africa in 1993 and 2002 was given as 50.9 and 46.3 respectively. Ethiopia's neighbouring countries are no different. Life expectancy in Eastern Africa was given as 42.4 in 2003 for males and 43.8 for females¹².

¹² State of World Population 2003 and 2004

2.2.3 Migration and Urbanization

In the past, Ethiopia experienced both international and internal migration. International migration, although minimal, was basically fuelled by economic hardships arising from conflicts in the past. Internal migration on the other hand, was driven by rural-urban migration caused by extreme poverty, especially from the long spells of drought in some parts of the country.

Table 2.14 gives trends in urbanization since 1975 and the projections to 2015. Urbanization will be about 20 percent in 2015. The growth shown is quite modest, almost growing at the rate of rural areas in some countries.

Table 2.14: Urbanization in Ethiopia

Year	Urbanization (%)
1975	9.5
1997	16.3
1998	16.7
1999	17.2
2000	15.5
2001	15.9
2002	15.4
2015	19.8

Sources: Human Development Index 1999 – 2004

Urbanization creates problems for urban planners. The Ethiopian rural-urban migration poses several problems including: poor urban management, lack of infrastructure and inadequate service delivery. The heavy population in urban areas has contributed to the deterioration of the urban infrastructure and services. The low levels of income and low levels of investment have also resulted in high unemployment. To address these problems, the government, through the Urban Management Capacity Building Programme, is currently focusing on urban governance, infrastructure provision in housing, etc.

Measures aimed at urban governance include:

- Formulation of urban development strategy
- Design urbanization strategy
- Mobilization of efficient management of city and municipal financial resources
- Strengthening urban planning management skills
- Improvements in delivery of municipal services

On the infrastructure, issues of focus include:

- Up-grading the existing old and dilapidated houses and infrastructure with full participation of the beneficiaries
- Awareness creation and networking in community involvement with regard to the construction and management of neighbourhoods level infrastructure
- Designing pilot infrastructure programs by which infrastructure standards and management approaches are experiments; constraining and improving various infrastructure such as markets, roads, drainage sewage systems

2.3 Implications of High Population Growth in the Country

2.3.1 National Population Policy

The rationale for the National Population Policy for Ethiopia is to harmonize the rate of population growth with economic development thereby improving the welfare of the people. More specifically, it is to address “demographic factors such as rapid population growth, young age structure and the uneven spatial distribution of the population fuelled by continuing high fertility regime that exacerbate severe state of underdevelopment in Ethiopia”. Thus, the major goal for the population policy is the harmonization of the rate of population growth and the capacity of the country for the development and rational utilization of natural resources to the end that the level of welfare of the population is maximized over time¹³.

The population policy aims at maintaining a balance between the size of population and the country's resource base. Thus, the policy focuses on the high fertility rates which include giving attention to the education status of women and high infant and child mortality. The general objectives of the policy are:

- Closing the gap between high population growth and low economic productivity through planned reduction of population growth and increasing economic returns
- Expediting economic and social development processes through holistic integrated development programmes designed to expedite the structural differentiation of the economy and employment
- Reducing the rate of rural to urban migration
- Maintaining/improving the carrying capacity of the environment by taking appropriate environmental protection
- Raising the economic and social status of women by freeing them from the restrictions and drudgeries of traditional life and making it possible for them to participate productively in the larger community
- Significantly improving the social and economic status of vulnerable groups (women, youth, children and elderly)

The specific targets in the policy include the following:

- Reducing the total fertility rate to 4 percent by 2015
- Increasing contraceptive prevalence rate use to 44 percent by 2015
- Reducing maternal, infant and child morbidity and mortality rates
- Significantly increasing female participation at all levels of education
- Removing all legal and customary practices militating against the full enjoyment of economic and social rights by women

In order to achieve the ambitious targets, the Government identified four major strategies, including:

- Improvements in the quality and scope of reproductive health service delivery
- Improving population research, data collection and dissemination
- Expansion and strengthening domestic capacity for training in population
- Expansion of IEC activities and social services

¹³ 1993, The National Population Policy of Ethiopia

Since its development, there are a number of new emerging issues that the next generation of policies should address. These include: reproductive health, HIV/AIDS (which is not mentioned anywhere in the document), STIs, TB and malaria.

2.3.2 Population Projections

The projections in Ethiopia are based on prevailing fertility rate and continuing mortality declines. Table 2.15 gives population projection from 1995 to 2020 by gender. Total population for Ethiopia will hit the 1,000 million mark in 2018, up from 71 million expected in 2004. For the sake of economic development, population growth should be seen in conjunction with productivity of capital, propensity to save and invest.

According to available evidence, there is abundance evidence that developing countries with lower fertility and slower population growth have higher productivity, more saving and more productive investment. In Ethiopia, it is observed that the large population will exert negative pressures on economic and social development; hence the Government should accelerate the rate of economic growth capable of coping with the inflated population.

Table 2.15: Projected Total; Population by Sex (1995 to 2020)

Year	URBAN + RURAL		
	Total	Male	Female
1995	54,649	27,499	27,150
1996	56,372	28,344	28,028
1997	58,117	29,202	28,915
1998	59,882	30,071	29,811
1999	61,672	30,956	30,716
2000	63,495	31,858	31,637
2001	65,344	32,775	32,569
2002	67,220	33,707	33,513
2003	69,127	34,653	34,474
2004	71,066	35,618	35,448
2005	73,044	36,604	36,440
2006	75,067	37,615	37,452
2007	77,127	38,644	38,483
2008	79,221	39,691	39,530
2009	81,343	40,753	40,590
2010	83,483	41,826	41,657
2011	85,647	42,911	42,736
2012	87,839	44,009	43,830
2013	90,050	45,119	44,931
2014	92,283	46,239	46,044
2015	94,526	47,367	47,159
2016	96,795	48,508	48,287
2017	99,083	49,659	49,424
2018	101,382	50,817	50,565
2019	103,695	51,983	51,712
2020	106,003	53,145	52,858

Source: OPHCC (1994 Census)

CHAPTER 3

REPRODUCTIVE HEALTH

3.1 General Health Situation

3.1.1 Infrastructure, Human Resources, Health Care Financing and Policies (Health Reforms, SWAP)

(a) *Infrastructure:*

Availability of adequate health facilities determines quality of services provided to a population of a country. According to the Health Sector Delivery Programme (HSDP), 55 percent of the population in Ethiopia lack access to health facilities that are within 10 kilometres of their home, and in some regions, access is limited to less than 11 percent of the population.

Table 3.1 below gives the growth of health types and number of health facilities over a five-year period. These include hospitals, health centres, health stations, health posts and staff.

Under the 1998 Health Sector Delivery Programme (HSDP), the health sector delivery system is being reorganized to a four-tier system:

- Primary health care units: Each is designed to serve 2,500 people and mainly focus on maternal and child care, immunization, family planning services, nutritional health and micronutrient supplements
- District hospitals: These are designed to cater for a population of 250,000, and to receive referrals from PHCUs, provide support services for PHCUs, and train frontline nurses and midwives
- Zonal and specialized hospitals: These are designed to cater for a population of more than one million and will provide specialized care for patients referred from lower units.

(b) *Human Resources*

The situation of health personnel in the country appears to be inadequate. In 2003-03, there were only 2,032 physicians and 14,160 nurses expected to serve a population of 69 million (as per the estimated population in 2003). This translated to 34,000 persons per doctor and about 5,000 persons per nurse.

(c) *Pharmacies and drug outlets*

Accessibility to affordable essential drugs is an important measure of the health status of a nation. In 1999, 50–79 percent of the Ethiopian population had sustainable access to affordable essential drugs (*HDR 2001*). Thus, about half of the population have no access to essential affordable drugs.

Table 3.1: Health Facilities and Human Resources

Indicator	Year				
	1991	1992	1993	1994	1995
Number of Facilities					
Hospitals	100	103	110	115	119
Health Centres	304	356	382	412	451
Health Stations	2,268	2,330	2,393	2,452	2,396
Health Posts	1,012	833	1,023	1,311	1,432
Private Clinics	966	1,119	1,170	1,235	1,229
Pharmacies	272	304	311	311	302
Drug Shops	243	250	249	309	299
Rural Drug Vendors	1,858	1,950	1,917	1,856	1,888
Human Resources (at Service)					
Physicians	1,283	1,263	1,366	1,888	2,032
Health Officers	144	201	296	484	631
Nurses	5,498	6,713	7,723	12,838	14,160
Health Assistants	10,641	8,330	7,386	8,149	6,856
Para Medicals	1,989	2,201	2,758	3,824	4,641
Human Resources (Graduate)					
Specialists	46	58	61	91	103
General Practitioners	136	152	128	152	182
Health Officers	79	157	181	183	181
Nurses	1,416	1,399	2,164	1,562	1,465
Para Medicals	613	671	917	656	1,054

Sources: Health and Health Related Indicators 2002, 2003 (MOH)

(d) Expenditure on health

Table 3.2 gives the trend of public and private health expenditures in the country since 1996. It indicates that both public and private expenditure on health has not reflected a particular pattern of growth. For example, public expenditure as a percentage of GDP is given as 3.0 in 1996 which then declined to 1.4 in 2001. Also, the health expenditure per capita has not shown any aspect of growth over the years, only increasing from 11 in 1998 to 14 in 2001 (*HDR, 2002-03*).

The international community has a long history of earmarking assistance to Ethiopia for the health sector. Contributions from the international community have been increasing over the years from 9.3 percent in 1997 to 34.3 percent in 2001 (*World Health Report*). It is important to note that the increase has been quite significant.

Table 3.2: Public and Private Health Expenditures as Percentage of GDP

Year	Value
1990	1.0
1996-1998	1.6
1998	1.2
2000	1.1
2001	1.4
2002	1.3
2003	4.7

Sources: Human Development Report (HDR) 2000, 2001, 2002, 2003, 2004
The State of World Population 1996, 1997, 1998, 2001, 2002, 2003

These indicators point to the poor quality of health care systems in the country. Also, it reflects the non-availability of deliberate policies and strategies for increasing expenditures for the health systems. It is therefore important that Government emulates the international community and puts in place deliberate and specific policies and strategies that will ensure increased expenditures on health systems in all regions of the country.

3.1.2 General Health Situation

(a) Health and Life Expectancy

Measures of life expectancy at birth for both males and females are one of the most direct measures of health situation in any country. Table 3.3 gives the trend of Life Expectancy from 1997 to 2005. Also, the health situation can be captured by probability at birth of not surviving to age 40 and probability at birth of surviving to age 65. The probability of birth not surviving to age 40 was given as 42.3 in 1997 and 43.6 in 2000 (HDR 1999 and 2002). It is observed that there are slight differences between males and females. These are good indicators and give specific measurement of country's health situation. It is an indirect measure of the status of the health infrastructure and availability of skilled human resources such as doctors, nurses and midwives among others.

Table 3.3: Life Expectancy at Birth

Year	Number of Years
1997	43.3
1998	43.4
1999	44.1
1995-2000	44.5
2000	43.9
2001	45.7
2002	45.5
2000-2005	45.5
2000	47.5
2001	48.0
2002	48.0

Source: Human Development Index 1997 – 2005

(b) Maternal Health

Maternal mortality ratio is one of the most important measures of maternal health in a country. Table 3.4 provides trends of Maternal Mortality Ratio (MMR) per 100,000 live births in

Ethiopia since 1995 based on several sources. It is clear that regardless of sources of data, MMR is alarmingly high.

Several causes of death (before, during and after birth) have been identified and include:

- Before birth: Poverty, malnutrition (of the mother), health condition and diseases (measles, syphilis); drugs including tobacco;
- During birth: Maternal age (too young or too old); prolonged labour due to maternal age, FGM presentation mode, etc.
- After birth: Poverty and malnutrition of the child; diseases.

Table 3.4: Maternal Mortality Ratio per 100,000 Life Births

Year	Value
1995	700
1996	1,400
1995	1,800
1990	1,400
1985-2001	870
1985-2002	870
Note: The above values are the reported ones, but the 2004 report includes the following adjusted value	
1996	1,400
1998	1,400
1999	1,400
2001	1,800
2002	1,800
2003	1,193

*Source: Common Country Assessment (CCA), (MOH)
Common Country Assessment (CCA), (WHO/UNICEF)
Millennium Development Goals (MDG) Indicators
Human Development Report (HDR) 1999, 2003, 2004
World Health Organization (WHO) Reproductive Health Indicators
The State of World Population 1996, 1997, 1998, 1999, 2001, 2002, 2003
United Nations Population Fund (UNFPA) Country Profile*

It is, therefore, important that Government and the international community address all the identified problems through the formulation of appropriate programmes. In planning for health development, it is important to consider the population dimension. These may include reducing fertility levels through family planning interventions. These will greatly cut down on outlays for general preventive and curative medical facilities and facilities for mother and children. The wellbeing of mothers during pregnancy, delivery and shortly thereafter depends on the quality of care received, as well as the socio-economic conditions of the woman. Also, the health risks of such mothers are greatly reduced if the proportion of babies delivered under the supervision of health professionals is increased.

The Government is greatly concerned with addressing the following:

- Improved access to ante-natal care
- Improved access to post-natal care
- Increased access to quality reproductive health services by men, women and adolescents

- Reduced unsafe abortion
- Improved education of women
- Improved access to delivery of care
- Increased number of deliveries in health facilities
- Improved access to obstetric care by trained providers
- Discouraging the practice of female genital mutilation

(c) Attendance by Skilled Personnel

Attendance by skilled personnel to health seeking persons is a good measure of any country's health status, especially attending to mothers during ante-natal, birth and post-natal periods. In 2000 and 2001 for example, skilled health personnel attended only 9.7 percent of births (*UNFPA Country Profile*). There are, however, significant differences between urban and rural areas. The percentage of births attended by skilled personnel in 2001 was 34.5 percent for urban and 2.3 percent for the rural areas. The concentration of skilled personnel in urban areas is not, however, unique to Ethiopia but common to most countries in the region. Thus, efforts should be made to improve the environment in rural areas so as to attract skilled personnel.

(d) Coverage of Ante-natal Care

The health of pregnant mothers at the time of delivery contributes to the wellbeing of the mother and child, and this can be greatly enhanced through widening ante-natal coverage. Good ante-natal care programmes normally have an important impact on maternal deaths due to the fact that danger signs are diagnosed early enough for appropriate action to be taken.

Coverage is assessed according to type of provider, number of ante-natal care visits, and the services and information provided. In 2001, the percentage receiving ante-natal care in Ethiopia was given as 27 percent, which is comparatively lower than the 90 percent found in neighbouring Kenya. For example, 83 percent of mothers in Addis Ababa received ante-natal care by skilled personnel while in Somali and Amhara regions; a mere one in five mother received ante-natal care¹⁴ by skilled personnel.

(e) Infant Mortality and Under-Five Mortality

Table 3.5 presents Infant Mortality Rate (IMR) and Under-Five Mortality Rates for the period 1990 to 2003. It is evident that IMR appears to have declined from 128 (observed in 1990) to 100 per 1,000 live births in 2003. Comparable figures for other African regions are 83 in 2001. The table also indicates that IMR are higher among males compared to females.

Table 3.5: Infant Mortality Rate per 1,000 Live Births

Year	Rate per 1,000 Live Births
1990	128
1996	107
1997	107
1998	107
1999	116
2000	116
2001	106
2002	106
2003	100

Sources: The State of World Population 1990 - 2003

¹⁴ Demographic and Health Survey (2000)

The under-five mortality rate shows some slight declining trend between 1990 when it was estimated at 193 and 2002 when it was estimated at 171. The decline may be due to various factors including improved health and environmental conditions.

The survival of infants and under-fives is related to the social and economic characteristics of mothers and the environment in which they live. For example, for those living in urban areas, the levels of education and access to quality health services are factors that can reduce infant mortality in Ethiopia. Issues of major concern in addressing the high levels of child and under-five mortality include increasing:

- Education levels for girls
- Access to delivery care
- Health care
- Improved sanitation
- Improved access to safe drinking water
- Improved status of women

3.2 Major Health Problems (Morbidity and Mortality), Malaria and Tuberculosis

Malaria is one of the major issues identified under MDGs as requiring specific attention. It is a major cause of death in Ethiopia. In 2000, malaria related mortality rates (per 100,000 persons) were given as 198 (*MDG Indicators*). Although there are no comparable figures for other diseases, the figure is thought to be quite high. There is little evidence that enough is being done to address the situation. The percentage number of children under five years sleeping under a net is given as only one percent in 2000. The percentage number of children with fever treated with anti-malarial drugs was three percent in the same period (*State of World Children 2000*).

Table 3.6 gives the trend of tuberculosis cases per 100,000 persons for the period 1996 to 2002. It is indicated that there were 508 cases in 2002 while there were only 116 cases in 1998. The difference is significant and may be explained with increased HIV/AIDS incidences.

Table 3.6: Tuberculosis Cases per 100,000 Persons

Year	Value per 100,000 People
1996	301.2
1997	97.4
1998	116.0
1999	118.0
2001	179.0
2002	508.0

Source: Human Development Report

3.3 Reproductive Health Rights and Sexual Health Rights

The Family Code, adopted in 2002, is fundamental in protecting the rights of women entering a marriage; managing marital property; and distribution of property after dissolution of marriage. It also sets the minimum age of marriage as 18 years for both men and women¹⁵.

¹⁵ Country Gender Profile of Ethiopia, May 2002

The Family Code makes it very clear that during marriage, the spouses owe each other respect, support and assistance. It is emphasized that the spouses should retain equal rights in the management of the family and administration of property. Furthermore, it requires that common property be co-jointly owned and requires the Court to intervene in contracts executed between spouses during marriage, another way of providing further protection to women.

The Family Code re-emphasises that only the Court is competent to decide on divorce and the effects of divorce. In the past, women and children were forced out of the matrimonial home following divorce. The revised law, however, emphasizes that whereas circumstances may require that the spouse leaves the family home, the Court shall take into account the interests of the children.

In 1997, the Government adopted the National Programme of Action to expand women's educational and work opportunities and to improve their property rights, labour rights and access to credit and education.

- **Property Rights:** Under the 1997 land reforms, the Federal Government confirmed the rights of women in respect to the use, administration and control of land.
- **Labour Rights:** Since the passage of a 1998 Proclamation, the Ministry of Labour and Social Affairs has reviewed employments agreements and does not approve contracts that do not meet certain requirements.
- **Access to Credit:** In an attempt to expand credit to women, a 1996 proclamation provides for licensing and supervising small-scale and micro-financing institutions for rural and urban women. Furthermore, a 2001 Bill seeks to establish the Ethiopian Development Fund which will support income-generating activities by women organizations.
- **Access to Education:** In line with Constitutional guarantees for affirmative measures to enable women to compete and participate on equal basis with men, the Government has introduced programmes that should increase the recruitment and enrolment of women in higher education.

Institutional Mechanisms for the Advancement of Women

Since the adoption of Ethiopia's National Population Policy in 1993, the Government has established 13 Women's Affairs Departments including 12 Women's Affairs Bureaus at regional level. A Women Affairs Committee was established at the Council of People's Representatives and its main task is to reviews laws, policies and programs in order to protect the rights of women.

There are also rights to the physical integrity of women including violence against women, rape and domestic violence, and sexual harassment.

3.4 Family Planning

Family Planning in the Country

Family planning programmes in Ethiopia can be divided into modern methods, traditional methods or a mixture of the two. The DHS conducted in 1998 and 2001 by Central Statistical Authority is the main source of information on the situation regarding family planning. Generally, information collected through DHS covers various aspects of contraceptive knowledge, attitudes and behaviour, and focuses on both men and women. Specific

information collected includes knowledge on contraceptive methods, ever-use of contraception and current use of contraception.

It is expected that basic knowledge of the physiology of reproduction enhances successful practice of coitus-related methods, especially periodic abstinence. Table 3.7 below gives information on the knowledge regarding the fertile period as a means of contraception. During the last DHS, it was observed that 30.3 percent of the women interviewed did not know when a woman is most susceptible to becoming pregnant. A population with adequate information and knowledge of available methods of contraception are well placed to make major decisions regarding their family.

Contraception is a good indicator of the extent to which couples have access to reproductive health services. Thus, levels and trends of Contraceptive Prevalence Rate have serious implications on the size of Ethiopia's population as well as changes in reproductive health. Table 3.8 gives the contraceptive prevalence rate for women (any method) based on the 1998 and 2001 DHS. It is significant to note that the CPR remained the same in 1998 and 2001 (at 8.1). For the period 1995–2002, CPR was given as 8, which is to date the lowest in sub-Saharan Africa. For example, the CPR for neighbouring Kenya was recorded as 33 percent for all methods¹⁶. The contraceptive prevalence rate is very low partly because of Article 802 of the 1957 penal code which prohibited the publicity and distribution of contraceptives. The article was amended in 1998 through Proclamation Number 141/1998, and it is expected that the use of contraceptives will pick up.

Table 3.7: Knowledge of Fertile Period

Percent distribution of women who use periodic abstinence and of women who do not use periodic abstinence, and knowledge of all women of the fertile period during the ovulatory cycle. Ethiopia 2000

Perceived Fertile Period	Users of Periodic Abstinence	Non-users of Periodic Abstinence	All Women
During her period	3.2	1.2	1.2
Right after her period has ended	37.2	29.6	29.7
Halfway between two periods	53.3	12.2	12.6
Just before her period begins	1.3	3.0	3.0
No specific time	2.9	23.4	23.2
Don't know	2.2	30.6	30.3
Total	100.0	100.0	100.0
Number	160	15,207	15,367

Source: Demographic and Health Survey, 2001

Table 3.8: Contraceptive Prevalence Rate for Women by Percentage

Year	Value
1990-1998	4
1990-1999	4
1995-2000	8
1995-2001	8
1995-2002	8
1998	8.1
2001	8.1

Sources: Human Development Report (HDR) 1999, 2000, 2001, 2002, 2003, 2004
World Health Organization (WHO) Reproductive Health Indicators
United Nations Population Fund (UNFPA) Country Profile

¹⁶ Demographic Health Survey Report, 2003, Kenya

The low levels of CPR in Ethiopia is an indication that family planning programmes have yet to have a significant impact on population growth, hence requiring new strategies. The Government and the international community, therefore, need to strengthen programmes that increase the modern methods.

3.5 Adolescent Sexual and Reproductive Health

Adolescent Reproductive Health

Although adolescents form a large segment of the Ethiopian population, they have virtually been marginalized as reproductive health clients. The 1999 assessment of health care facilities, schools and community development agencies revealed that a large number of adolescents face unwanted pregnancies, die from unsafe abortions and contract sexually transmitted infections. It also found that although many adolescents know about contraception, many do not use them.

Adolescent and Unsafe Abortion

The Ministry of Health (MOH) reports indicate that the number of youth dying from unsafe abortions are shocking. Close to 70 percent of women who seek medical attention for incomplete abortions are less than 24 years of age¹⁷. As one of the leading causes of maternal mortality in Ethiopia, abortion causes 56 percent of fatalities, 13 percent of whom are adolescent girls. Death from abortion, especially among the youth, is due to lack of health facilities that provide adequate preventive and post-abortion services.

Government delivery services and Adolescent Reproductive Health

It is noted that in Ethiopia, reproductive health services were designed to cater for mothers. Thus, Adolescent Reproductive Health services that should cater for the youth are not sufficient. Furthermore, health care providers are often ill equipped to address adolescent-specific needs.

Scarce youth-friendly facilities further contribute to the exclusion of adolescents from reproductive health care. The 1999 MOH assessment revealed that even if facilities offered counselling for young people, providers made little attempt to ensure the privacy and confidentiality of their clients.

On a more positive note, however, NGOs have been active in addressing reproductive health services for the youth. In particular, the Planned Parenthood Federation-affiliated Family Guidance Association of Ethiopia has opened youth centres in three towns where they offer family planning counselling and services, and diagnosis and treatment of sexually transmitted infections.

Commencement of Sexual Intercourse for the Youth

Most teenagers in Ethiopia have their first sexual intercourse long before marriage. Table 3.9 below gives the percentage of women and men who had their first sexual intercourse by specified ages and median age, according to current age. It shows that 29.8 percent of women aged between 25 and 49 had their first sexual intercourse by age 15; 68.9 percent by age 18; and 92.0 percent by age 25.

On the other hand, 3.8 percent of men aged between 25 and 59 had their first sexual intercourse by age 15; 24.6 percent by age 18; and 78.8 percent by age 25. Urban-rural differentials as well as various backgrounds show a variation in first intercourse. Generally, it

¹⁷ Women of the World: Laws and Policies Affecting their Reproductive Lives (1997)

is observed that the median age at first intercourse is lower for women than for men. The observation justifies formulation of female specific programmes.

Age at First Marriage

In most African communities, age at first marriage determines the onset of the socially acceptable time for childbearing. Women who marry early have, on average, longer exposure to childbearing. Hence, a higher number of children are born to such young mothers compared to those who marry at a later age. Since the early 1970s, young women in Africa have increasingly delayed their first marriage for a number of reasons that include the pursuit of education, and the changing roles of women and their participation in the labour market. In Kenya for example, the percentage of women aged between 20 and 24 who had never been married rose from 21 percent in 1978 to about 35 percent in 1998¹⁸. In Ethiopia, the mean age at first marriage for women aged between 20 and 49 was given as 15.8 for women with no education, 17.3 for women with primary education and 21.2 for women with secondary education. The age at first marriage for men aged between 25 and 59 was given as 22.7 for men with no education, and 23.3 for men with primary education.

Table 3.9: Age at First Sexual Intercourse

Percentage of women and men who had their first sexual intercourse by specified exact ages and median age, according to current age, Ethiopia 2000

Current Age	Percentage who had First Sexual Intercourse by Exact Age:					Percentage Never Having Intercourse	Number	Median Age at First Intercourse
	15	18	20	22	25			
WOMEN								
15-19	13.5	NA	NA	NA	NA	69.3	3,710	a
20-24	19.4	49.5	65.6	NA	NA	24.6	2,860	18.1
25-29	24.5	57.1	72.3	81.9	88.1	7.4	2,585	17.0
30-34	29.3	73.4	83.7	88.7	92.4	1.6	1,841	15.8
35-39	34.5	70.9	82.7	90.2	93.0	0.4	1,716	15.8
40-44	32.0	76.9	88.5	93.3	94.8	0.3	1,392	15.7
45-49	32.3	75.2	86.1	92.4	95.0	0.0	1,264	15.8
20-49	27.2	64.2	77.4	84.2	87.6	8.0	11,657	16.4
25-49	29.8	68.9	81.3	88.3	92.0	2.6	8,797	16.0
MEN								
15-19	5.1	NA	NA	NA	NA	84.6	600	a
20-24	3.2	22.3	39.7	NA	NA	46.8	408	a
25-29	5.3	22.0	38.8	54.3	77.8	14.9	343	21.3
30-34	2.6	26.1	52.5	65.9	77.8	3.4	276	19.7
35-39	4.8	29.6	55.3	73.0	85.6	0.0	304	19.1
40-44	3.4	24.1	47.9	65.1	76.2	0.4	182	20.2
45-49	2.9	23.6	46.1	62.8	80.8	1.2	207	20.4
50-54	1.6	20.8	37.5	60.6	75.0	0.0	142	20.7
55-59	4.1	23.7	45.2	61.1	73.4	0.1	146	20.4
25-59	3.8	24.6	46.7	63.4	78.8	4.0	1,599	20.3

NA = Not applicable
^a Omitted when less than 50 percent of respondents in the age group x to x+5 have had intercourse by age x

Source: Demographic and Health Survey, 2000

¹⁸ Kenya and Macro International 1990, 1994 and 1999)

3.6 STIs and HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) is caused by the human immunodeficiency virus (HIV) that weakens the immune system, making the body susceptible to and unable to recover from other opportunistic diseases that leads, in most cases, to death. Globally, since the beginning of the epidemic, more than 20 million people have died and about 40 million are living with HIV/AIDS. Most of them are expected to die in the next ten years.

In Africa, the impact of HIV/AIDS in terms of human loss and poor economic growth is high and keeps on rising. The principal mode of HIV transmission is through heterosexual contact, which accounts for more than 75 percent in most countries in sub-Saharan Africa where the pandemic continues to have its greatest impact. The latest estimates from WHO and UNAIDS show the infection rates of more than 10 percent in 12 countries, including Ethiopia.

At the end of 2001, UNAIDS estimated that 58.5 percent of all HIV infections in sub-Saharan Africa were among pregnant women. Furthermore, it was thought that at the peak of HIV infection, high prevalence occurred within the younger age group for men (around 25 years compared to age 30–40 for men).

Based on the current AIDS-related mortality figures, the US Bureau projects that average life expectancy in sub-Saharan Africa will be less than 30 years by 2010, which implies that these countries will start experiencing population declines before that period.

The future trend of the epidemic depends on changes in sexual behaviour and the extent of knowledge of how HIV/AIDS is spread.

It is estimated that in 1997, about 2.6 million Ethiopians (aged 0–49 years) were living with HIV/AIDS (*HDR, 2000*). In percentage terms, in 1999 and 2001, it was estimated that 10.63 percent and 6.41 percent of adults aged 15–49 respectively were living with the virus. Comparative figures for countries in sub-Saharan Africa indicate lower figures. For example, in 2001, Burundi estimates on HIV prevalence was given as 13.34 for females and 7.59 for males. The figures for Ethiopia were given as 13.75 percent and 9.04 percent for females and males respectively. Interestingly, estimates for Uganda, which used to lead with HIV/AIDS infection rates, was given as 8.99 percent for females and 5.12 percent for males.

In Ethiopia, HIV/AIDS is not confined to adults only; a number of children are victims of the pandemic. Close to a quarter of children aged 0–14 are living with HIV/AIDS. Specifically, in 2001, the estimated number of children aged between 0–14 living with HIV/AIDS was given as 230,000 (*State of the World Children 2003*).

In Ethiopia, a higher number of pregnant women are infected with HIV/AIDS. In the period 1999–2002, pregnant women living with HIV/AIDS was about 15 percent. Prevalence among females aged 15–24 is higher than that recorded for males in the same age group. For example, in 2003, prevalence for females was 7.70 compared to 4.4 recorded for males (*Millennium Development Goals indicators*).

In 1998, the Government issued a policy on HIV/AIDS which aims at promoting overall health care. Services include the psychological care for people living with HIV/AIDS, provision of STI services, HIV testing and screening, and protecting the human rights of those affected by the virus. The need to address the contribution of gender inequality to the spread of HIV/AIDS in the country is among the reasons given for the formulation of the policy.

Condom Use

It has been established that consistent and proper use of condoms, especially during high-risk sex behaviour, can reduce the spread of HIV/AIDS.

During the last DHS in Ethiopia, respondents were asked to indicate whether a condom was used during the last sexual intercourse with partners outside marriage.

Table 3.10 provides the percentage of female and male population aged 15–24 that used a condom during their last sexual intercourse. It can be observed that the differences between males and females are almost double (17 percent for males and 30 percent for females). Reasons provided for this large difference includes the fact that girls do not have the power to negotiate sexual activity with their male partners. Thus, if these differences have to be bridged, programmes that encourage power relations need to be strengthened.

Table 3.10: Percentage of males and females aged 15–24 that used Condoms in High Risk Sexual Behaviour

Year	% Male	% Female
1998 – 2001	30	17
1996 – 2002	30	17

Source: Millennium Development Goals

Knowledge and practice on HIV prevention

During the Demographic and Health Survey conducted by CSA in 1999-2000, women and men respondents were asked to state their knowledge of HIV/AIDS related issues, including whether a healthy looking person could have AIDS, how HIV was transmitted from mother to child, and if they personally knew someone living with HIV/AIDS. Table 3.11 gives the percentage of how both men and women responded to these questions according to their background (age, marital status, urban/rural, education and region). For instance, 37 percent of women and 55 percent of men believed that a healthy looking person could have AIDS, once again demonstrating significant differences in knowledge between men and women on the issues regarding AIDS. There are other differentials on other issues, with men showing better knowledge than women.

Children Orphaned by AIDS

One of the consequences of HIV/AIDS is that children become orphaned and, in most cases, are left with no adult person to look after them. It has been observed in a number of studies that children-headed households are on the increase, with its attended effects on the growth of these children.

In Ethiopia, close to one million orphans were estimated in 2001 (*the DHS*). With the current high prevalence rates, the figure is bound to increase. Another effect of AIDS is the high rates of school-going dropouts. In 1995–2001, orphan school attendance rate, as a percentage of non-orphaned school attendance rates, was given as 60 percent. Simply translated, this means that unless some help is provided, many of the AIDS-orphaned children will end up being school dropouts.

Table 3.11: Knowledge of HIV/AIDS-related issues

Percentage of women and men based on responses to questions on various HIV/AIDS-related issues according to background characteristics, Ethiopia 2000

Background Characteristic	Percentage who say that a healthy-looking person can have the AIDS	Percentage who say they personally know someone who has AIDS or died of AIDS	Percentage who say that a healthy-looking person can have the AIDS	Percentage who say they personally know someone who has AIDS or died of AIDS
Age				
15-19	39.1	23.9	49.1	21.6
20-24	38.5	24.8	60.7	22.9
25-29	40.3	27.4	53.1	23.1
30-39	35.7	26.6	61.9	41.4
40-49	32.2	23.4	52.5	42.2
50-59	NA	NA	48.2	39.2
Marital status				
Never married	44.5	27.1	53.7	23.2
Never had sex	72.5	38.7	75.5	27.1
Ever had sex	42.8	26.4	45.8	21.8
Married or living together	34.1	24.4	55.3	37.3
Divorced, separated, widowed	39.2	26.1	56.3	30.8
Residence				
Urban	69.8	45.2	81.8	53.6
Rural	29.9	20.8	50.1	27.7
Region				
Tigray	38.5	26.0	48.9	16.7
Affar	29.3	17.8	55.4	25.0
Amhara	39.0	26.0	58.0	35.4
Oromiya	37.6	23.0	56.0	25.3
Somali	16.8	18.3	38.2	24.0
Benishangul-Gumuz	40.3	22.6	57.3	26.0
SNNP	25.3	25.5	45.6	39.9
Gambela	40.6	20.2	65.8	30.7
Harari	47.9	35.9	86.0	42.4
Addis Ababa	81.8	40.4	79.5	49.5
Dire Dawa	61.5	36.1	77.6	37.4
Education				
No education	27.6	19.2	42.9	25.3
Primary	56.1	36.5	58.6	28.5
Secondary and higher	83.6	55.3	87.3	59.6
Total	37.2	25.2	54.7	31.4

Source: Demographic and Health Survey, 2000

3.7 Other Reproductive Health Conditions (Fistula)

3.7.1 The Fistula Treatment at Hamlin Hospital

Estimates of new fistula cases in Ethiopia are about 9,000 a year. Currently, the Hamlin Fistula Hospital, which started its operations in 1970, treats about 1,200 cases a year, implying that more 80 percent of cases go unattended. Although the repairs are free, many women do not use the facility because of distance, lack of information, insufficient funds to travel to hospital, etc. Reports from the hospital indicate that cases are sometimes very complicated.

To date, Hamlin Fistula Hospital has provided repairs to about 20,000 women. Most of them have been trained to become good ambassadors, while others have been trained to perform medical and nursing duties at the hospital itself.

In addition, the hospital provides training for Ethiopian post-graduate students as well as students from outside the country.

CHAPTER 4

GENDER EQUALITY, EQUITY AND WOMEN EMPOWERMENT

The 1994 census estimated the number of female population in 2002 as 33.5 million (about 49.8 percent), among whom 84.1 percent live in rural areas. The youth, defined as the population between ages 15-49 years, was given as 13.1 million, making up 20 percent of the total population. Among these, 49 percent are female; 82 percent of the youth live in rural areas.

Like many other developing countries, the status of women in Ethiopia is low. Generally, women lack opportunities to make decisions. For example, although representation in Parliamentary seats has gone up from 2.4 percent to 7.7 percent in the previous two elections, their participation in decision-making is still low. In addition, women enjoy a low participation in formal employment (30.8 percent), have a high illiteracy currently estimated at 75 percent, and low consideration is paid to women's special needs in health coverage.

Furthermore, it is estimated that HIV/AIDS awareness among women is only 8 percent as compared to 23 percent for men. The female youth is more vulnerable to HIV/AIDS infection mainly due to widespread practices such as rape, early marriage and high teenage prostitution.

The situation for female youth is worse especially in the rural areas. According to a survey conducted by the Ministry of Labour, 11 percent of girls were found to have never been in school as opposed to 3 percent males.

A number issues are discussed below including domestication of international frameworks, cultural contexts of gender, harmful practices, gender equality, women empowerment and mainstreaming of gender.

4.1 Domestication of International and Regional Frameworks related to Gender

(a) The UN Charters (UDHR and CEDAW)

Ethiopia has ratified many international conventions on women rights and some are well reflected in the Constitution. However, we are yet to see improvements in women's rights. Although the ratification of the conventions was followed by appropriate policy formulation, implementation continues to experience problems mainly due to limited capacity, inadequate understanding of the policies and the attitude of the implementers.

The Ethiopian Government has paid great attention to international developments on the advancement of women. It has, for example, ratified both the UN Charter adopted in 1948 and the Universal Declaration of Human Rights (UDHR) of 1949. It is important to note that UDHR prohibits the negative discrimination of women based on their sex and identifies a number of targets that requires promotion and protection of civil, political and economic rights of the people. Following the UN Charter and the UDHR, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) was adopted in 1981. It basically aims at accommodating the special needs of women and accelerating the process of closing the gap between men and women. Specifically, CEDAW outlines the political, social, economic

and legislative issues countries have to put in place in order to eliminate discrimination against women and establish equality between men and women. It also spells out the procedures that countries have to adopt in order to achieve women's human rights as identified in the Convention. Further, it identifies procedures to be followed in reporting and follow up the measures to be undertaken. It is interesting to note that Ethiopia ratified the Convention the same year.

In 1995, Ethiopia adopted a far-reaching Constitution which assured women of equal rights with men in every sphere of life. It adopted Affirmative Action that addressed inequalities created before that caused the suffering of women and aimed at remedying the situation. The Constitution is very clear on a number of specific issues including:

- Equality between men and women on property ownership
- Women's rights to family planning services and paid pre and post delivery maternity leave
- Amendments to all discriminatory laws. For example, pension benefits for women civil servants are now given to their survivors
- Extension of maternity leave from 45 days to 60 days (three months)
- Revision of Family Law

However, in spite of the changes, there are still a number of discriminatory issues that need to be addressed.

(b) *The Beijing Platform of Action*

The United Nations Fourth Conference in 1995 resulted with the Beijing Declaration and Platform of Action which showed a renewed commitment towards achieving equality, development and peace for women. Twelve critical issues were identified and believed to be the major barriers hindering the advancement of women. These include poverty, education and training, health, violence, armed conflict, participation, power sharing and decision-making, women focused institutions, human rights, mass media, environment and girl child.

An assessment undertaken in 1998 by the UN Division on the Advancement of Women (UNDAW) showed that, except for a few isolated examples, the lives of women in Africa had improved, though progress had been slow in a number of cases.

With regard to Ethiopia, the report showed that many of the concerns addressed in the Beijing Platform of Action had been considered and placed on the Government's priority list. A review of the Government policies, plans and activities showed that although attempts had been made to implement policies and proclamations to bring about gender equality, not much had been accomplished. Specific constraints identified included high illiteracy levels, deep-rooted gender stereotyped cultural beliefs and practices, and lack of resources.

4.2 Cultural Context for Gender Issues

Although the Ethiopian Government has ratified international treaties that advocate the elimination of discrimination against women, certain cultural, social and traditional practices have continued to undermine women's progress in the country. For example, although women make up about 49.8 percent of the country's total population, they continue to have limited access to land and control of resources such as credit. Part of the problem remains the cultural context under which some of these changes have to be addressed.

4.2.1 Positive Achievements

In response to the international treaties, the Government formulated a Cultural Policy in 1997 which views culture as incorporating different social, economic, political, moral, religious, material and practices of all the people and nationalities of Ethiopia. It also recognized that for any meaningful development to take place, the culture and aspirations of the beneficiaries have to be taken into account. Furthermore, the policy clearly recognizes that cultural behaviours, practices and attitudes that support and promote stereotypes and prejudices against women, that constrain the expansion of family planning services and the promotion of reproductive health, should all be eliminated. The policy clearly elaborates the unfavourable situation of women, articulating the need for changes in order to ensure women's active participation in all cultural activities and guaranteeing equal rights.

The ratification of the international conventions has gone a long way in changing the cultural, social and religious beliefs that kept women away from being active participants in the affairs of the State. For example, the Constitution of Ethiopia clearly states that the Government will accord equal treatment to its people regardless of sex.

There are a number of programmes that address the negative aspects of culture on women. For example, there are programmes on FGC and early marriage which are contributing towards the elimination of discrimination against women.

4.2.2 Negative Issues

Ethiopia is a patriarchal society that keeps women at a subordinate level by using religion and culture as an excuse. These cultural and religious excuses have been reinforced over the years by laws and legislation that uphold patriarchy and women's subordination. As a result, disparities between men and women in the division of labour and share of benefits at household level interrelations among household members continue to be witnessed. This negative cultural and religious subordination has resulted in the low status of women where they:

- Are generally poorer than men
- Are less educated
- Do not enjoy due acknowledgment for their labour
- Do not have decision-making power

4.3 Harmful Practices

The inequality and discrimination of women in Ethiopia is manifested through harmful traditional practices. It is observed that most of the harmful practices such as female genital cutting, early marriage, gender-based violence, kidnapping, rape, etc., are directed towards women.

4.3.1 Female Genital Cutting

Table 4.1 below gives the percentage of women who have been circumcised and the percentage that support the practice. Female Genital Cutting, or FGC as it is commonly called, is a serious violation of women's rights as well as being harmful to their health. The table also indicates that the practice is widespread with about 80 percent of women having undergone FGC. There are, however, major differences among regions with the practice being lower in Tigrey (36 percent) and Gambela (43 percent). The response also varies by background - for example, 18.6 percent among educated women and 67 percent among women without education.

The DHS findings show widespread support for the practice among women. When asked whether they think the practice should continue, 60 percent answered in the affirmative. Analysis of data by background indicates that the support is influenced more by the place of residence.

FGC is widespread among Christians and Muslims. However, the type of FGC varies from region to region. Clitoridectomy (the removal of the fold covering the skin) is the most widespread in Ethiopia, and is prevalent among the Amhara and Tigrignia speaking peoples. Infibulation (the excision or radical removal of the clitoris) is practiced among the Gurage and communities in Oromo.

The physical effects of FGC are sometimes severe, and they include post-operative haemorrhage, swelling, painful menstruation, painful sexual intercourse, psychological trauma, etc.

Table 4.1: Prevalence of Female Circumcision

Percentage of women who have been circumcised and the percentage who support the continuation of the practice of female circumcision (by background characteristics) Ethiopia 2000

Background Characteristic	Percentage of Women Circumcised	Percentage Who Support Practice	Number
Age			
15-19	70.7	53.4	3,710
20-24	78.3	57.0	2,860
25-29	81.4	58.5	2,585
30-34	86.1	65.2	1,841
35-39	83.6	63.6	1,716
40-44	85.8	66.3	1,392
45-49	86.8	66.7	1,264
Residence			
Urban	79.8	31.0	2,791
Rural	79.9	66.1	12,576
Education			
No education	80.4	67.0	11,551
Primary	78.4	48.5	2,425
Secondary and Higher	78.2	18.6	1,391

Source: Demographic and Health Survey, 2000

Table 4.2: Decision on Use of Earnings

Percent distribution of women who worked in the 12 months preceding the survey receiving cash earnings by person who decides how earnings are used, according to background characteristics, Ethiopia 2000.

Person Who Decides How Earnings Are Used								
Background Characteristic	Self Only	Husband/ Partner	Jointly With Husband/ Partner	Some-one Else	Jointly With Someone Else	Missing	Total	Number of Women
Current Marital Status								
Never married	82.9	0.0	0.0	5.3	11.6	0.2	100.0	1,127
Currently married/ living together	62.4	4.1	32.3	0.1	0.3	0.9	100	1,956
Divorced, separated, widowed	94.3	0.0	0.1	0.8	3.7	1.2	100	764
Residence								
Urban	75.8	1.8	15.2	2.0	4.4	0.8	100.0	1,229
Rural	74.3	2.2	17.0	1.6	4.2	0.7	100.0	2,623
Education								
No education	73.9	2.5	17.3	1.9	3.7	0.8	100	2,611
Primary	80.7	0.4	11.0	1.5	5.6	0.8	100.0	716
Secondary and Higher	71.2	2.1	19.3	1.4	5.6	0.5	100	524

Source: Demographic and Health Survey, 2000

4.3.2 Early Marriage

Early marriage in Ethiopia is almost total. The 1990 survey, for example, found that the mean age at first marriage for females was 15.6 years for the whole country, and 16.2 years for Addis Ababa. Factors contributing to early marriage patterns include:

- Customs, especially in northern Ethiopia where girls under the age of 15 are married off to young men. The marriages are usually arrangements between two families that are sometimes contracted even before the child is born.
- Desire to ensure a daughter's virginity
- The desire to secure a child's future

Whatever the reasons for early marriage, the consequences are usually negative. By remaining in subservient roles, opportunities to develop the psychological and social skills necessary to make decisions and life choices remain severely restricted. In addition, these girls are denied educational opportunities. The impact of early marriage on the girl's health is enormous. Since they begin childbirth before maturing physically and psychologically, the risks to obstetric complications increase significantly.

4.3.3 Gender-Based Violence (GBV)

Data on gender-based violence in Ethiopia is not readily available. However, information from the 2000 DHS (as collected by CSA) on women attitudes towards wife beating and female circumcision is a good indicator of GBV. The women were asked whether a man is justified in beating his wife if she burns food, argues with a man, refuses sexual intercourse, goes out without telling the husband, etc. Table 4.3 gives attitudinal percentages of women who agreed with specific reasons justifying women beating.

Table 4.3: Women's Agreement with Reasons for Wife Beating

Percentage of women who agree with specific reasons justifying a husband hitting or beating his wife and percentage who agree with at least one of the reasons, by background characteristics, Ethiopia 2000

Background Characteristic	Reasons justifying a husband hitting or beating his wife					Agrees with at least one specified reason	Number
	Burns the food	Argues with him	Goes out without telling him	Neglects the children	Refuses sexual relations		
Current marital status							
Never married	57.7	53.5	49.4	60.3	38.7	77.9	3,688
Married or living together	67.9	64.7	59.4	66.4	55.9	87.3	9,789
Divorced, separated, widowed	59.5	59.2	52.5	63.1	48.5	83.0	1,890
Residence							
Urban	41.0	39.6	38.2	51.6	29.0	69.0	2,791
Rural	69.7	66.1	60.2	67.4	55.7	87.9	12,576
Education							
No education	69.5	65.6	60.4	67.0	56.2	88.1	11,551
Primary	61.6	59.6	53.0	65.8	44.8	83.0	2,425
Secondary and higher	27.4	28.3	27.0	41.8	17.1	56.9	1,391
Employment							
Not employed	63.7	59.5	54.8	62.5	49.6	84.0	5,630
Employed for cash	60.1	56.9	52.6	63.9	47.1	81.4	3,852
Employed not for cash	68.0	65.9	59.9	66.8	54.5	87.0	5,885

Source: Demographic and Health Survey, 2000

It was found that 85 percent of women believed that a husband was justified in beating his wife for at least one reason provided. The table also highlights differences in attitudes for women with different backgrounds including age, religion, marital status, residence and education. The higher percentage indicates that women in Ethiopia still suffer from very low status in the society, even those who are more educated.

4.4 Gender Equality

4.4.1 Gender Disparities in Education

Education is a means towards social mobility and a driving force towards economic, social and cultural development. It is globally accepted that women's education is closely related to major economic development in relation to their participation in productive activities, population growth, reproductive health, education of children, etc.

According to the Ministry of Education (2000), the illiteracy rate among the female population was 75 percent compared to 54 percent for the males.

Table 4.4 gives the trend of adult population (15 years and above) literacy rate for the period 1990 to 2002, while Table 4.5 gives differences between the female and male adult literacy rate. In the 2002, adult literacy was 41.5 percent. That for males was 49.2 percent while for females was 33.8. Table 4.6 gives the ratio of literate females to males as 0.81 in 2001.

Table 4.4: Adult Literacy Rate (15 Years and Above)

Year	Literacy Rate
1990	28.6
1997	35.4
1998	36.3
1999	37.4
2000	39.1
2001	40.3
2002	41.5

Sources: Human Development Index (1999 to 2004)

Table 4.5: Adult Literacy, Male and Female, Age 15 Years and Above

Year	Rate (Male)	Rate (Female)
1997	41.5	-
1998	42.1	30.5
1999	42.8	31.8
2000	47.2	30.9
2001	48.1	32.4
2002	49.2	33.8

Source: Human Development Index

Table 4.6: Adult Literacy Rate (15 Years and Above) - Female

Year	Value			
	Female	Male	Total	Females to Males (Ratio)
1990			28.6	0.66
1991				
1997		41.5	35.4	
1998	30.5	42.1	36.3	
1999	31.8	42.8	37.4	
2000	30.9	47.2	39.1	
2001	32.4	48.1	40.3	0.81
2002	33.8	49.2	41.5	

Sources: Human Development Report (HDR) 1999, 2000, 2001, 2002, 2003, 2004
Millennium Development Goals (MDG) Indicators

With regard to primary education, major differences exist among women and men, and between urban and rural areas. Table 4.7 provides percentage net primary enrolment ratio for males and females during the period 1995 to 2000. It shows that in the period 1995–99, net primary enrolment ratio was 28 percent for females and 34 percent for males. For the period 1997–2000, the percentage was given as 41 for females and 53 for males.

Table 4.7: Percent Net Primary Enrolment Ratio (Male and Female)

Year	% (Male)	% (Female)
1995 - 1999	34	28
1997 - 2000	53	41

Sources: State of the World Children 2004
World Health Organization Reproductive Health Indicators

4.4.2 Gender Disparities in Access to Health Services

In Ethiopia, like in many other developing countries, women suffer more from poor health than males due to a number of reasons:

- Socially condoned violence against women such as early pregnancy, female genital cutting, abduction and rape
- Socio-culturally endorsed division of labour that exposes girls and women to severe - physical and psychological stress
- Nutritional depletion as a result of unfair food distribution

Women are more vulnerable to HIV/AIDS than men because of epidemiological, biological and social-cultural reasons. Thus, it is important to strengthen health systems that address these root causes of imbalances. Table 4.8 shows the HIV prevalence rate for young people aged 15–24 for the periods 2001 to 2003. The table indicates clear differences between the two sexes. For example, in 2003, HIV prevalence for females was 7.8 percent while it was only 4.4 percent for males. The only good explanation for the huge differences is the socio-cultural and biological reasons explained above.

Table 4.8: HIV Prevalence Rate (Ages 15-24) Males and Females

Year	Value	
	Male	Female
2001	7.50	11.86
2002	4.40	7.82
2003	4.40	7.80
2001	5.62	9.99
2001	3.17	5.65

Sources: *The State of World Population 2001, 2002, 2003*
United Nations Population Fund (UNFPA) Country Profile

To address the biases within the health systems in the country, the Government is putting in place policies and programmes that can alleviate the problem. The health policy gives special attention to the special needs of women. In the Health Sector Development Programme (HSDP), gender mainstreaming is among the main components recognized as a crosscutting issue. In the HSDP document, specific health problems facing men and women are recognized. In implementing the programme, lack of disaggregated data by sex has been recognised as one of the handicaps for addressing separate issues affecting men and women.

The Government has identified health related measures for enhancing participation of women. These are:

- Priority and sustainable investment in basic health services with focus on accessible and appropriate reproductive health care through expediting the implementation of HSDP
- Annual planning of the sector to be informed of women's health issues and concerns
- Creating improved access for women and girls to health information, reproductive health, service delivery systems and sources
- Social mobilization and opinion creation, enforcement of laws targeting reduction of violence against women and harmful traditional practices which all affect women's health

4.4.3 Gender Division of Labour, Employment and Resources Disparities

In Ethiopia, 85 percent of the population, most of them women, depends on agriculture for their livelihood. It is estimated that the average Ethiopian woman has a working day of 12–14 hours, most it related to agriculture. At the peak of agricultural activities, women spent close to 10 hours in the field.

In rural areas, women play a vital role in food production, preservation and storage. Although women's participation in traditional food processing is high, their participation in food processing industries is insignificant. According to a statistical survey conducted in 1999, of the total number of employees engaged in manufacture of food products and beverages in public and private, only 10 percent were female.

In terms of formal employment, women are under-represented in the formal sector. Among Government employees in 1999-2000, women constituted only 30.75 percent, and this varied greatly within regions. For example, the percentage of women employees in Somali and Afar was 19.94 percent and 27.19 percent respectively. However, Addis Ababa appears to have equal representation of female and male in formal employment. The figures, however, vary greatly among professions. For example, at the Federal level, women constitute only 13.1 percent of the employees engaged in professional and scientific fields and 14 percent in administrative positions. It should be mentioned that women are highly concentrated in clerical, fiscal and other less attractive jobs (63.35 percent), and in custodial and manual (48.07 percent)¹⁹

It is observed that a great number of women are involved in the informal sector. According to a survey conducted by the CSA in 1996, women constituted 64.93 percent of those engaged in the formal sector, which included self-employed or employed by other people. Many of these women were engaged in small businesses that usually required small capital, e.g. selling vegetables, baking bread, making enjera, traditional drinks, etc.

4.5 Gender Policies and Equity

4.5.1 Policies Addressing Gender Issues

The Federal Democratic Republic of Ethiopia has formulated several policies aimed at rehabilitating the social infrastructure and creating an environment for sustainable development. Among the policies are; the National Policy of Ethiopian Women; the National Population Policy; the Ethiopian Education and Training Policy; and the Health Policy.

The main objectives of the National Policy of Ethiopian Women are:

- Creating and facilitating conditions for equality between men and women
- Creating conditions to make rural women benefit from social services like education and health
- Eliminating stereotypes and discriminatory perceptions and practices that constrain the equality of women

In addition, a number of strategies have been designed to alleviate the low status of women including:

¹⁹ Gender Document (May 2002, Haregewoin Cherinet and Emebet Mulugeta, Country Gender Profile Ethiopia, Swedish International Development Cooperation Agency (SIDA))

- Participation of women in the formulation of policies, rules, laws and regulations
- Ensuring democratic and human rights of women

The 1993 National Population Policy highlights issues related to women. The policy gives serious attention to the issues of gender and describes the important roles played by women in population growth and economic development. For example, the policy makes it very clear that the status of women plays a direct role on the fertility levels of any population. It also makes it clear that education, employment and reproductive health are quite important. The objectives of the National Population Policy include:

- Raising the economic and social status of women
- Empowering the vulnerable segments of the society such as young children and women
- Removing all legal and customary practices constraining women's economic and social development and enjoyment of rights

The Ethiopian Education and Training policies have made adequate provisions for women. In particular, one of the specific objectives is to introduce a system of education that would rectify the misconceptions and misunderstanding regarding the roles and benefits of female education. It is indicated that the design of development of the curriculum and books would give special attention to gender issues.

The Health Policy has been designed by the Government to improve the health status of its people and to facilitate the provision of basic health services. The health policy supports democratisation and the decentralization of the health services system, and strengthening intersectional activities. It is important to note that the policy accords special attention to the health of the family, particularly women and children.

4.5.2 Legislation

Legal Notice (of 1943) of the Ethiopian legislation and legal notices classifies women status in society. Thus, according to that notice, women cannot, therefore, represent themselves in a legal tussle, including issues related to administration of property. It is in respect of these facts that the Government issued the National Policy on Women, which ensures women participation in all developmental spheres.

Currently, women associations are being established at all levels to address the problems facing women. In some rural areas, there are calls for equitable distribution of land among women farmers.

4.6 Women Empowerment and Affirmative Action

With changes in policies, laws and programmes, the gender empowerment measure is changing. (See Table 4.9 where Ethiopia was ranked 86 in 1996. This may be said to have been a positive indication on how effective the programmes were. The gender empowerment measure rate was given as only 0.255

Table 4.9: Gender Empowerment Rank and Value

Year	Gender Rank	Gender Value
1996	86	0.255

Source: Human Development Report 1996

Another indicator for measuring empowerment in Ethiopia is the number of seats held by women at the National Parliament. The number has steadily increased from 2 to 7.8 in 2004. This however, is much lower compared to other African countries like Tanzania, with about 30 percent and Rwanda, with about 49 percent.

4.6.1 Women in Decision-Making

Assessment of women in decision-making is difficult in Ethiopia due to lack of relevant data. As indicated, being a conservative society means that decisions are made by husbands or other men. The decision making process was measured indirectly through the 1999-2000 DHS by assessing the control women have on their own earnings. Employed women were asked to state the main decision maker regarding their own earnings.

Table 4.2 above gives the responses given by working women to a number of specific questions. It shows that a greater percentage (about three-quarters) of women make decisions on the use of their own money. It further shows that younger women (aged 40–49) are likely to make their own decisions.

4.6.2 Women Organizations and Participation in Development

The Government has established elaborate structures within government ministries to oversee the activities related to women. These include:

- Women's Affairs Office, under the Prime Minister's Office
- Regional Women's Affairs Office
- Zonal Women's Affairs Office
- Women Affairs Department in various Ministries

4.7 Mainstreaming Gender in National Policies and Development Programmes

The Ethiopian Government has given prominence to gender in all important documents including the Constitution and the Sustainable Development Programme Reduction Programme (SDPRP). The Government has renewed its commitment to address gender inequalities and set long lasting change and specific developments in programmes and plans. For example, it has endorsed the National Policy for Ethiopian Women that creates supportive constitutional provisions to establish women's equality with men. Other specific actions undertaken by the Government include:

- Establishment of the Women's Development Initiative Project (WDIP), which offers poor women critical economic opportunities to help fight their poor status
- Changes in the Family Code which was recently initiated
- Active attempts by ministries, commissions and other authorities to institute sectoral policies guidelines to address gender issues within their operational frameworks

Issues that will be addressed by the SDPRP include:

- Expediting the socio-economic development process which will ensure that progress made in women's lives is proportionate to the progress made in the policy and legal environment

- Ensuring that women have adequate access to facilities related to agricultural production.
- Raising levels of education for all women by expediting the implementation of ESDP II

The Government recognizes the need for a gender sensitive health system for equitable development. Through strengthening the implementation of the Health Sector Development programme, the Government intends to address the existing biases within the health system.

Recognizing that women have greater vulnerability to HIV/AIDS than men, the Government is strengthening and devising mechanisms for the implementation of gender responsive HIV/AIDS prevention. These include various activities such as raising awareness, information delivery methods, and availability of adequate counselling services.

The international community has put in place programmes for assisting the Government in gender mainstreaming. Specifically, the UN-Inter Agency Working Group on Gender and Development coordinates gender mainstreaming efforts within UN agencies. It also operationalizes the Beijing Platform of Action in the Ethiopian context and identifies potential areas of collaboration. The agency is also involved in increasing gender awareness within different sections of Ethiopian society and supporting Women's Affairs Bureaus in the Prime Minister's Office.

CHAPTER 5

CONFLICT, EMERGENCIES AND HUMANITARIAN RESPONSE²⁰

In the 21st Century, the African continent experienced the greatest number of conflicts and other humanitarian crises. The causes of conflict and emergencies in the region are civil strife and natural disasters; the latter is mainly caused by failure of rains. The consequences of conflict and emergencies are usually high mortality and morbidity; vast movement of population especially children and women; malnutrition; and, disease such as HIV/AIDS, tuberculosis, malaria, acute respiratory infections, etc. Other consequences of such disasters include limited access to minimum health services, food shortages, poor access to safe drinking water and high levels of poverty.

Ethiopia has emerged from a series of conflicts and emergencies over the last decade. The many conflicts in the horn of Africa have ended in Ethiopia playing host to refugees from Somali, Sudan, Kenya and Djibouti. In addition, there has been famine caused by acute shortage rains. On a more positive note, the Government and the international community have consistently addressed the humanitarian situation created by both natural and man-made disasters.

5.1 Nature of Conflicts and Emergencies

Since 2003, there has not been any conflict within the country but refugees from neighbouring countries are still living within camps situated in Ethiopia. The major basic humanitarian concerns in 2004 included implications of the resettlement programme and the upcoming *Meher* rains.

Ethiopia is in the tropics and variations in altitude have resulted in a diversity of climate, soil and vegetation. Rainfall is seasonal, varying in amount, space and time. The country experiences four types of rainfall, some specific to regions.

- (a) The *Meher* Rains, which falls in the whole country from June-September, sometimes referred to as the heavy rains
- (b) The *Belg Rains*, which falls in crop growing regions and extends from February to May, sometimes referred to as the short rains
- (c) The *Gu Rains*, which falls mainly in the Somali region and comes in from late March through early June
- (d) The *Deyr Rains* or short rains, which fall in southern Somali and comes from late September to early December

Whenever the rains fail, the country experiences drought (a period with insufficient water initiated by reduced precipitation). Naturally, the first to suffer are the food crops, with the resultant shortage of food for the Ethiopian population. The variations in rainfall have been blamed for food shortages in the past.

²⁰ Depending on Country Situation

Other current basic problems are: malaria (which is a major problem that occurs immediately after the rains); the volatile conditions in the Somali region which has a large number of internally displaced persons (IDPs); the intensified clashes in the Gambela region; and, the deadlock of the Eritrea-Ethiopia border.

Ethiopia suffers an almost annual problem with the rains which come either too late or don't come at all. The Government and the international community have effectively addressed the resulting humanitarian crises.

5.2 Consequences of the Conflicts and Emergencies in Ethiopia

5.2.1 Refugees

Ethiopia has for over three decades been and still is host to large numbers of refugees. Table 5.1 provides the numbers of refugees since 1997. It is apparent that, in the recent past, the number has decreased by more than a third. Specifically, the number of refugees in 1997 was 323,100 but it decreased to 130,000 in 2003. The reasons provided for the observed decrease include the reduction of the conflict in the horn of Africa and the programmes of voluntary repatriation. For example, recently, 59,115 Somali refugees were voluntarily repatriated from Hartisheik, Darwanagi and Teferi Ber refugee camps.

Table 5.1: Number of Refugees (Thousands)

Year	Value
1997	323.1
1998	262
1999	258
2000	198
2001	153
2003	130

Sources: Human Development Report (HDR) 1999, 2000, 2001, 2002, 2003, 2004

There have also been a large number of returnees to the country. The UNHCR office in Addis Ababa is providing necessary assistance in their reintegration in various locations. Table 5.2 gives a breakdown of refugee population by country of origin and location in 1998.

Table 5.2: Breakdown of Refugee Population by Country of Origin and Location in 1998

Country of Origin	Estimated Population	Location
Somali	195,129	East
Sudan	58,602	West
Kenya	4,980	South
Djibouti	3,000	North East
Urban Refugee	484	Addis Ababa

Source: Humanitarian Appeal for Ethiopia, 2004

5.2.2 Basic Needs

The basic needs for 2004 were to improve the long-term food and livelihood security for some five million vulnerable groups in the country. Plans are at an advanced stage to address food and livelihood security through two programmes, namely:

- New Coalition for Food and Livelihood Security in Ethiopia: It is important to mention that some aspects of the Coalition are already being implemented, including the resettlement programme which will settle the food-insecure population.
- Safety Net Programme: This is under preparation and will become operational in 2005. It is expected that, after long term funding is secured, the programme will have a real impact.

The basic needs for 2004 include food assistance, health and nutrition, HIV/AIDS and child protection, agriculture, livestock, water supply and environmental sanitation, emergency education and emergency coordination and capacity building.

5.3 Overall Response to Humanitarian Appeals

The 2004 Humanitarian Appeal is based on Ethiopia's comprehensive countrywide assessment of food, health and nutrition, water and sanitation situations. It is the result of efforts by the Government of Ethiopia, UN organizations, international and national NGOs. The overall objective is to address the humanitarian needs of most vulnerable populations and to reduce the suffering caused by drought. It is noted that due to relatively better *Meher* rains from June–September, 2004, prospects for adequate domestic food supply are good. Although the humanitarian needs are reduced, however, other structural problems remain such as pests, malaria, climate, etc, which should all be addressed. Specific responses for 2004 are given below:

5.3.1 Food

The food requirement for 2004 is estimated at approximately 964,690 tonnes, or US\$ 365 million. The contributions so far, amount to US\$ 226 million. Thus, un-resourced amount is US\$ 1,389 million (or 38 percent). These figures are higher than 2003 which was 481,950 tonnes with a total cost of US\$ 205 million. As of mid-May, contributions towards the World Food Programme (WFP) was 214,000 Metric Tons (MTs), specifically: 13,000 MTs cereals, 31,000 MTs pulses, 7,000 MTs vegetable oils and 46,000 MTs blended food, all representing 46 percent of WFP emergency food requirements for the year.

The beneficiary population for 2004 was 7.2 million, of which 5 million were considered predicable beneficiaries while the rest were victims of emergencies. Pastoral areas of the country remain comparatively more vulnerable, with some areas moving towards crisis. Afar appears better compared with the neighbouring areas. Specifically, while many areas of Afar region experienced sufficient rains, communities in surrounding areas were still vulnerable because of less rainfall than normal. The goats, camels and sheep that survived the 2002–03 drought were in a better shape because of improved water and fodder sources. However, the pastoral areas of Somali, lowland Bale and Borena zones of Oromiya, South Omo zone of SNNP Region, all developed signs of crisis.

The failure of the Gu rains was compounded by the late onset of the *Deyr* rains in most parts of the Somali region.

The current malaria epidemic in the country, especially in the mid and lowland areas, continues to exacerbate the impact of food shortage. It has also raised mortality thus making recovery from the crisis of 2003 low. The loss of labour from households can be a critical factor in household food security.

5.3.2 Non-Food Items

The non-food items include: health and nutrition, water and sanitation, agricultures, HIV/AIDS, child protection, education, disaster response, capacity development and overall coordination.

(a) Health and Nutrition

The major recurring health threats in Ethiopia are meningitis, malaria and measles. UNICEF and WHO are assisting the Government with measles vaccinations and an expanded programme on immunization activities which achieved coverage of 92 percent in 2003–04. The measles coverage campaign was extended into 2004 to reach all areas.

Malaria is widespread in Ethiopia and is especially serious during the rainy season. Significant progress has, however, been made between the Government and WHO and UNICEF. WHO activities during the period include control of communicable diseases such as malaria, meningococcal meningitis, measles, nutritional disorders and building capacities of federal, regional, zonal and district health facilities. NGOs in the country are also contributing to the emergency nutrition programmes. In addition, UNICEF continues to support Therapeutic Feeding Centres across the country. Through the extended Outreach Strategy/Child Survival Programme, there is a concerted response by UNICEF and WFP to change of the effects of the chronic food insecurity on children.

Humanitarian assistance requirements (revised) for 2004 for the non-food sectors are US\$ 85.3 million. So far, the contribution amount is US\$ 17.3 million. Thus, 80 percent is yet to be resourced. Generally, all sectors in the non-food resources requirements face serious deficits which need to be attended. Contributions, for example, have not been made towards education, HIV/AIDS and capacity development.

(b) Water and Sanitation

Water shortage in affected areas remains acute and yet programmes to address them remain under-funded. The acute shortage of water in Harar town has been addressed through the Emergency Water Task Force, assisted mainly by UNICEF.

Emergency assessment has been undertaken in 43 Woredas. Other activities include training for pump caretakers, community water communities, sanitarians, hygiene education and sanitation clubs in schools.

Humanitarian assistance requirements for 2004 for water and sanitation were US\$ 24.8 million. However, the contribution so far is US\$ 5.5 million, which translates into un-resourced funding of about 78 percent.

(c) Agriculture

During 2004, 450 farming households were in need of seeds while 720 farming and pastoral households were in need of veterinary assistance. The total emergency needs for agriculture was US\$ 13.2 million but only 43 percent had been pledged. About 50,000 farming households were deemed to have a problem because no funds were received to provide Belg season seeds. Only US\$ 3.7 million was pledged for seed supply for the *Meher* season to benefit about 250,000 farmers. Total grain import was estimated at 210,000 MTs.

(d) HIV/AIDS and Child Protection

During the period 2003–04, Government efforts were devoted to developing a long-term programme to address HIV/AIDS in food insecure areas. An emergency preparedness Task Force was established. Some of the tangible activities undertaken included:

- UNICEF and other partners delivered HIV/AIDS education in drought-affected communities in SNNPR
- Undertaking training programmes focusing on emergency affected areas

Humanitarian assistance requirement for 2004 for HIV/AIDS and child protection was US\$ 2,699,500. However, there have not been any contributions which, therefore, spell out problems in terms of implementing identified activities.

(e) Education

Assessment made in a number of regions including Somali, Afar, Tigray, SNNPR, Amhara and Oromiya, revealed that drought had increased absenteeism and dropout rates. UNICEF and WFP are working jointly on the school feeding programme, training staff and providing necessary materials in Somali and Afar regions. The assistance targets 39 primary schools. UNICEF also established temporary learning sites in Afar, SNNP and Somali regions.

Humanitarian assistance requirement for 2004 for education was US\$ 10,449,330. However, there have been no contributions.

(f) Overall Coordination

The WFP and the Office of Humanitarian Affairs (OCHA) supported DPPC (Disaster Prevention and Preparedness Commission) in setting up a Humanitarian Centre. OCHA has also helped secure new funding to cover the costs of establishing Local Area Network connectivity with several other regional DPPC and food security offices. The UNCT has also helped in conducting computer-training programmes for Government officials in SNNPR region.

CHAPTER 6

CRITICAL ISSUES IN POPULATION, REPRODUCTIVE HEALTH AND GENDER

6.1 Population

(i) Poverty

A high number of Ethiopia's population live below the poverty line. The percentage population living below the poverty line in 1995-96 was estimated at 45.5. In addition, the population living below US\$ 1 a day in the period 1990–2000 was 82 percent. There are significant disparities in poverty levels between urban and rural. There are also high variations among regional poverty levels.

The adult literacy rate in Ethiopia for persons aged 15 years and above has shown minimal increase since 1990. The rate increased from 28.6 percent in 1990 to 41.5 percent in 2002, which is still very low compared to other African countries. There are major differences in literacy rates between male and female. There are also major differences in illiteracy between urban and rural as well as among regions.

Limited access to safe water shows that a large proportion of Ethiopians are exposed to water-borne diseases including diarrhoea. A population without access to sanitation facilities is another measure of the extent of poverty in Ethiopia and elsewhere in the world. Nationally, 87 percent of all households have no access to sanitation facilities.

The first goal of the Millennium Declaration is reduction in poverty. To ensure the achievement of this goal, the Government of Ethiopia has to build a free-market economic system. However, specific challenges include:

- Ensuring that the poverty head count ratio declines by about 10 percent by 2004-05 from its 1999-2000 level of 44 percent
- Achieving an average of 7 percent growth rate of GDP during the period
- Achieving adequate commitment by the Government to work towards meeting the Millennium Development Goals by 2015
- Improving Institutional efficiency, ensuring poverty rights, maintaining peace and stability, and improving the functioning of public services
- Reducing the deficit, by use of fiscal policy, to a sustainable level while at the same time re-orienting investment and current spending towards key sectors such as agriculture

(ii) Education

The gross and net enrolment ratio in primary and secondary schools are good indicators of progress within education sector. Primary and secondary net/gross enrolment is low. The ratio is worse in tertiary education. There are also differences between girls and boys. There are also differences in gross and net enrolment for males and females between rural and urban population.

There is evidence that high fertility in Ethiopia undermines the education of children because families have less to invest in children. Thus, the Government has to plan education in the face of high population growth. The high rate of population growth in Ethiopia has set a limit on the attainment of education goals. There are obstacles hindering enrolment ratios because actual enrolment must progress faster than the increase in population itself. Although some progress has been achieved in increasing primary school enrolment rates in the past, there is still a lot of room for improvement.

(iii) Economic Growth

Ethiopia remains one of Africa's poorest countries. It has a very low income per capita and a population that is almost two-thirds illiterate. The real GDP in 2003 was US\$ 6.1 billion while the annual growth rate was 3.8 percent. The per capita income was US\$ 92, while the annual inflation rate in the last three years was 0 percent.

From 1990 to 2001, a constant growth rate of 2.4 was realised. On the other hand, a negative growth rate of 0.4 was realised from 1975-98. It is worthwhile to note that negative growth occurred when the government of the day followed socialist policies. Furthermore, UN reports note that Ethiopia's per capita income remains the second lowest in sub-Saharan Africa.

The fundamental development objective of the Federal Democratic Republic of Ethiopia is to ensure rapid economic development, and to ensure that poor people become the main beneficiaries of economic growth.

The specific targets and objectives of the Ethiopian Government include:

- Achieving an average of 7 percent growth rate of GDP during the period
- Reduction of the deficit, by use of fiscal policy, to a sustainable level while at the same time re-orienting investment and current spending towards key sectors such as agriculture
- Laying the foundation for strong revenue performance, which is foreseen to grow from 14.3 percent of GDP in 2000-01 to 17.7 percent in 2004-05
- Gearing monetary policy towards containing inflation and achieving the international reserve target
- Commitment to enhancing efficiency and effectiveness of the financial sector
- An average growth rate of 7.7 percent in agricultural sectors, giving more emphasis to the transformation of the rural economy

The main strategies during the sustainable development programme include the following:

- Overriding and placing intentional focus on agriculture, which is a source of livelihood for 85 percent of the population
- Strengthening private sector growth and development especially in industry as a means of achieving off-farm employment and output growth
- Rapid export growth through production of high value agricultural products and increased support to export-oriented manufacturing sectors, particularly the intensified processing of high quality skins, leather and textile garments
- Undertaking major investment in education and strengthening the on-going effort in capacity building to overcome critical constraints to the implementation of development programmes
- Deepening and strengthening the decentralization process to shift decision-making closer to the grass root population so as to improve responsiveness and service delivery

- Improvements in governance to move forward in the transformation of society, improving empowerment of the poor and setting frameworks that will provide an enabling environment for private sector growth and development
- Agriculture research, water harvesting and small scale irrigation
- Focus on increased water resource utilization to ensure food security

(iv) Data for Development

Data from all sources has been harnessed to assess achievement of SDPRP, MDGs, NEPAD and other national frameworks. The required data, however, is limited both in scope and coverage and is subject to many missing values. To address this data limitation, the Government has produced “The Medium Term National Statistical Programme for Ethiopia, 2003-04 – 2007-08”. The objective of this document is to take stock of existing data and prepare plans for generating relevant and reliable data for monitoring progress in achieving SDPRP and MDGs.

The main data concerns include: human resource development and utilization; capacity building for population programme management; basic data collection, analysis and dissemination, research and policy studies; monitoring and evaluation of population programmes.

(v) Population Dynamics (Fertility, Mortality, Migration)

In Ethiopia, the most important population factor associated with social and economic development is the high rate of population growth. High growth rate affects development, the age structure, rural-urban migration, and regional densities. Population growth in Ethiopia has been due to the interplay of population age structure on the one hand, and current and future fertility, mortality and migration on the other.

In the first half of the 21st century, Ethiopia’s fertility level will be the key in understanding its long-term potential and the way age composition evolves. However, like many other countries in sub-Saharan Africa, Ethiopia does not have a complete, reliable and accurate vital registration system.

Like other African countries, Ethiopia has experienced high fertility rates in the past. In general, high fertility levels are major detriments of fast growth for any country. Therefore, the expected significant declines during the later part of this century are encouraging.

Mortality contributes to population change by affecting the number of people who exit a population.

Simply defined, migration is the movement of people from one civil division to another for an extended period of time. In the past, Ethiopia experienced both international and internal migration. While internal migration is confined to the boundaries of Ethiopia, international migration implies moving out of the international boundary. International migration, though minimal, was basically fuelled by economic hardships arising from past conflicts. On the other hand, internal migration was mainly from rural-urban migration, and was caused by extreme poverty and the long spells of drought in some parts of the country.

Urbanization creates problems for urban planners. Rural-urban migration in Ethiopia poses problems including: poor urban management, lack of infrastructure, and inadequate service delivery. The heavy population in urban areas has contributed to the deterioration of urban infrastructure and services. To address the urbanization problem, the Government is currently focusing on urban governance, infrastructure provision in housing, etc.

Implications of High Population Growth

In Ethiopia, the specific aspects of population that affect development include: the current and projected sizes; and several population characteristics such as age and sex composition, rural and urban composition, population distribution and density. Population dynamics have significant implications on the achievement of the overall plan, and social and economic development of a country. These include poverty reduction programmes, improvements in health and accessibility to social services and infrastructure including education, health, potable water sanitation, housing and environment.

The rationale for the National Population Policy for Ethiopia was the need to address “demographic factors such as rapid population growth, young age structure and the uneven spatial distribution of the population fuelled by continuing high fertility regime that exacerbates the severe state of under-development in Ethiopia.”

Through consistent application of the population policy, the Government aims to maintain a balance between size of population and the country’s resource base. Main concerns, therefore, include the following:

- Closing the gap between high population growth and low economic productivity through planned reduction of population growth and increasing economic returns
- Expediting economic and social development processes through holistic integrated development programmes designed to expedite the structural differentiation of the economy and employment
- Reducing the rate of rural to urban migration
- Maintaining and improving the carrying capacity of the environment by taking appropriate environmental protection
- Raising the economic and social status of women by freeing them from the restrictions and drudgeries of traditional life and making it possible for them to participate productively in the larger community
- Significantly improving the social and economic status of vulnerable groups (women, youth, children and elderly)

The specific targets in the policy include the following:

- Reducing the Total Fertility Rate to 4 percent by 2015
- Increasing Contraceptive Prevalence Rate use to 44 percent by 2015
- Reducing Maternal, Infant and Child Morbidity and Mortality Rates
- Significantly increasing female participation at all levels of education
- Removing all legal and customary practices militating against the full enjoyment of economic and social rights by women

6.2 Reproductive Health

(i) Maternal mortality

Maternal mortality ratio is one of the most important measures of maternal health in a country. The MDG target is to reduce maternal mortality by three-quarters. MMR in Ethiopia is one of the highest in world, and has actually been rising. This presents the greatest challenge to the Government. It is, therefore, important that the Government and the international community address all the identified problems through formulation of appropriate programmes. The wellbeing of mothers during pregnancy, delivery and shortly thereafter depends on the quality of care received, as well as the woman’s socio-economic condition. The health risks of such mothers are greatly reduced if the proportion of babies delivered under the supervision of health professionals increases.

The Government is greatly concerned with addressing the following:

- Improved access to ante-natal care
- Improved access to post-natal care
- Increased access to quality reproductive health services by men, women and adolescents
- Reduced unsafe abortion
- Improved education of women
- Improved access to delivery of care
- Increased number of deliveries in health facilities
- Improved access to obstetric care by trained providers
- Discouraged practice of female genital mutilation

(ii) Infant and Under-Five Mortality Rates

Both Infant Mortality Rate (IMR) and Under-Five Mortality Rates in Ethiopia are high. Survival of infants is related to the social and economic characteristics of their mothers and the environment in which they live. For example, for people living in urban areas, their levels of education and access to quality health services are factors that can reduce infant mortality in Ethiopia.

Issues of major concern in addressing the high levels of child and under-five mortality include:

- Increasing education levels for girls
- Increasing access to delivery of care
- Increasing health care
- Increasing improved sanitation
- Increasing improved access to safe drinking water
- Increasing improved status of women

(iii) Malaria and Tuberculosis

Malaria is one of the major concerns identified under the MDGs as requiring specific attention as it is a major cause of death in Ethiopia. There is little evidence that enough is being done to address the situation and, lately, cases have been increasing at alarming rates, mainly fuelled by HIV/AIDS incidences.

(iv) Family Planning

Family planning programmes in Ethiopia can be divided into modern methods, traditional methods, and a mixture of the two. Contraception is a good indicator of the extent to which couples have access to modern reproductive health services. Thus, levels and trends of CPR have serious implications on the size of Ethiopia's population as well as changes in reproductive health. CPR has remained low, the highest so far being 8.1. The low levels of CPR in Ethiopia is an indication that family planning programmes have yet to have a significant impact on population growth, meaning they require new strategies.

(v) Adolescent Reproductive Health

Although adolescents form a large segment of the Ethiopian population, they have virtually been marginalized as reproductive health clients. A great number of adolescents face unwanted pregnancies, die from unsafe abortions and contract sexually transmitted infections. It is also found that although many adolescents know about contraception, many might not use them. Death from abortion, especially among the youth is due to lack of access to health facilities that provide adequate preventive and post-abortion services.

Unfortunately for the youth, reproductive health services were designed to cater for mothers. Thus, Adolescent Reproductive Health (ARH) services that should cater for the youth are not adequately available. Furthermore, health care providers are often ill equipped to address adolescent-specific needs. Scarce youth-friendly facilities further contribute to the exclusion of adolescents from reproductive health care.

(vi) STI/HIV/AIDS

In 1997, the estimated population living with HIV/AIDS in Ethiopia was 2.6 million (or 6.41 percent of adults aged 15-49). HIV/AIDS is not confined to adults only; a number of children are victims of the pandemic. Close to a quarter of children aged between 0-14 are living with HIV/AIDS. A higher number of pregnant women are infected with HIV/AIDS.

During the last DHS in Ethiopia, respondents were asked to indicate whether condom was used during their last sexual intercourse with partners outside marriage. While the percentage of those who used condoms was found to be low, there were large differences between male and females. Reasons for the differences included the fact that girls do not have the power to negotiate sexual activity with their male partners. Thus, if these differences have to be bridged, programmes that encourage power relations need to be strengthened.

Knowledge and practice on HIV prevention varies between males and females as well as between urban and rural areas. Once again, significant differences between men and women regarding knowledge on the issues surrounding HIV/AIDS were demonstrated.

One of the consequences of HIV/AIDS is that children become orphaned and, in most cases, are left with no adult to look after them. In Ethiopia, close to one million children were estimated as orphaned in 2001 (*DHS*). With the current high prevalence rates, the figure is bound to increase. Another effect of HIV/AIDS is the high school-going dropout rates. In the period 1995–2001, orphan school attendance rate (as a percentage of non-orphaned rates) was given as 60 percent. Simply translated, this meant that, unless some help is provided, many of the AIDS orphaned children will end up being school dropouts.

Issues that require Government intervention include:

- Service delivery points to provide integrated HIV/AIDS services
- Strengthen national frameworks for implementing HIV/AIDS programmes
- Mainstream HIV/AIDS into development plans and projects
- Service providers to be trained to handle syndromic management of STIs
- Develop and disseminate IEC materials on sexual and reproductive health and rights
- Establish and support maintain orphanages
- Establish and support home-based orphan care in the community

(vii) Fistula Treatment

Estimates of new fistula cases in Ethiopia are about 9,000 a year. Currently the Hamlin Fistula Hospital, which began its operations in 1970, treats about 1,200 cases a year, implying that more 80 percent of cases go unattended. Although the repairs are free, many women do not use the facility due to various reasons that include: distance, lack of information, and/or insufficient funds to travel to hospital. Reports from the hospital indicate that cases are sometimes very complicated.

6.3 Gender

(i) Cultural Context for Gender Issues (Negative Issues)

Women in Ethiopia account for about 49.8 percent of the total population. However, they still continue to have limited access to land and control of resources such as credit. A major hindrance remains the cultural context under which some of these changes have to be addressed.

Ethiopia is a patriarchal society that keeps women at a subordinate level by using religion and culture as an excuse. These cultural and religious excuses have been reinforced over the years by laws and legislation that upholds patriarchy and women's subordination. As a result, disparities between men and women in the division of labour and share of benefits at household level interrelations among household members continue to be witnessed. The negative cultural and religious subordination has resulted in the low status of women where they:

- Are generally poorer than men
- Are less educated
- Do not enjoy due acknowledgment for their labour
- Do not have decision-making power

(ii) Harmful Practices (FGC, Early marriage, GBV)

The inequality and discrimination of women in Ethiopia is manifested through harmful traditional practices. It has been observed that most of the harmful practices are directed towards women in the form of female genital cutting, early marriage, gender-based violence, kidnapping, rape, etc.

FGC is widespread with about 80 percent of the women having undergone the cut. FGC is widespread among Christians and Muslims, though the type of FGC varies from region to region. What is more disturbing is that there is widespread support for the practice among the women themselves. The physical effects of FGC in Ethiopia are often severe and include post-operative haemorrhage, swelling, painful menstruation, painful sexual intercourse, psychological consequences, etc.

(iii) Gender Disparities in Education

Education is a means towards social mobility and a driving force towards economic, social and cultural development. It is globally accepted that women's education is closely related to major economic development in relation to their participation in productive activities, population growth, reproductive health, education of children, etc. Wide gender disparities in Ethiopia include the following:

- The illiteracy rate among the female population is 75 percent compared to 54 percent for their male counter parts
- In 2002, male literacy was 49.2 percent while female literacy was 33.8 percent
- Between 1995–99, net primary enrolment ratio was 28 percent for females and 34 percent for males
- For the period 2000–01, ratio of girls to boys in secondary was given as 0.66

If these differences have to be removed, the root causes have to be addressed.

(iv) Gender Disparities in Access to Health Services

In Ethiopia, like in many other developing countries, women suffer more than men from poor health due to a number of reasons that include:

- Socially condoned violence against women such as early pregnancy, female genital cutting, abduction and rape
- Socio-culturally endorsed division of labour that exposes girls and women to severe physical and psychological stress
- Nutritional depletion as a result of unfair food distribution

Women are more vulnerable to HIV/AIDS than men because of epidemiological, biological and social-cultural reasons.

To address the biases within the country's health systems, the Government has identified health-related measures to enhance the participation of women. These are:

- Priority and sustainable investment in basic health services with focuses on accessible and appropriate reproductive health care through expediting the implementation of HSDP
- Annual planning of the sector that is informed of women's health issues and concerns
- Creating improved access to women and girls health information, reproductive health, service delivery systems and sources
- Social mobilization, opinion creation, enforcement of laws targeting reduction of violence against women and harmful traditional practices which all affect women's health

(V) Women Empowerment and Affirmative Action

In Ethiopia, women lack opportunities to make decisions. In addition, women's participation in formal employment is low (30.8 percent), have high illiteracy (currently estimated at 75 percent), and consideration of women's special needs in health coverage is low. Furthermore, it is estimated that HIV/AIDS awareness among women is only 8 percent compared to 23 percent for men. Also, the female youth are more vulnerable to HIV/AIDS infection, mainly due to widespread practices like rape, early marriage and high teenage prostitution.

The situation for young women is worse, especially in the rural areas. According to a survey conducted by the Ministry of labour, 11 percent of girls had never been to school opposed to 3 percent of boys.

The Ethiopian Government has paid great attention to international developments on the advancement of women. It has, for example, ratified both the UN Charter adopted in 1948 and the Universal Declaration of Human Rights (UDHR) of 1949.

However, although Ethiopia has ratified and domesticated all international conventions on women, there are still a number of discriminatory concerns that need to be addressed. A review of Government policies, plans and activities show that, although attempts have been made to implement policies and proclamations that are aimed at bringing about gender equality, not much has been accomplished. Specific obstacles identified include high illiteracy, deep-rooted gender stereotypes, cultural beliefs and practices, and lack of resources.

The immediate challenge is to implement what is already contained in the Constitution and laws and they include ensuring:

- Equality between men and women on property ownership
- Women's rights to family planning services and paid pre and post delivery maternity leave
- Amendments to all discriminatory laws. For example, pension benefits for women civil servants are now given to their survivors
- Extension of maternity leave from 45 days to 60 days (three months)
- Revision of Family Law

(vi) *Mainstreaming Gender in National Policies*

The Ethiopian Government has given prominence to gender in all important documents including the Constitution and the Sustainable Development Programme Reduction Programme (SDPRP). The Government has renewed its commitment to address gender inequalities and set long lasting change and specific developments in programmes and plans. For example, it has endorsed the National Policy for Ethiopian Women that creates supportive Constitutional provisions to establish women's equality with men. Other specific actions undertaken by Government include:

- Establishment of the Women's Development Initiative Project (WDIP) which offers poor women critical economic opportunities to help fight their poor status
- Changes in the Family Code which was recently initiated
- Active attempts by ministries, commissions and other authorities to institute sectoral policy guidelines to address gender issues within their operational frameworks

Issues that will be addressed by the Government include:

- Expediting the socio-economic development process which will ensure that progress made in women's lives is proportionate to the progress made in the policy and legal environment
- Ensuring that women have adequate access to facilities related to agricultural production.
- Raising levels of education for all women

Recognizing that women have greater vulnerability to HIV/AIDS than men, the Government is strengthening and devising mechanisms for the implementation of gender responsive HIV/AIDS prevention. These include activities such as raising awareness, information delivery methods, and availability of adequate counselling services.

Country Situation Analysis



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