

**UNFPA**

# 50 Years of Ensuring Rights and Choices for All in Ethiopia

2023







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## **UNFPA THREE + TRANSFORMATIVE RESULTS**

- 1. Ending preventable maternal deaths**
- 2. Ending unmet need for family planning**
- 3. Ending gender-based violence and all harmful practices**
- 4. Ending sexual transmission of HIV**



**“UNFPA is the backbone, frontliner, and champion for the sexual and reproductive health programs in Ethiopia. UNFPA has supported interventions that have saved tens of thousands of mothers who were in dire situation due to civil and armed conflicts. UNFPA is among the first to respond with the provision of life-saving services to women and young people.”**

Zemzem Mohammed, Maternal Health Team Leader,  
Maternal and Child Health Directorate, Ministry of  
Health, Ethiopia.





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# ACRONYMS

<b>ANC</b>	Antenatal care	<b>EPMCD</b>	Ending preventable maternal and child deaths
<b>BEmONC</b>	Basic emergency obstetric and newborn care	<b>ESDP</b>	Education Sector Development Plan
<b>CARMMA</b>	Campaign for the Accelerated Reduction of Maternal Mortality in Africa	<b>ESS</b>	Ethiopia Statistical Service
<b>CBCM</b>	Catchment-based clinical mentorship program	<b>FGAE</b>	Family Guidance Association of Ethiopia
<b>CEmONC</b>	Comprehensive emergency obstetric and newborn care	<b>FGM</b>	Female Genital Mutilation
<b>COVID-19</b>	Coronavirus disease 2019	<b>FP</b>	Family planning
<b>CP</b>	Country Programme	<b>HEP</b>	Health extension program
<b>CPR</b>	Contraceptive Prevalence Rate	<b>HEW</b>	Health extension workers
<b>CSE</b>	Comprehensive sexuality education	<b>HSDP</b>	Health sector development plan
<b>DHS2</b>	District health information system	<b>HSTP</b>	Health Sector Transformation Plan
<b>EDHS</b>	Ethiopian Demographic and Health Survey	<b>ICPD</b>	International conference on population and development
<b>EHSP</b>	Essential health service package	<b>IESO</b>	Integrated emergency surgical officer
<b>EMDHS</b>	Ethiopian Mini Demographic Health Survey	<b>IMR</b>	Infant Mortality Rate
<b>EmONC</b>	Emergency obstetric and newborn care	<b>IUCD</b>	Intrauterine contraceptive device
<b>EPCD</b>	Ending preventable child deaths	<b>LB</b>	Live birth
<b>EPMD</b>	Ending preventable maternal deaths	<b>MDG</b>	Millennium Development Goal
		<b>MHTF</b>	Maternal and newborn health thematic Fund
		<b>MISP</b>	Minimum Initial Service Package
		<b>MMR</b>	Maternal Mortality Ratio
		<b>MoF</b>	Ministry of Finance
		<b>MoH</b>	Ministry of Health

# ACRONYMS

**MOWSA** Ministry of Women and Social Affairs

**MCTC** Mother to child transmission

**MWH** Maternity Waiting Home

**NGO** Non-governmental organization

**NMR** Neonatal Mortality Rate

**PHCU** Primary Health Care Unit

**RH** Reproductive Health

**SARA** Service Availability and Readiness

**SBA** Skilled Birth Attendance

**SBR** Stillbirth rate

**SDG** Sustainable Development Goal

**SGBV** Sexual and gender-based violence

**SNNPR** Southern Nations, Nationalities, and Peoples' Region

**SPA** Service provision assessment

**SRH** Sexual and Reproductive Health

**SRHR** Sexual and Reproductive Health and Rights

**STI** Sexually Transmitted Infections

**TFR** Total fertility rate

**UHC** Infant Mortality Rate

**U5MR** Under five Mortality Rate

**UN** United Nations

**UNDAF** United Nations Development Assistance Framework

**UNICEF** United Nations Children's Fund

**UNFPA** United Nations Population Fund

**USAID** United States Agency for International Development

**UNSDCF** UN Sustainable Development Cooperation Framework

**USD** United States Dollar

**WHO** World Health Organization



# TIMELINE

## UNFPA'S MISSION RELATED MILESTONES IN ETHIOPIA

Family planning  
services initiated in  
Ethiopia by Family  
Guidance Association



UNFPA started its  
mission in Ethiopia



1966

1967

1973

1978



UNFPA started operating  
as trust fund for  
population issues



Alma-Ata Declaration  
(PHC and health for all,  
including maternal and  
child health)

UNFPA supported the first Ethiopian population and housing census Association



Safe Motherhood Initiative to reduce maternal mortality by 50% by 2000



1984

1985

1987

1988



The WHO inter-regional meeting on maternal mortality



UNFPA started supporting the family planning program in Ethiopia

# TIMELINE

## UNFPA'S MISSION RELATED MILESTONES IN ETHIOPIA

Ethiopian Health Policy  
developed and  
implemented

UNFPA supported the  
development of the first  
family planning  
guidelines



UNFPA supported the  
second population and  
housing census

1993

1994

1996

1997

UNFPA supported the  
development of the  
Population Policy in  
Ethiopia

Ethiopia was a signatory  
at the International  
Conference of Population  
and Development (ICPD)  
held in Cairo and  
supported by UNFPA



Ethiopia developed the  
first of the 20-year  
Health Sector  
Development Plan  
(HSDP)



UNFPA organized the  
African Forum on  
Adolescent  
reproductive health  
held in Addis Ababa

Ethiopia adopted the  
Millennium Development  
Goal (MDG) and aligned  
with HSDP II



Criminal code  
prohibiting Female  
Genital Mutilation  
(FGM) enacted

1998

2000

2003

2004

UNFPA supported the first  
EDHS

UNFPA supported the  
launch of the Health  
Extension Program  
(HEP)

National youth policy  
enacted



# TIMELINE

## UNFPA'S MISSION RELATED MILESTONES IN ETHIOPIA

The liberalized abortion law was enacted

UNFPA supported the first national reproductive health (RH) strategy development

UNFPA supported the first national adolescent and youth RH strategy



UNFPA-UNICEF jointly launched accelerated abandonment of FGM

2005

2006

2007

2008

UNFPA supported the second EDHS



UNFPA supported the third population and housing census strategy development

UNFPA initiated and supported the first EmONC census

Africa Union launched  
the Campaign for the  
Accelerated Reduction  
of Maternal Mortality



UNFPA supported HIV testing  
in Gambella was the Guinness  
Book of World Records

Ethiopia was a  
signatory at the London  
summit for family  
planning 2020



2009

2011

2012

2015

UNFPA supported the  
innovative IESO  
Master's program

UNFPA supported third  
EDHS

Ethiopia adopted the  
SDGs and aligned with  
HSTP I





# TIMELINE

## UNFPA'S MISSION RELATED MILESTONES IN ETHIOPIA

UNFPA supported the fourth EDHS, urban total fertility rate declined to 2.3

UNFPA supported Addis Ababa Ministerial Declaration on Ending Preventable Maternal and Child Deaths (EPMCD)

COVID-19 pandemic disrupted regular health services



Regular health services in the North and West of Ethiopia disrupted by conflict

2016

2017

2020

2021

UNFPA supported the second EmONC census



UNFPA reached to nearly 3 million internally displaced women and adolescents with services

UNFPA allocated huge resources to conflict-affected areas





UNFPA  
commemorates  
its 50  
Anniversary in  
Ethiopia  
**2023**



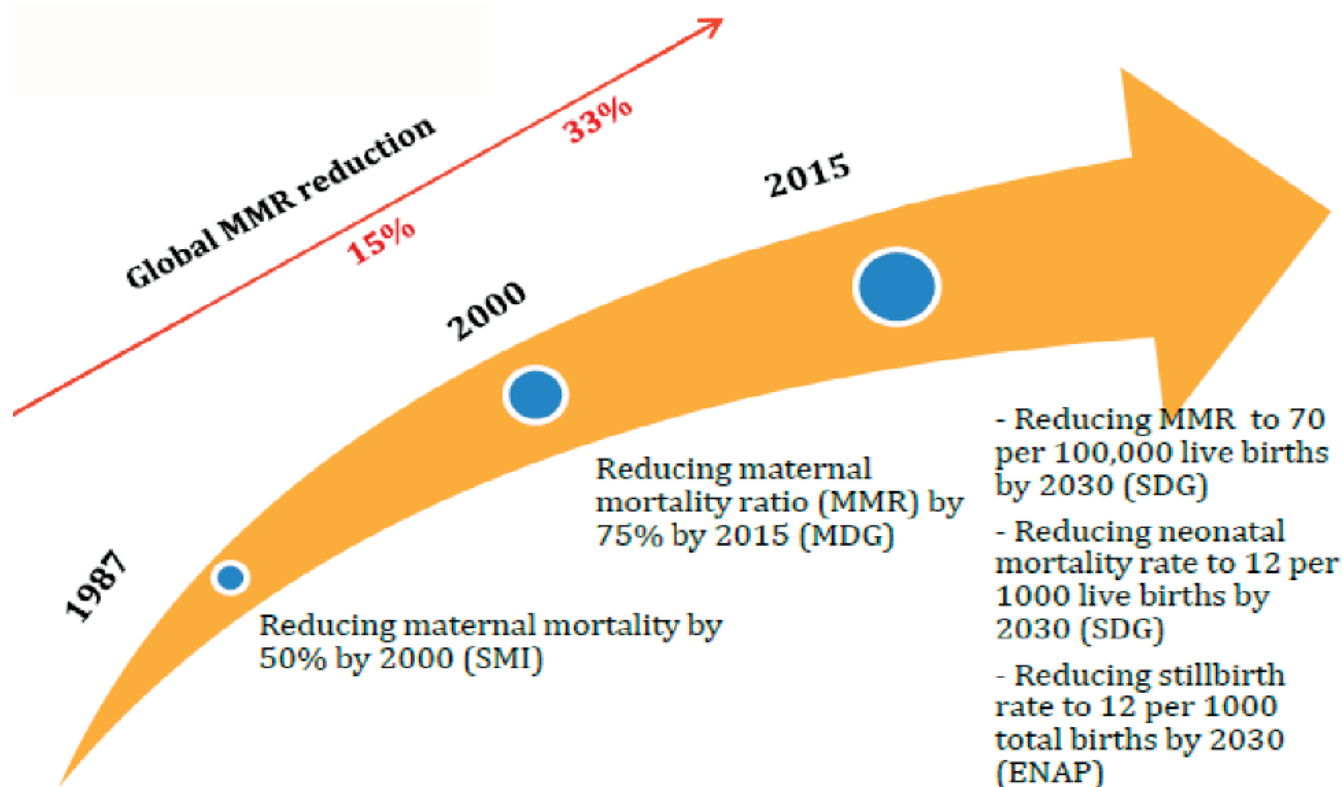


# EXECUTIVE SUMMARY





## PROTOTYPE INTERNATIONAL COMMITMENTS AND ACHIEVEMENTS



## EXECUTIVE SUMMARY

UNFPA, the United Nations Sexual and Reproductive Health Agency, started its mission in Ethiopia in 1973 and has implemented 9 Country Programmes aligning them with the Ethiopian government priorities, MDG-SDG, and UN development frameworks. UNFPA has been providing both financial and technical support to the government of Ethiopia in collecting and using national gender-disaggregated population and reproductive health data for nearly three decades, which were critically important for national policy, strategies, and guidelines development, and ultimately in ensuring the rights and choices of citizens. UNFPA's 50 years of support to the Ethiopian government's efforts in poverty reduction and ensuring sustainable development through ensuring universal access to reproductive health services and rights started paying dividends since the commencement of the new millennium. Steady progresses were witnessed in outcome indicators and accelerated decline in mortality and other impact indicators, including a rise in women's life expectancy from 46 years in 1990 to 69 years in 2020. The developmental changes are in all three plus transformative results - ending preventable maternal deaths; ending unmet need for family planning; ending gender-based violence and harmful practices against women and girls; and ending new HIV infection.

## Ending preventable maternal deaths

UNFPA has been supporting the Ethiopian government's efforts of improving the maternal and newborn health programs for more than three decades, which enabled reducing the maternal mortality ratio (MMR) by 79% in three decades and neonatal mortality rate (NMR) by 55% in about four decades. The overall decline of MMR in Ethiopia in 30 years was nearly 2-fold higher than Sub-Saharan Africa and global average. Improvement in the continuum of maternity care after 2000 (including 10-fold increased skilled birth attendance) has contributed to the drastic decline of the MMR, NMR, and still birth rate.

From the outset, UNFPA has been supporting the locally generated innovative health programs (health extension program and integrated emergency obstetric surgical officers training at Master's level for emergency surgery), accelerated midwifery and anesthetist nurse training, and nationwide maternity waiting homes expansion, which have contributed to improvement in basic and comprehensive emergency obstetric and newborn care, thereby reducing maternal and newborn morbidity and mortality. UNFPA's unwavering support to the elimination of obstetric fistula has brought the incidence down to 0.03% in 2020, with an aim to reduce it to zero by 2025. Abortion and obstructed labor (the cause for obstetric fistula) have become the least among the top direct obstetric causes of maternal mortality, for which UNFPA's contribution has been applauded.

## Ending unmet need for family planning

UNFPA started supporting the family planning program in Ethiopia in the late 1980s. The continuous and multifaceted support (including policy documents' development, demand creation and providing contraceptive methods free of charge) has resulted in an increase in the national modern contraceptive prevalence rate by more than 14-fold in three decades. The outcome of the FP program was well observed in Ethiopia over the last three decades as the total fertility rate (TFR) of Ethiopia declined by more than 2-fold between 1990 and 2020 (from 7.7 in 1990 to 3.8 in 2020 with urban areas near replacement level). Unmet need for contraceptives was reduced by about 38%.

## Ending gender-based violence and all harmful practices against women and girls

Gender equality, preventing GBV and harmful practices have been UNFPA's priorities for decades. It has been providing technical and financial support to government line ministries in developing policies, strategies, and guidelines, and building capacity to implement and mainstream the national policy directions on gender equality and preventing GBV and harmful practices. By mid-2022, UNFPA had supported the establishment of more than 50 one-stop centers in public hospitals across the country for survivors of GBV and several 'safe houses' that are able to accommodate as high as 80 GBV survivors.

The 16% female genital mutilation (FGM) prevalence among 0-14 years old girls as compared to the 65% of women 15-49 years old is a great achievement in the effort at eliminating the practice. Child marriage has declined by 47% between 1990 and 2016. The female youth mortality rates of all causes per 1000 population have declined by more than two-fold among women aged 15-19 years and nearly three-fold among women aged 20-29 years. Adolescent fertility rate of Ethiopia has declined by nearly two and half-fold.

## Ending sexual transmission of HIV

UNFPA has been contributing a lot to the fight against HIV vertical and sexual transmission in Ethiopia for more than three decades by linking HIV transmission with sexual and reproductive health programs, as the majority of HIV transmission in Ethiopia is sexual. While dealing with sexual behavior of the most vulnerable group, UNFPA has been supporting condom programming and interventions protecting adolescents, youth, and women in emergency situations from sexual violence and unprotected sex. UNFPA has played its part to reduce the national HIV prevalence from 2.3% in 2002 to 0.8% in 2021.

Overall, UNFPA has significantly contributed to the remarkable improvements in the government efforts towards ending preventable maternal deaths, ending unmet need for family planning, ending GBV and harmful practices, and ending new HIV infection. However, UNFPA has experienced quite a lot of challenges over the decades. The protracted conflicts and droughts in the first two decades since UNFPA started its mission in Ethiopia and the recent inter-communal conflicts and large scale war in the North and West of Ethiopia have been challenging the country and UNFPA's successive Country Programmes. UNFPA has been spearheading the humanitarian-development-peace nexus approach in humanitarian response. Inclusion of SRH and GBV in the emergency preparation and response, ensuring health system and community resilience, and meaningfully engaging women and youth in peace building was priority areas of UNFPA in humanitarian settings. Unless peace is secured, the humanitarian crises may continue absorbing much of the resources and the regular developmental programs may be deeply challenged.

The regional and rural-urban disparities in contraceptive demand, contraceptive use, adolescent pregnancy and fertility rate among others were remarkable. A large body of data has shown the high incidence of unintended pregnancies. Half of pregnant women were giving birth at home and more than half were not attending antenatal care visits in 2016. The neonatal mortality continued being the major contributor to early childhood mortality. prevalence of GBV, gender inequality, child marriage, and FGM are among the highest in the world. These all may guide where the future actions of UNFPA need to focus.

## Data for development

UNFPA has provided financial and technical support to the government of Ethiopia in the collection and use of national gender-disaggregated population and reproductive health data for nearly three decades. UNFPA has supported three population and housing censuses, four national demographic and health surveys, and two health facility-based emergency obstetric and newborn care surveys.

In 1993, UNFPA supported the government of Ethiopia to develop an effective and realistic population policy aimed at ensuring that the rate of economic and social development is ahead of the rate of population growth. The implementation strategy of the policy was also supported by UNFPA. The process of revising the policy is currently underway with the support of UNFPA.

The UNFPA development mission is to bring about demographic transition by ensuring women and adolescent girls' health to enable reaping of the demographic dividend. UNFPA is providing financial and technical assistance to the government of Ethiopia to compile the demographic and socioeconomic profile for reviewing the demographic and socioeconomic contexts within which the country aims to harness the demographic dividend. UNFPA is also supporting the development of a road map for harnessing the demographic dividend in Ethiopia.



# 1. INTRODUCTION





## 1.1 DEMOGRAPHICS

According to United Nations (UN)-world population prospects, Ethiopia is the second most populous country in Africa and 11th in the world with an estimated population size of 126 million in 2023, which is higher than the Ethiopia Statistical Service (ESS) projection of 107 million [1]. A projection done some 40 years back (1979) by Ethiopian demographers is exactly in line with the UN estimate. Between 1990 and 2020, the population growth rate declined from 3.5% to 2.1%; however, the population size increased by more than 70 million in the same period.

Ethiopia is characterized by a young demographic profile; children and youth constitute more than two-thirds of the population. About 78% of the populations live in rural areas, typically characterized by scattered settlement, and mostly relying on subsistence farming for a living (agrarian and pastoralist). As a reflection of the population size, the population density increased from 30 persons in 1980 to 104 persons per square kilometer in 2020, with a maximum annual growth rate of 14% in 1993 and the least growth rate of 3% in 2020 [2]. Women in the reproductive age (15-49 years) are estimated at 24%.

Ethiopia is also going through a remarkable demographic transition. For decades, the population pyramids of Ethiopia were known as broad-based and narrow apex. As the total fertility continues to decline and child survival improves, the base is relatively narrowing and the middle to apex is expanding [3]. In other words, there is a progressive youth bulge and ageing over the last two decades as the adult mortality rate keeps on declining. The dependency ratio declined from 99 in 1985 to 75 in 2021, but it is still unacceptably high as 75 economically inactive persons are dependent on 100 economically active persons.

It is known that the more the dependent population, the lower the economic growth and the poorer the living standard of the people. One of the ways to lower the dependency ratio and improve economic growth is accelerating the fertility decline while addressing the unemployment, underemployment, and governance issues at the same time. The government of Ethiopia (GoE) aspires to reap the demographic dividend by improving family planning (FP) services and increasing job opportunities.

## 1.2 ORGANIZATION OF THE HEALTH SYSTEM

Following the Alma-Ata declaration in 1978, based on the six-tier health system, the GoE adopted primary health care (PHC) as a national health strategy to achieve equitable access to health services. The health policy enacted in 1993 by the transitional government of that time announced a four-tier system defined as PHC unit (five health posts and one health center), district hospital, zonal hospital, and specialized hospital, which was later changed to a three-tier system (Primary, secondary and Tertiary levels) with defined target population to serve.

Primary level (sometimes called Woreda/district level) comprises of a primary hospital with coverage of 60,000–100,000 people, a health center for 15,000-25,000 population, and five satellite health posts, each for 3,000-5,000 people. Secondary level/general hospitals and Tertiary level/specialized hospitals are expected to serve 1 to 1.5 million and 3 to 5 million population respectively. Five satellite health posts, a health center and primary hospital form a PHCU. The contribution of private-for-profit and non-governmental organizations (NGO) to the health service coverage and utilization (mainly in urban areas) cannot be underestimated. Health post is the lo-

lowest level health facility, functionally connected to the nearby health center and administratively accountable to the nearby Woreda (the lowest budgetary unit, administered by a Council, established for an average population of 100,000 people).

In 2021, there were 17,550 health posts, 3,777 health centers, and 367 primary to tertiary level public hospitals. The hospital-to-population ratio increased from 1:500,000 in 1990 to 1:280,000 in 2020, but the hospital beds per 10,000 population reduced from 3.2 to 2.7 in the same period. The set health center to population ratio (1:25,000) is near to satisfaction. Emergency obstetric and newborn care (EmONC) facilities (sum of basic and comprehensive EmONC facilities at least 5 per 500,000 population) were far less than the requirement, but progressive (11% in 2008 and 40% in 2016) [4]. Of interest, digitalizing the health facility and community-based services and referral linkage to ensure continuum of optimal maternity care and health system continuum of care are still under developed. In 2017, MoH introduced the district health information system (DHIS2) for data reporting and archiving.

The existing health workforce in the health system is estimated at 150,000-170,000. The physician-to-population ratio (1:8,000) and midwife-to-population ratio (1:6,000) are more or less to the WHO quantitative standard for low-income countries. However, skill mix of health work forces (Medical Doctors, Health Officers, Nurses and Midwives) density was estimated at 0.96/1000 population, which is lower than the African density of health workers (2.2/1000 population) and five times less than the minimum threshold of 4.45 per 1000 population set by the WHO to achieve UHC and SDG [5,6]. To meet the minimum threshold, therefore, Ethiopia needs to increase the health workforce by more than four-fold, but the current annual production is less than 10,000, and paradoxically many are not employed due to lack of budget and limited number of hospitals.

### 1.3 HEALTH POLICY FOR SRH, POPULATION, AND DEVELOPMENT

Historically, the 1957 Ethiopian Penal Code (Article 805) prohibited the use and advocacy for modern birth control methods. This was an expression of the Ethiopian governments' stand during the reign of Emperor Hailesele. Although the law was against the use and advocacy for Family planning, the government of Derg (the military administration) was somehow more liberal. Since 1991, the Ethiopian Peoples' Revolutionary Democratic Front (EPRDF) government has been highly supportive and promotive of FP, including the 1994 Constitution. However, the aforementioned law was not amended until December 1998 (Federal Negarit Gazeta, 1998) and it is now aligned with the economic, health, women, and population policies of the government.

Currently, the health policy and strategies of Ethiopia are highly supportive to reproductive, maternal, newborn, child, and adolescent health, and protection from harmful practices. The 1993 national health policy was the basis of the Health Sector Development Plan (HSDP I-IV) for the period of 1997-2015. The 20 years 'Envisioning Ethiopia's Path to universal health coverage (UHC) through strengthening of Primary Health Care (2015-2035) has served as a roadmap for the development of health sector transformation plans (HSTP I and II) as part of the second Growth and Transformation Plan of the country.

Highlights of the maternal care in Ethiopia include, comprehensive abortion care, and modern contraceptive methods in Health Care Financing strategy as UHC benefits package, the liberalized abortion law (since 2005), series of FP guidelines (since 1996), reproductive health strategies



(since 2006), series of obstetric fistula elimination strategies (since 2015), series of adolescent and youth health strategies (since 2007), the National Road Map for Accelerating Reduction of Maternal and Newborn Morbidity and Mortality (2012), the Health Extension Program (HEP) and its optimization roadmap, and the MDG Performance Fund which gave priority to maternal health. These strategies are responsible for the observed improvement in maternal and child health indicators.

The GoE has also taken several positive steps towards protecting women, children, and girls from violation of their basic human rights by signing international conventions and reiterating them in proclamations, regulations, and strategies. Among others, the Ethiopian Civil Code on any action that causes bodily harm (1960), the criminal code prohibiting female genital mutilation (FGM) (2004), the National Strategy on Harmful Traditional Practices against Women and Children (2013), National Costed Roadmap to End Child Marriage and FGM (2020-2024), and others are commendable actions. In general, reproductive, maternal, newborn, child, and adolescent health have been priorities of the Ethiopian health policy.

## 1.4 GIRLS FORMAL EDUCATION

Emperor Menelik II is applauded for initiating modern education in Ethiopia by enacting the first education proclamation in 1906 that included girls as students, which was not the case in the traditional faith-based education practice of the preceding times [7]. In about 20 years of the Education Sector Development Plan (ESDP I-V, 1997-2020), the primary school gross enrollment rate has increased from 5.7 million to more than 20 million. Initially, there was a nearly ten percent differential in girls' enrollment. But recently it is near universal with little or no difference between boys and girls enrollment. High school attendance, however, is about 50% of the expected regardless of gender [8]



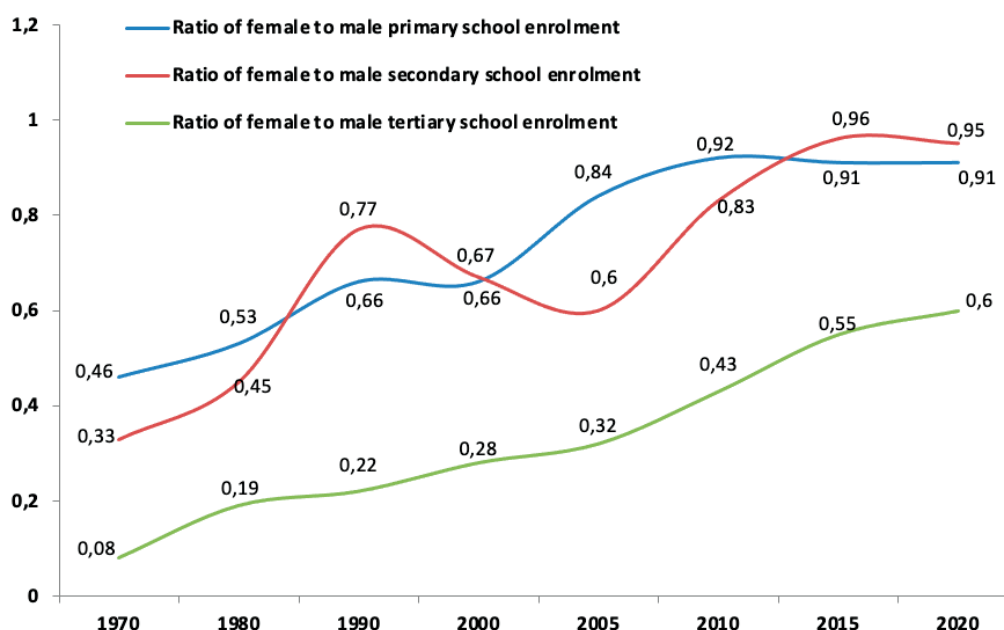
"Attending the boarding school has protected me from early marriage and other harmful practices. I want every girl to get this opportunity," said Asiah Hagere, 17, from Semera, Afar Region. She attends Girls' Boarding School supported by UNFPA Ethiopia.

Overall, nearly half of the Ethiopian population under 30 years of age is attending formal education in schools with a wider base at primary levels and narrow apex at tertiary levels of education [9]. A significant increment in female students attendance at higher education was observed over the last decade, which is in line with ESDP and SDG4, both stipulating inclusiveness and equitable quality education [10], and the UN youth Strategy (Youth 2030) that puts supporting young people's greater access to quality education as priority [11].

As shown in Figure 1, the female to male ratio of enrolment in primary and secondary school was almost comparable (sometimes even higher) for nearly 50 years. The gap between males and females in tertiary school enrolment, however, was very wide until a decade back at which time the ratio was about one female to two male students.

Nevertheless, ESDP VI situational analysis and the Education Development Road map study have identified a significant disparity between urban and rural, emerging and bigger regions in secondary and tertiary level enrolment. Although the education sector has been taking the largest share of the government budget for three decades, there have been several drawbacks and challenges limiting girls' class attendance and increasing drop out, including inaccessible secondary schools for many of the rural girls, poverty, drought, conflict, child marriage, and the need for child labor [8].

**Figure 1. Trends of female students school enrolment at primary, secondary, and tertiary schools.**



To cope with the observed pupil drop out, the introduction of digital learning (which was not considered as one form of learning method in the ESDP VI and Education Development Road map) is a timely action for girls to have access to both formal and informal education (training) without geographic barriers. Furthermore, digital learning in the digital age (supported by virtual reality and augmented reality applications) enhances creativity, innovation, critical thinking, problem-solving capacity, research and leadership skills development of girls and youth. Since educating the girl child is a key to the abandonment of child marriage and increased gender equality, stakeholders working on girls' and youth health and education (including UNFPA) may take it as a lesson for their future possible engagement.



2.

## METHODOLOGY





## 2. METHODOLOGY

Desk review and literature review was applied to collect the relevant data and carry out descriptive and narrative analyses. Selected UNFPA Country Programmes, MoH strategies, roadmaps, UNFPA project evaluations, annual national reports, national surveys by the Central Statistics Agency since 1990, MoH national health facility surveys (EMoNC, SARA, SPA+), old maternal and child health-related chronicles starting from 1960s, international commitments and vital statistics estimates (UN, WHO, UNICEF, World Bank), the WHO recommendations, and international conferences prospectuses were reviewed. The majority of these documents were accessed from electronic publications.

Thousands of scientific literature searches were done as well from international electronic databases (like PUBMED, Google scholar, African Journals of Library) by using long list of search terms addressing the issue of FP, maternal health, newborn health, unintended pregnancy, health extension program, maternity waiting homes, human resource for health, adolescent and youth health, HIV transmission prevention, SRH in humanitarian settings, gender-based violence, health policy, obstetric fistula, and population dynamics and development. The majority of scientific publications were excluded from the in-depth review after reading the titles and/or abstracts. Lastly, 54 scientific publications were reviewed in-depth and cited in this report.

Data are synthesized and narrated and some are presented in line graphs. Review and analysis of some of the maternal and early childhood health status indicators dated back to the 1970s. Some milestones for the UNFPA mission in Ethiopia are indicated in the timeline graph. The main document is organized in the line of 1) Sexual and Reproductive Health and Rights (SRHR); 2) Adolescent and Youth Development; 3) Gender and Social Norms; and 4) Population Change and Data. The purpose of this analysis is to shed light on UNFPA's contribution to the Ethiopian FP, maternal and newborn health, women and adolescent girls' rights, response to humanitarian crises, and updating national data for policies and programs.

A close-up portrait of a woman with a contemplative expression, looking off to the side. She is wearing a vibrant, multi-colored headscarf with geometric and floral patterns in shades of pink, red, and blue. Her dress is a bright blue with a colorful, intricate patterned border at the neckline. The background is a soft, out-of-focus light green.

# **3. UNFPA 50 YEARS SUPPORT IN ETHIOPIA**



### 3.1 UNFPA ENGAGEMENT AND MISSION

UNFPA's mission to Ethiopia started in 1973, just six years after it was created in 1967 as a trust fund for population issues, and four years later after it was established in its own right in 1969. In the same year (1973), UNFPA was officially given the full mandate by the UN Economic and Social Council. In Ethiopia, UNFPA is currently implementing the 9th Country Programme (CP). The CPs lasted for five years with the exception of the 7th CP, which was four years long to align with the MoH annual planning cycles (Ethiopian fiscal year). All UNFPA Country Programmes are within the framework of the Ethiopian government development priorities and the UN Development Assistance Framework (UNDAF)/UN Sustainable Development Cooperation Framework (UNSDCF). UNFPA's mission is to deliver a world where every pregnancy is wanted; every child birth is safe; and every young person's potential is fulfilled.

UNFPA Ethiopia evolved from its earlier engagement in population dynamics (population and development programs) and research to reproductive health and rights, population and development, and gender equality following the 1994 International Conference on Population and Development (ICPD), which continued up to the 7th Country Programme (CP). Taking the national and international context, a highly transformative agenda (Three plus) drawn from the global UNFPA Strategic Plan (2017-2021 & 2022-2025) was incorporated in the 8th and 9th CPs with further amendments to the latter when there was the need to program for the humanitarian situation in the country. The "three plus" transformative results were coined earlier as the "Three-pronged strategy"- ensuring all women have access to: contraception to avoid unintended pregnancy, skilled birth attendance, and quality emergency obstetric care. Interventions were targeted to address maternal mortality, gender-based violence (GBV), and harmful practices against women, sexually transmitted infections (STI)/HIV, adolescent reproductive health, and FP.

The shift in the areas of focus towards mutually reinforcing and interdependent SRHR matters was highly strategic for the achievement of the ICPD promise/goals, specifically in improving maternal health, promoting voluntary FP, avoiding harmful practices, and protecting women and girls from GBV, with continuation of the support to population census and national surveys. The adoption of universal access to sexual and reproductive health/SRH (amendment of 'improving maternal health') targets in the MDG in 2005, which was invigorated in the SDG,<sup>12</sup> is another global commitment to reinforcing the UNFPA SRHR engagement, local and international partnership.

The current 9th CP is aligned to the sustainable development goals (SDG), UNFPA global Strategic plan (2022-2025), and Ethiopian government development plan. UNFPA has taken a big lesson from the preceding 8 CPs on areas the agency can bring about maximum impact by availing essential resources (human, financial, and material) where needs are greatest and technically supporting the government endeavors on maternal health, FP, human resource for health, capacity building, policy development, RH commodities, maternity waiting homes, and humanitarian response. With this premise, UNFPA Ethiopia has adapted the revised UNFPA Strategic Plan (2022-2025) that identified six outputs and six accelerators [13].

UNFPA has been executing the CPs in partnership with government line ministries mandated on women and adolescent reproductive health (MoH), women, children, and adolescents wellbeing and safety/gender affairs (Ministry of Women and Social Affairs), financial transaction/regulation (Ministry of Finance), law enforcement and justice (Ministry of Justice), and population and development including national statistics (Ministry of Planning and Development). As a funding



agency, UNFPA has a long list of governmental and non-governmental implementing partners working on SRH, gender equality, and population and development. It has also been working with civil society organizations, media, and faith-based organizations in Ethiopia. In 2006, UNFPA initiated the innovative “Developmental Bible” project through partnership with the Ethiopian Orthodox Church. The project sought to incorporate critical health related messages in the daily teachings of the Church to its followers. The messages focused on maternal health, obstetric fistula prevention, complete avoidance of harmful traditions (FGM and child marriage), and HIV/AIDS. UNFPA also supported implementing partners working on community dialogue and capacity development.

UNFPA is a regular member of the national UN inter-agency and government working group (technical working group) for joint actions, including execution of the national priorities, national strategic document development, and work progress and performance evaluation on cross cutting issues. For coordination and harmonization of planning and implementation in maternal and RH programs, UNFPA partners with other UN agencies, including the so called H4+ (comprising UNFPA, UNICEF, World Bank, WHO, UNAIDS).



Adanech, 26, is a mother of five from Gelana Woreda, in the West Guji Zone of the Oromia Region. She recently welcomed her fifth child at the UNFPA-supported Gelana Primary Hospital. This was her first time giving birth in a health facility. "They saved our lives. Both me and my baby are doing well" she said.

UNFPA's contribution to the Ethiopian government's effort in poverty reduction and ensuring sustainable development is demonstrated by 1) engaging on initiatives that improve the health of mothers, newborns, children, adolescents and youth; 2) promoting gender sensitive and equitable reproductive health services and protection from violence; 3) availing representative and up-to-date and disaggregated population and RH data for advocacy, national policy, and program management; 4) sustainably supplying RH commodities and ensuring RH commodity security; and

5) being at the forefront in humanitarian responses to ensure the continuity of SRH services as well as prevention and response to Gender-based violence. UNFPA has also been supporting scale-up of HIV prevention initiatives in partnership with donor and implementing partners; supports youth-friendly services across the country; and supports cervical cancer prevention and improvement of clinical service quality.

Basically, UNFPA evolved its transformative results to align with global initiatives and priorities from “reduction” to: ending unmet need for FP, ending preventable maternal deaths, ending harmful practices against women and girls, and ending sexual and vertical transmission of HIV. Its intervention includes supporting the health system functions with relevance to reproductive health (RH) as per the WHO health system building blocks: leadership/governance, health workforce, health information, service delivery, financing, health commodities and technologies.

Specifically, UNFPA supports FP advocacy and services, continuum of maternity care and emergency obstetric services, women's decision making, elimination of harmful practices and GBV, platforms creating awareness of policy and legal provisions for women and children, and conducting national censuses and surveys. Adolescent and youth sexual and reproductive health education and life-skills development are important components of UNFPA actions. The agency continues promoting and supporting universal access to SRHR to accelerate progress towards ICPD and SDG to bring about a favorable policy environment for CSE and sexual health for all in the life-course. Cultivating the young persons' potential through knowledge translation and skills development, and supporting the government in evidence-based policy development and innovation are part of the 9th CP.

### **3.2 UNFPA SUPPORT TO HEALTH AND HEALTH-RELATED POLICY AND STRATEGY DEVELOPMENT**

Over the years, UNFPA has supported the formulation of a large number of national policy-related documents and roadmaps, starting from the population policy, HSDP, and FP guidelines in the 1990s to the HSTP II launched in 2015. UNFPA has been in the forefront in supporting the development and revision of national roadmaps, strategies or guidelines and development of national survey tools focusing on maternal health, FP, gender issues, adolescent SRH, and population and development.

With its close engagement, UNFPA has used its comparative advantage to incorporate the SRH and population development agenda in national survey tools and regional and national policy documents by supporting the work both financially and technically. Sector Ministries and relevant non-governmental organizations have benefited a lot from UNFPA's unwavering support to the development of policies, strategies, guidelines, and manuals in the areas of UNFPA mandate. UNFPA participation in technical working groups organized in the line ministries is another opportunity for initiating policy development, implementation, and monitoring the progress.

### 3.3 UNFPA SUPPORT TO POPULATION AND DEVELOPMENT

As noted earlier, UNFPA's mission has shifted from focusing on population dynamics to broader population and development goals, particularly after 1994 ICPD (the time RH matters gained more momentum after the Alma-Ata declaration and the Safe Motherhood Initiative ensuring universal access to RH). Specific to population and development, UNFPA has supported the GoE in collecting and using national gender-disaggregated population and reproductive health data for the development of national policies, strategies and guidelines for nearly three decades. Among others, UNFPA has provided financial and technical support to the ESS to conduct a series of Demographic and Health Surveys (EDHS in 2000, 2005, 2011, 2016, and the mini-EDHS in 2019) and three consecutive population and housing censuses. UNFPA was the lead UN agency in mobilizing technical and financial support for the conduct of the censuses in 1984, 1994, and 2007.

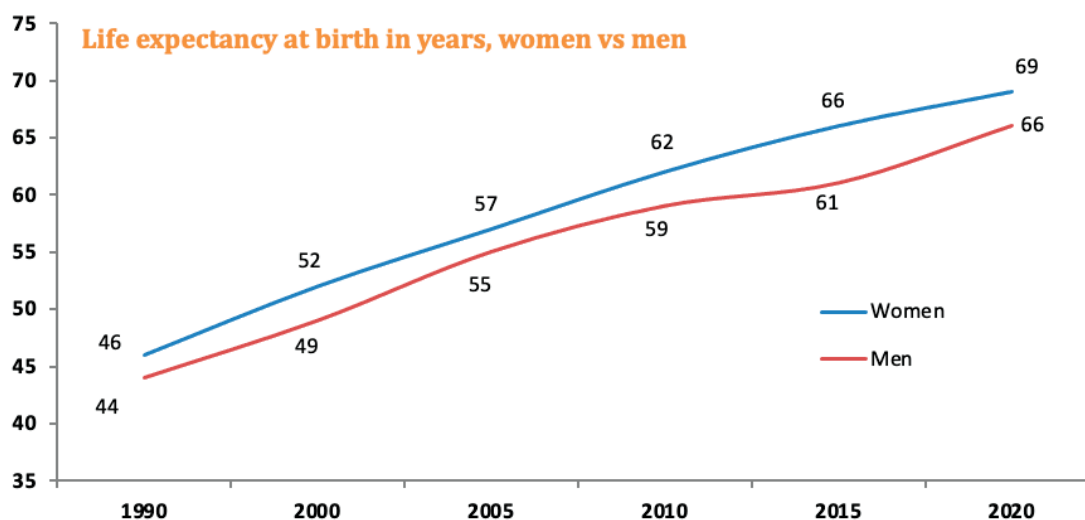
UNFPA-initiated and financially supported the 2008 and 2016 EmONC health facility surveys focusing on maternal and neonatal health, which were the basis for the development of HSTP I and HSTP II and several strategies. The survey findings helped UNFPA to convince policy makers to integrate maternal health and RH into policy frameworks and development, as well in the designing of the CPs and presenting objective evidence to donors. The fourth population and housing census planned for 2017 and the fifth EDHS planned for 2021 could not be conducted due mainly to the security situation in many parts of the country.

The UNFPA economic development mission is taking advantage of the demographic transition Ethiopia is going through to reap the demographic dividend. The rationale is that healthy and productive women with low TFR can have healthy babies, and get engaged in productivity. Later, the inevitable baby boom and bulging young population/workforce will be an advantage for the nation's economic development provided that investment for employment and good governance are in place. Reducing the HIV burden, ensuring the safety of women and girls who constitute half of the population, and supporting young people to develop their potential are also other development priorities UNFPA is supporting.

There are multiple national development indicators in Ethiopia. The trends in healthy life expectancy of Ethiopia (defined as "the average number of years that a person can expect to live in "full health" from birth") increased from 44 years to 60 years getting closer to the global average (64 years). The life expectancy of women at birth was ahead of men (Figure 2), which is also the case globally. The Ethiopian population life expectancy at birth has increased from 43 years in 1970 to 69 years in 2020, and getting closer to the global average (Figure 3) [14]. It is the reflection of a dramatic change in child survival and progressive reduction in adult mortality over the last two decades. Female and male adult mortality rate of Ethiopia declined by 60% and 56% in about two decades (1993-2016) (from 6.7 and 8.0 in 2000 to 2.7 and 3.5 per 1000 population aged 15-49 years, respectively) [15]. According to UN estimate, the proportion of the Ethiopian population below poverty line (< \$1.9 a day) fell gradually from 69% in 1995 to 27% in 2015. The GoE report has shown that population below the poverty line (with same criterion) fell from 48% in 1990 to 19% in 2019 [15].

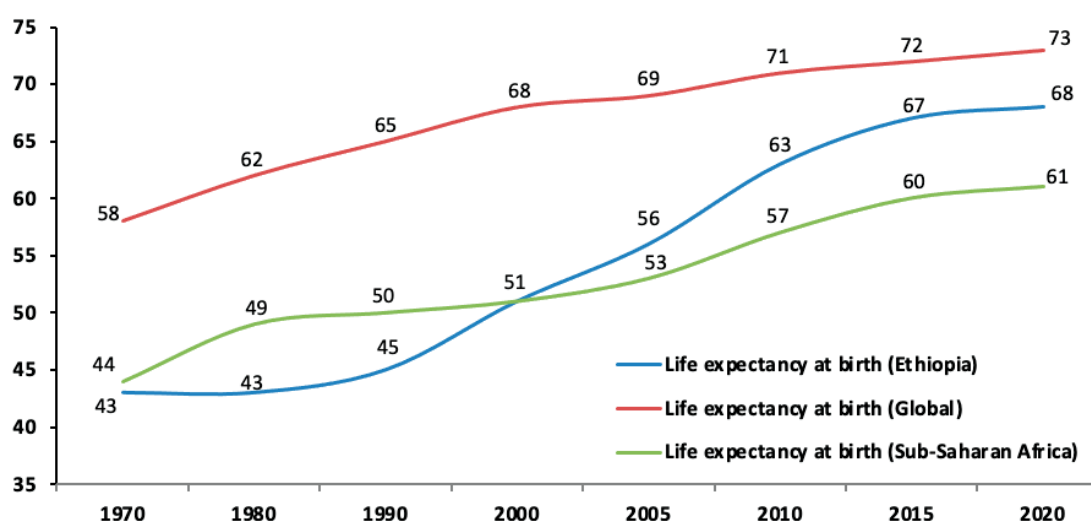


Figure 2. Trends in life expectancy of Ethiopia between 1990 and 2000.

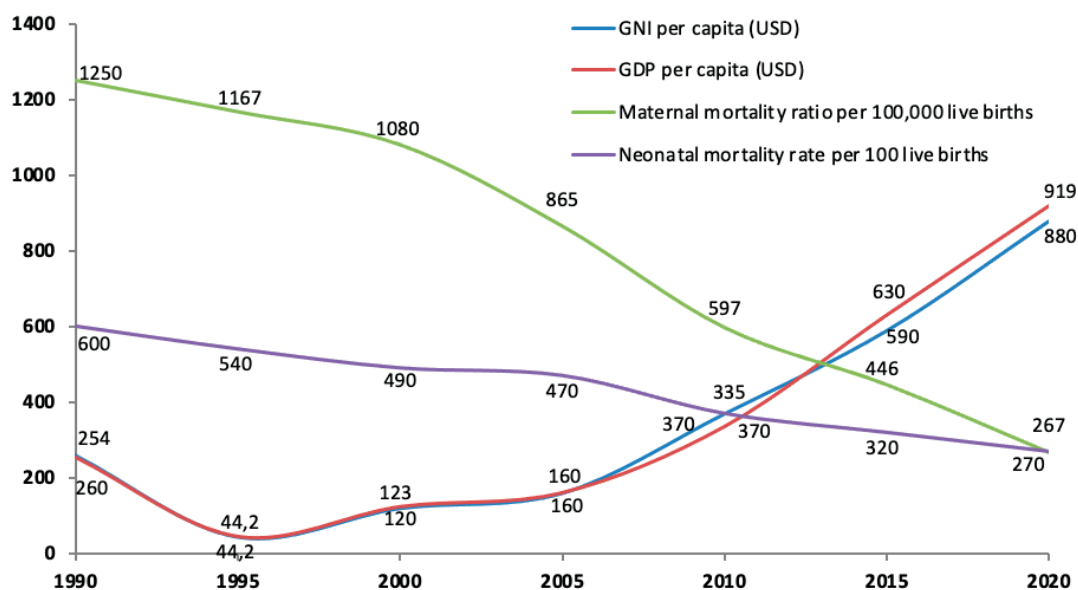


It is interesting to see the relationship between economic development and maternal and newborn health (Figure 4). Since 2000, the maternal and child health status indicators have been showing progressive improvement. Similarly, according to the World Bank estimate, the economic growth indicators have been gearing up; the GNI per capita has increased from 120 USD in 2000 to 880 USD in 2020, and GDP from 8 to 107 billion USD in the same period. Until proved otherwise, the maternal and child health status could indirectly indicate the economic status of the country. The return of investment on maternal and child health is economic growth and population development.

Figure 3. Trends in life expectancy at birth of Ethiopia, Sub-Saharan Africa, and the world. Data source: UN-population prospects.



**Figure 4. The relation of maternal and neonatal health with the economic growth, Ethiopia.**



Sindayu (18), an aspiring singer, is a regular at the UNFPA-supported Women & Girls Friendly Space (WGFS) at Sebacare IDP camp in Mekelle. She often receives standing ovations from the women. Sindayu visits the space for psychosocial support.



**4.**

# **UNFPA THREE Plus TRANSFORMATIVE RESULTS**



In this section, quantitative indicators for the progress in key milestones/transformative results are emphasized. Some detailed data are presented for the past two to three decades. In short, as per the series of CPs plans and performance reviews, UNFPA Country Programmes were instrumental in: 1) creating demand for FP, increasing utilization of the continuum of maternity care, preventing and opting for HIV testing, and reducing the gender inequality; 2) provision of high-quality information and services on maternal health, FP, and GB; and 3) capacity building in terms of supporting pre-service education at tertiary levels and in-service training and providing essential life-saving maternal and newborn health commodities and modern FP methods and quality services to public health facilities.

## 4.1 ENDING PREVENTABLE MATERNAL DEATHS

### 4.1.1. UNFPA SUPPORT TO THE MATERNAL AND NEWBORN HEALTH PROGRAM

UNFPA started supporting maternal health programs by sponsoring the Safe Motherhood Conference held in Nairobi/Kenya in 1987 (known as the first international conference on maternal mortality) that had drafted four pillars for maternal health improvement/safety (FP, antenatal care, clean and safe delivery, and essential obstetric care) [16]. Later, the safe motherhood pillars were narrowed down to “three pillars” to reduce maternal mortality (FP, skilled birth attendance, and EmONC) [17]. Then after, UNFPA became the lead advocate on maternal health globally; improving maternal and newborn health has become one of its key priority areas. With this intent, UNFPA has been supporting the Ethiopian government’s efforts to improve maternal health and RH programs for more than three decades.

In the earlier times, because of myriad factors, the government and development partners’ interventions were not that much successful; the continuum of maternity care was at its infancy and women were predominantly giving birth at home. As a result, all maternal and newborn health indicators were among the worst in the world. A tremendous change in maternal and newborn health indicators was observed after the Ethiopian government and partners adopted the MDGs and made maternal health a political agenda at national and regional level.

The African Union launched the UNFPA initiated and supported Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009 - which aims to ensure universal access to quality maternal, newborn, and child health services - in the presence of African Health Ministers [17]. CARMMA was launched in 2010 in Ethiopia during the celebration of the safe motherhood month. The regional conference on task-shifting was another major milestone spearheaded by UNFPA on South-South cooperation where it provided financial, technical, and logistics support. In 2019, the African Union review showed that 51 member countries launched the CARMMA campaign and has been implementing it. The target was changed from reduction to ending preventable maternal and child deaths (EPMCD) by 2030 and ensuring a sustainable path towards Africa’s Transformation.

From literature it is known that many of the developed nations had made preventable maternal and neonatal mortality history nearly a century back. But Ethiopia and many other low-income countries in Africa and Asia continued to report a staggering number of preventable maternal deaths until a steady reduction was noted after 2000 as presented hereunder. The development partners’ support (including UNFPA) has played a significant role to bring about equity in

continuum of maternity care and reduction in maternal and neonatal mortality in Ethiopia, which were recognized as some of the indicators of the greatest health inequity in the world [16].

To accelerate the progress towards MDG focusing on maternal health, UNFPA Headquarters launched the Maternal Health Thematic Fund (MHTF) in 2008. It was designed to be a rapid and flexible funding mechanism in 30 countries that had the greatest maternal health needs, including Ethiopia. The funding scheme, aiming for country-owned and country-driven initiatives (health system strengthening), made it innovative and instrumental to reduce maternal morbidity and mortality in countries with a large burden. The Campaign to End Obstetric Fistula and the UNFPA-International Confederation of Midwives (ICM) Midwifery Program were integrated into the MHTF scheme. In 2012, UNFPA also launched a 'Cluster Approach' to improve institutional delivery, which has probably contributed to the drastic increment in skilled persons' attended delivery in Ethiopia. Furthermore, UNFPA partnered with the Countdown Initiative, mainly to stimulate the progress towards MDG5 (maternal mortality reduction by 75% from the 1990 baseline).

The mid-term evaluation of the Ethiopian MHTF for the period of 2000 to 2010 has shown that the initiative was strategic to support the MoH interventions to accelerate the progress towards the achievement of MDG 5, primarily by focusing on the weakest links in the maternal health programs, including increasing access to quality EmONC services through supporting pre-service training, provision of essential medical equipment, and purchasing ambulances [18]. The support to the introduction of the Integrated Emergency Surgical Officers (IESO) program for CEmONC services in remote areas and the upgrading of midwifery skills to provide basic EmONC services were highly impactful among UNFPA's interventions.



Zahara, 17, visits the UNFPA-supported Women & Girls Friendly Space (WGFS) in Chifra, Afar region, after school. "I enjoy making jewelry. The women here taught me that," she says. The WGFS offers a safe space for girls like her to discuss issues like early marriage.

#### 4.1.2. THE IMPACT OF UNFPA SUPPORT ON MATERNAL AND EARLY CHILDHOOD SURVIVAL

The collective efforts (government, UNFPA, and some other partners) enabled Ethiopia to reduce the maternal mortality ratio (MMR) by 64% in 2015 (from 1,250 in 1990 to 446 per 100,000 LB) and 79% in 2020 (267 per 100,000 LB), probably indicating an accelerated annual rate of reduction in the early phase of SDG, which was not the case globally [19]. Noteworthy to mention is that an MMR of 267 per 100,000 LB was the MDG5 target for Ethiopia. The overall decline (79%) of MMR in Ethiopia in 30 years was nearly 2-fold higher than Sub-Saharan Africa (37% decline) and global average (44% decline).

In Ethiopia, home delivery was nearly universal before 1990, and maternal mortality ratio (MMR) was estimated as ranging from 1000 to 1500 per 100,000 live births (LB).<sup>20</sup> The UN-interagency estimate for 1990 was also 1,250 per 100,000 LB. SBA in 2000 (estimated for the period of 1995-2000) was 5% with little change in 2005 (6%) [15]. The prenatal care was also estimated to be below 14%. The near universal home delivery, therefore, was the major risk factor as more than two-thirds of maternal deaths occur during delivery and after birth (11%-17% and 50%-71%, respectively) [21].

As shown in Figure 5, antenatal care (ANC) four visits increased by more than four-fold and SBA increased by 10-fold in about two decades (2000-2019) [22]. Improvement in the continuum of maternity care after 2000 has drastically reduced the MMR, neonatal mortality rate (NMR), and stillbirth rates (SBR) of Ethiopia (Figures 6-9). As a demonstration for the mother-newborn/child health pair, improvement in maternal and neonatal survival was also reflected in the infant mortality rate (IMR) and under-5 mortality rate (U5MR). The comparisons of the decline in MMR, NMR, SBR, and IMR over two to five decades have shown where Ethiopia was and what progress has been made in the last two decades; in all these indicators, Ethiopia bypassed Sub-Saharan Africa and closed the gap with the global average, probably achieving convergence in less than two decades from 2020.

Although the MMR decline is commendable, Ethiopia is still among the six major contributors for global maternal deaths (Nigeria, India, DR Congo, Ethiopia, Afghanistan, and Pakistan) for the last 40 years: these six countries accounted for 50% in 1980, 51% in 2000, and 55% in 2020 of all maternal deaths worldwide [20,24-26]. Specific to Ethiopia, the MMR decline was highly remarkable (against the very large total LB) and the WHO target for 2030 (MMR of at least 140 per 100,000 LB) may be achievable unless the climate related calamities, civil and armed conflicts worsen.

Most importantly, the absolute number of maternal deaths per annum in Ethiopia declined from 33,000 in 1990 to 10,000 in 2020 (70%), which was still unacceptably high, as the majority of women died of preventable causes [27]. As per the 2020 estimate, Ethiopia was 4th with highest maternal deaths and 31st with MMR (moderate category). Ethiopia was also 5th among the top ten countries with highest sum of maternal deaths, neonatal deaths, and stillbirths [20,28,29].

As maternal and newborn health is usually inseparable and included on the line of the continuum of maternity care, both deterioration and improvement commonly go in parallel. Literally, the UNFPA support to the improvement of maternal health over the years has also been saving many newborns and infants in later ages; the accelerated reduction in MMR accompanied by accelerated reduction in NMR, SBR, and IMR is an important evidence to consolidate the linkage.



Figure 5. Trends of antenatal care visits, skilled birth attendance, and postnatal care. Data source: EDHS 2000-2019 and HSTP II projection for 2024 and 2029.

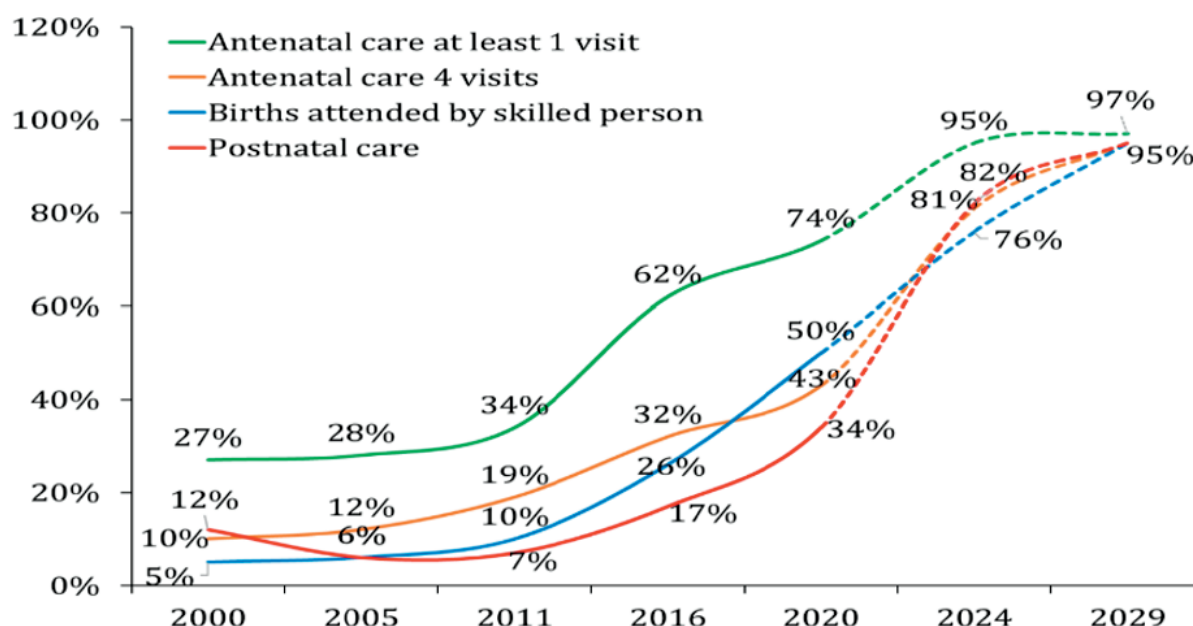


Figure 6. Maternal mortality ratio (MMR) earlier trends and prediction to 2030 assuming the 1990-2020 trends of UN interagency estimates for the world, Sub-Saharan Africa, and Ethiopia. Highlighted in red are Ethiopian maternal deaths in absolute numbers.

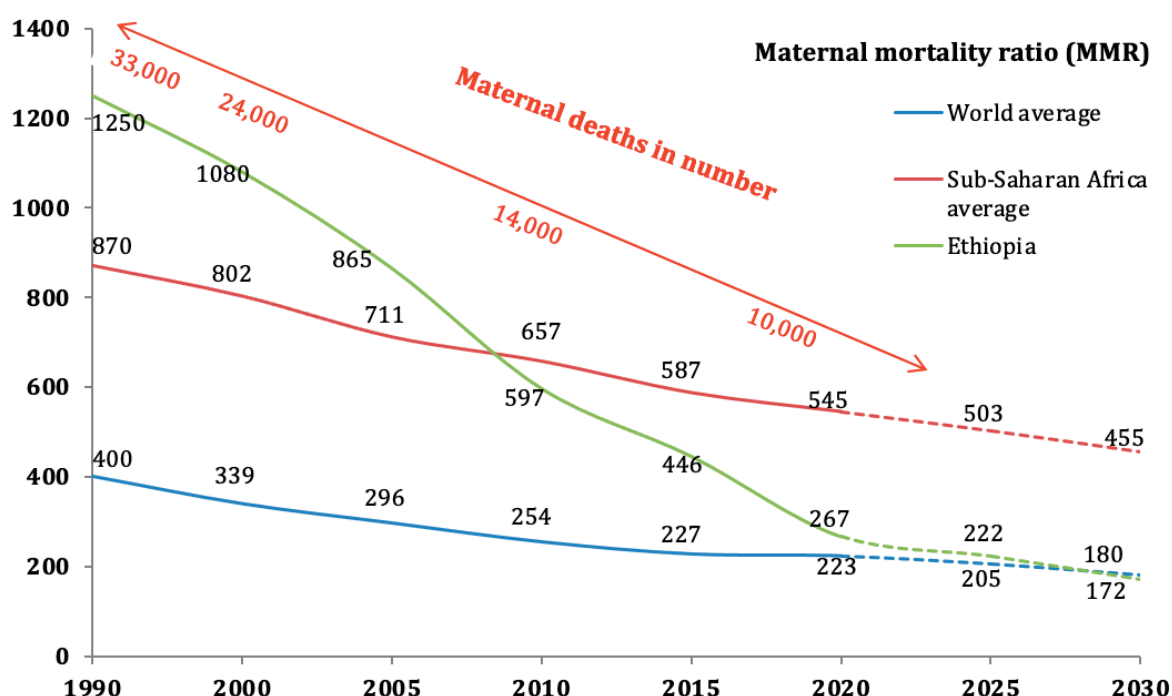


Figure 7 was developed from Ethiopian national surveys data (1990 Family Fertility Survey report and EDHS 2000-2019). Three early childhood indicators (NMR, IMR, and U5MR) for the 4 preceding years of each survey were selected to show the trends. After about 40 years, U5MR, IMR, and NMR declined by 4-fold, 3.6-fold, and more than 2-fold, respectively. The decline in NMR

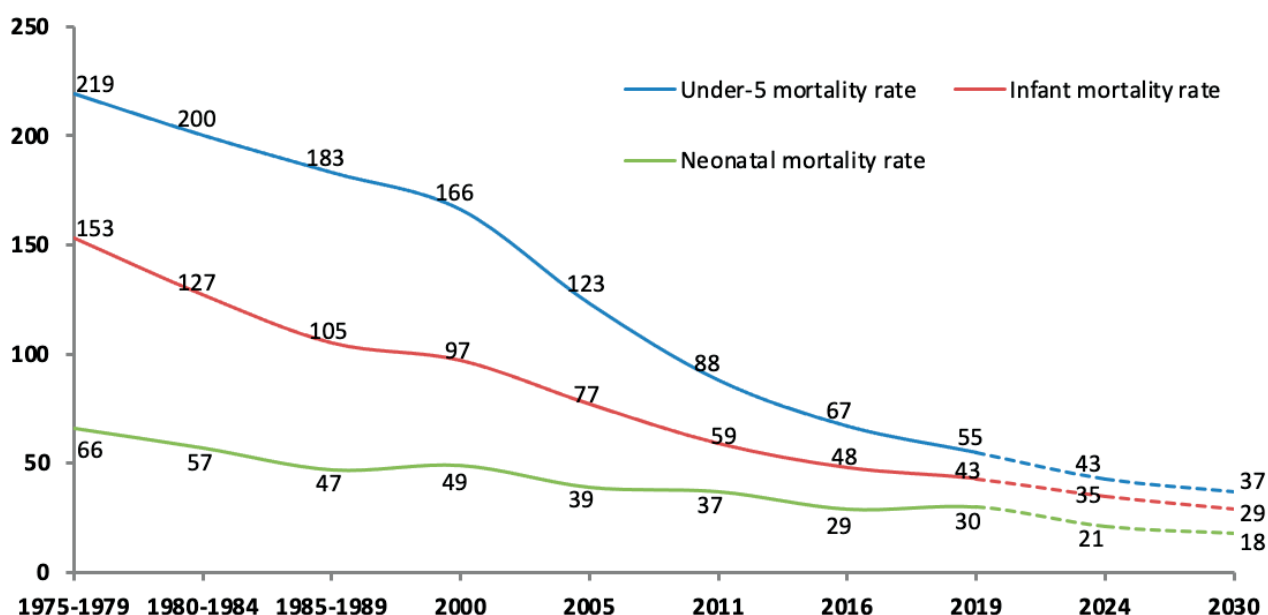
was by half less than the U5MR. Interestingly, the postneonatal mortality rate (28 days to 1 year of age) declined by more than 3.7-fold (from 48.3 in 2000 to 13 per 1000 LB in 2019), and no other indicator declined as high in the same period. These could lead to the conclusion that the early neonatal mortality (usually associated with obstetric care during delivery and after birth) has been the major contributor to early childhood mortality [15,30,31].

It was noted that the earlier UN NMR estimate for Ethiopia was a bit higher than the national survey findings (Figure 8). The estimates for the last decade, however, were proximate one for the other. Although NMR was the major contributor for early childhood mortality, the rate of decline was comparable with Sub-Saharan Africa and global average; almost a parallel decline was noted with a bit of decline of the Ethiopian NMR between 2005 and 2020.

The SBR (the commonly neglected indicator of the continuum of maternity care) of Ethiopia showed similar trends with the NMR (Figure 9). The global SBR declined from 21.3 in 2000 to 13.9 in 2021 per 1000 total births. The Sub-Saharan Africa and Ethiopian SBR remained more than 1.5-fold higher than the global average throughout the two decades. With the current rate of decline, the goal of the UN Global Strategy for Women, Children, and Adolescents' Health (2016-2030) and SDG target for every country of reducing NMR to 12 and U5MR to 25 per 1000 LB (SDG target 3.2) may not be achieved [32]. Similarly, the target for SBR (12 or fewer per 1000 total births) [33] may not be achieved unless the pace of reduction is further accelerated by introducing new initiatives.

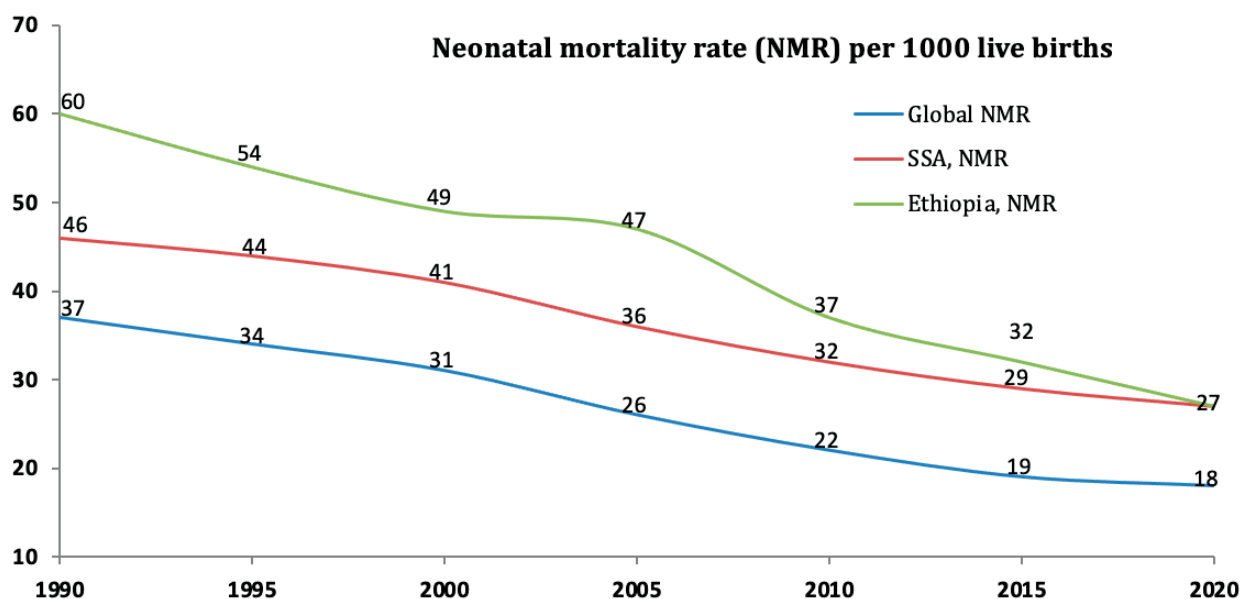
In one of the teaching hospitals, the perinatal mortality rate was 71.6 per 1000 live births between 1995 and 1996 [34]. According to EDHS, perinatal mortality rate (number of stillbirths and early neonatal deaths) per 1000 pregnancies lasting 7 months or more has also declined by about 37% from 52 in 2000 to 33 in 2016 [15]. According to UN estimate, as compared to the Sub-Saharan Africa average, IMR of Ethiopia showed a dramatic decline, and predicted to converge to the global average by 2030 (Figure 10). In about 50 years, the IMR declined by more than 4.9-fold.

**Figure 7. Trends of early childhood mortality in Ethiopia 1975-2019 with projection to 2030. Data source: 1990 Family Fertility Survey report and EDHS 2000, 2005, 2010, and 2016.**

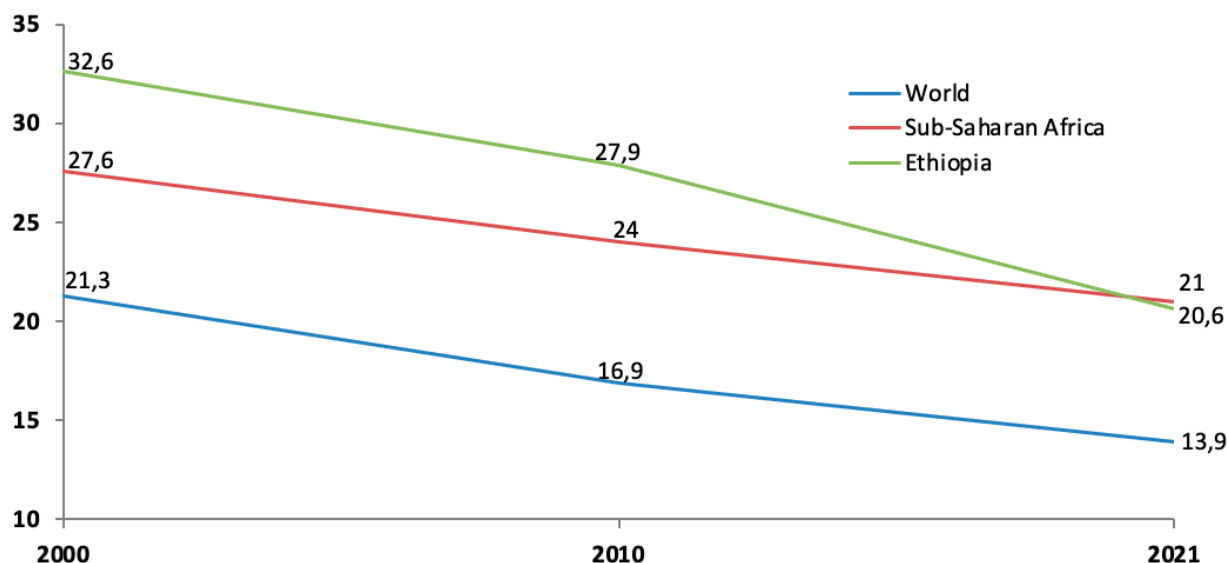


In general, despite a substantial progress in the ratio of maternal mortality and rates of early childhood survival, the number of maternal and perinatal deaths are still very high; the NMR declined to the Sub-Saharan Africa average, but the number of neonatal deaths in 2020 was higher than 2015 (87 thousands vs 104 thousands), all indicating that access to and quality continuum of maternity care (during pregnancy, labor and delivery, and the postpartum maternal and neonatal care) are not yet optimal. The rural-urban disparity is much better than before, but still very large (in 2016 and 2019 urban vs rural SBA were 79% vs 20% and 72% vs 43%, respectively, which were partly the results of maternity waiting homes expansion as noted below).

**Figure 8. Global, Sub-Saharan Africa, and Ethiopian neonatal mortality rate trends, 1990-2020. Data source: UN-Population prospects, UN IGME, 2022.**

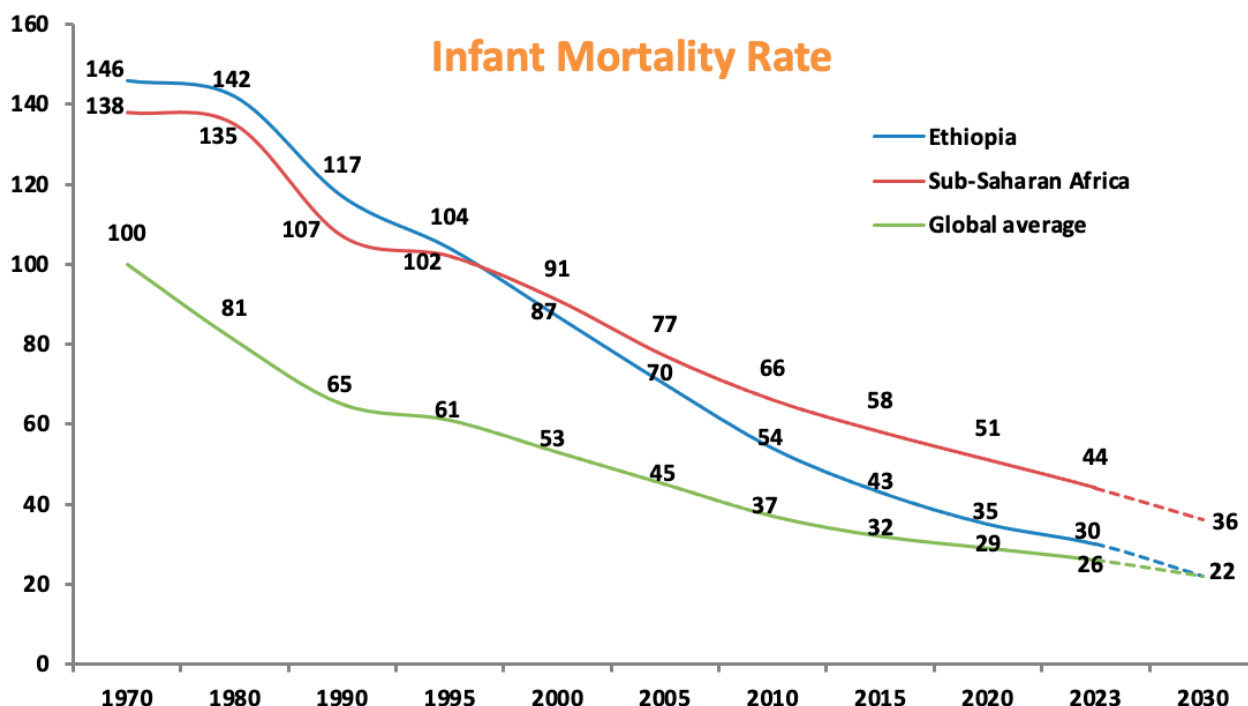


**Figure 9. The global, Sub-Saharan Africa, and Ethiopian trends of stillbirth rate per 1000 total births between 2000 and 2021 as per the SDG region. Modified from UN IGME, 2022 data.**





**Figure 10. Trends of infant mortality rate (IMR) per 1000 live births for Ethiopia, Sub-Saharan Africa, and the world, 1970-2023 with projection to 2030. Data source: World Bank and UN-Population prospects.**



#### 4.1.3. UNFPA SUPPORT TO THE HEALTH EXTENSION PROGRAM

UNFPA was at the forefront in supporting the health extension program (HEP) which was initiated in 2003 as a pilot and fully implemented since 2005. The HEP (a nation-wide community health program) was one of the most successful initiatives in Ethiopia to deliver preventive and promotive health services at community level by bringing community participation and engagement through creation of awareness, behavioral change, and establishing Women Development Team/Army (each led by a network woman leader) and giving recognition to “model family”. Each Women Development Team could have many One to Five Networks, which had a weekly performance evaluation and action plan [35]. The Health Extension Worker (HEW) and a staff from the nearby health center join the monthly Women Development Team meeting represented by One to Five Network leaders. Related, pregnant women’s conferences were introduced in most parts of the country for the same purpose (creating community awareness and motivating service utilization, including maternity waiting homes).

The contribution of the community structure (One to Five Networks and Women Development Teams) and pregnant women’s conferences to the improvement of health status in general and maternity care, vaccination, and FP service in particular was remarkable. Both platforms gave an opportunity for pregnant women to have ANC, make optimal birth preparedness, and deliver in a health facility. A longitudinal study by Pankhurst and Espinoza has identified that access to the HEP has resulted in a significant improvement in SRH [36].

In the first decade since launching, amongst others, the HEP was applauded for increasing the FP service utilization, maternity care utilization, vaccination, HIV testing, insecticide treated mosquito

nets' utilization, household latrine construction, hand washing, environmental sanitation, bridging the gap between the community and health facilities through the deployment of the HEW with the principle of "live with the community, learn from the community, and love the community ideas and commitment (basically starting the service with what they know; build the health post with what they have; and let them own the problem and find the solution) [37]. All these interventions are in line with the 1978 Alma-Ata Declaration on primary health care.

Roll out of the community level programs, including implant insertion, the use of misoprostol for postpartum hemorrhage, treatment of child pneumonia, SMARTSTART (to scale up contraceptive use and support adolescent-girls to delay pregnancy), pregnant women conference, integrated community case management (ICCM), earlier community based newborn care (CBNC), and later integrated community management of newborn childhood (ICMNC) illnesses were possible and impactful with the HEP. Out of 16 packages level I HEW are supposed to provide, five are interlinked and in the category of family health services (maternal and child health, FP, immunization, adolescent reproductive health, and nutrition).

The HEP is praised for its contribution to the earlier cited MMR, U5MR, IMR, NMR and SBR reductions, 90% decline in new HIV infections, 73% decline in malaria-related deaths, and more than 50% decline in TB-related mortality between 1990 and 2015 [38]. As a revitalization and optimization of the HEP, a roadmap was developed for 2020-2035: The aim was to staff the health posts with two health officers, nurses, midwives, environmental health professionals, and HEWs; upgrading health posts infrastructure; digitalizing the health information system; availing water, electricity, sanitation; and increasing accountability and responsiveness to the community needs [39].

Thirteen Blended Learning Modules for HEW training were developed with the support of UNFPA and UNICEF in 2010. UNFPA's support continued in-service training of HEWs in a number of areas, including refresher training on community conversations and clean and safe delivery [40]. In parallel, HEP advocacy and promotion works were getting high media coverage and community awareness creation through conferences and other meetings. Government slogans of that time were: "no mother should die while giving birth", "universal access to health facility delivery", and "home delivery free Kebeles." (Kebele is the smallest administrative structure).

In general, UNFPA's and others' support and the government's commitment to the implementation of the HEP and by design the program giving priority to community engagement, ownership, and women's empowerment is the secret for the remarkable improvement in maternal and child health over the last two decades. The very exceptional legacy of the HEP is community health demand creation. Lack of contraceptive method mix, community fatigue with only prevention services by HEW, inaccessibility of health facilities for delivery, and limited career development for HEW were some of the challenges of the program.

#### 4.1.4. UNFPA SUPPORT TO MATERNITY WAITING HOMES

In Ethiopia, the first maternity waiting home (MWH) was established in the 1970s by a Catholic missionary hospital (Atat hospital), but was not given attention by the MoH until about a decade ago. There has been a large expansion of MWHs since 2014. The GoE has expressed its commitment to establish MWH at all public health centers and hospitals as per the WHO

recommendations in the 1990s. UNFPA was one of the earliest to support the scale up of the initiative through its implementing partners, by technically and financially supporting the program, primarily to equip and furnish the MWHs, to make pregnant women feel at home or better. Facilities provided included individual beds with mattresses/only mattresses, bed sheets, blankets, television set, kitchen utensils, and carpets. During the 7th CP, UNFPA supported six regional health bureaus to establish MWHs in health centers and hospitals. During the 8th CP, two more regional health bureaus in Gambela and Benishangul Gumuz, where the 2016 EmONC survey showed lack of MWHs, were supported.

Structural foundation of the MWHs could be a dedicated room in a health facility (constructed for other purposes but used for maternity waiting), nearby residential home serving as MWH, or a standalone house constructed within the health facility compound (very common type). The MoH developed a guideline on the establishment of standardized MWHs in 2015. The major purpose is to address geographical barriers (limiting/obstructing access to health facilities emergency services) to utilization of maternal health services, regardless of risks identified. Financial and material sources for the construction of MWHs were from the Woreda administration, health facility internal revenue, and community contribution. At the minimum, frequent ANC checkups, daily vital sign measurement, 24 hours delivery services, and three meals per day are provided.

The impact of MWH was highly significant in improving maternal and perinatal health; a review of the 2016 EmONC national census of 3,804 public and private health facilities has shown that 53% health facilities (56% among health centers and 27% among hospitals) had established MWHs. The perinatal mortality and direct obstetric complication rate were 47% and 49% lower in hospitals with MWH than those without MWH [41,42], for which the contribution of UNFPA was immense. Keeping pregnant women in MWHs is not only to increase the SBA, but also to detect high-risk pregnancies or labor and post-delivery complications and facilitate early referral. A multicountry review (including Ethiopia) has shown that lack of pre-referral communication, poor referral system monitoring, inadequate transportation system, and poor referral documentation as health system factors had been contributing to increased maternal and neonatal morbidity and mortality [43].

More evidence has been emerging on the importance of MWH in terms of improving access to SBA and reducing maternal complications [44,45]. Basically, it is a means to ensure health facility-based care throughout the continuum of pregnancy, delivery, and postpartum period for both the mother and her baby. Such intervention has critical impact in reducing the three-quarters of maternal and newborn deaths occurring before and during childbirth [46,47]. A wealth of data from other countries has shown the effectiveness of MWHs in increasing utilization of maternal and newborn care services and improving birth outcomes [48,49]. But, its utilization in pastoralist areas of Ethiopia was significantly lower than in agrarian areas unless previous pregnancy complications was experienced and supported by family and the community [50].

The programmatic implication is that supporting pregnant women from hard-to-reach areas to deliver at a health facility by keeping them in MWHs is not sustainable. The long lasting solution is making the health facilities more accessible by constructing more health centers. Instead of adhering fast to the strategy of one health center to 25,000 population, the approach should also take into account the geographic distribution of the people, topography, and mode of living (the mobile pastoralists in particular). Contributions by the community in the form of money and cereals for the construction and running of the MWH services will bring about community fatigue sooner or later. Therefore, either the government has to budget it or some other source needs to be sorted out, like diversifying the health facilities income generating schemes.



#### 4.1.5. UNFPA SUPPORT TO STRENGTHEN HUMAN RESOURCE FOR REPRODUCTIVE HEALTH DEVELOPMENT

The UNFPA commitment to support the EmONC was also through building the health workforce for maternal health; building the capacity of government training institutions for midwives, anesthetists, and non-physician clinicians for emergency obstetric care by strengthening partnerships with key stakeholders and mobilizing adequate resources was capitalized on in the 7th CP, the period in which health workers in all service portals were meager [51]. The MoH developed a Human Resource for Health Strategy for the period of 2009-2020 that has recognized the need for scale-up of midwives and the new cadre of the Integrated Emergency Obstetric and Surgical Officers (IESO). The strategy (developed with the support of UNFPA) also targeted producing 8,635 midwives, 820 obstetricians, and 233 anesthetists by the year 2015. The IESO program, in particular, was developed with the principle of task-sharing approach for emergency obstetric care by training non-physician clinicians (health officers) at Master's level to alleviate shortages of skilled human resource particularly in rural areas.



A school Girl who received a Dignity Kit from UNFPA at Dawit elementary school in Dilla city, Gedeo Zone, SNNP Region.

Invariably, prior to the 6th CP the UNFPA support for EmONC was on the line of in-service training. The extremely low health workforce to provide maternal health service along the continuum of care and the desperate demand from MoH has compelled UNFPA to shift the support to pre-service training, practically supporting medical schools and colleges to produce large number of midwives, nurse anesthetists, and integrated emergency surgical officers, to make the EmONC team complete fully functional. MHTF was an appropriate platform for such urgent GoE demand and priority. The support to higher education includes equipping training facilities, hiring academic staff, travel for benchmarking other countries' experiences, and learning about non-doctor clinicians providing emergency surgery by organizing international conferences. A task sharing/shifting conference in 2009 in Addis Ababa that had gathered 42 countries with experience of deploying non-physician clinicians to increase access to EmONC or those who showed significant interest in similar undertaking was a learning curve for the launching of an innovative non-doctors training program in integrated emergency surgery.

Although UNFPA had been engaged since 2007 in supporting three year training for health officers at Master's degree level in Integrated Emergency Obstetrics and Surgery curriculum validation, its full support started in January 2009 when the program was launched in three public Universities (Jimma, Mekele, and Jimma). Later three more universities launched the program, and it was possible to graduate more than 1200 IESOs who are able to perform emergency surgery, including caesarean section and laparotomy. The impact of this program at national level was rigorously assessed in 2015 by an independent body (Ethiopian Society of Obstetricians and Gynecologists) by surveying 96 hospitals. The conclusion was: "The deployment of ESOs in all health facilities (Primary and General Hospitals) has remarkably increased access to MNH and emergency surgical care services with improved maternal and perinatal outcomes." Furthermore, it was noted that the volume of maternal and newborn health and emergency surgical services showed remarkable increment in the years after the deployment of IESOs, whose contribution to the reduction in maternal and perinatal mortality was substantial.

There are also other bodies that have conducted a national survey on the program and showed the improved access and increased maternal and neonatal health services in remote areas after deployment of the IESOs. This is because IESOs and midwives are critically important to prevent maternal and perinatal deaths during the most critical time (intrapartum and postpartum); SBA is a well substantiated intervention to reduce maternal and perinatal morbidity and mortality [52].

From the national EmONC assessment, UNFPA was also shown to have supported training for nurse anesthetists and for midwives at Diploma and Bachelor level (a few at Master's level) in ten Colleges/Universities. That is why investigators agreed that UNFPA has been instrumental in the implementation of task-shifting for non-physician clinicians and the development of relevant curricula [53,54]. UNFPA's human resource capacity development has also continued financing the in-service training of doctors, midwives, nurses and health extension workers in areas such as family planning, EmONC, obstetric fistula, and STI/HIV prevention and management with lower scale. The contribution of UNFPA for the 25-fold increment in midwives number (from 818 in 1990 to 20,228 in 2019) was remarkable.

#### **4.1.6. UNFPA SUPPORT TO PREVENTING AND TREATING OBSTETRIC FISTULA**

Ethiopia was known for exceptionally high prevalence of obstetric fistula (the worst indicator for lack of obstetric care), FGM, trachoma, and stunting for about a century. The only isolated fistula hospital in other parts of the world known from literature was closed in 1895 in New York city when the injury was totally prevented by caesarean deliveries. Obstructed labor cases were totally prevented between 1935 and 1950 in the United States of America (US) and Europe. Dr Reginald Hamlin and Dr Catherine Hamlin, the couple who came to Ethiopia in early 1959 to serve as gynecologist, were heartbroken by the flood of fistula patients to Addis Ababa and were determined to heal the physical and psychological wounds of ostracized and desperate women. With generous support of international donors and their commitment, it was possible to construct and establish the Hamlin Fistula Hospital and its five satellite centers across the country, and provided free curative services to more than 60 thousand women with obstetric fistula since the first Hamlin hospital was established in 1974.

All the way, UNFPA has been a strong partner of Hamlin Fistula Hospitals in supporting curative services, tracing fistula patients in the community, and preventing the occurrence of obstructed labor (the cause for obstetric fistula) by enhancing access to health facility and improving the quality of basic and comprehensive obstetric services. It has been observed that obstructed labor and obstetric fistula cases were progressively and significantly declining, to the extent that no obstructed labor and fistula cases were coming to hospitals (as many gynecologists shared their experience in different national meetings) for more than a decade.

Hamlin Fistula Hospital and its centers were also reporting that they were not performing up to their capacity over the last decade due to lack of fistula cases (3-4 cases on average per week while the capacity of regional centers was 9-10 and central was 15-18 cases). Earlier, EDHS 2016 report has shown obstetric fistula prevalence of 0.6% out of the total deliveries and 0.4% out of the total women aged 15-49 years. The national strategic plan for elimination of obstetric fistula (2021-2025) target is to reduce the obstetric fistula prevalence to <1% and incidence from 0.03% to zero [55].

To ensure that no fistula cases are left behind, the central Hamlin Fistula Hospital has been organizing fistula tracing campaigns by going house-to-house, but the yield has been extremely low; many of the cases traced were pelvic organ prolapses and urinary incontinence due to some other pathology. Some other implementing partners with similar intentions were not able to get many fistula cases. In late 2022, another house-to-house survey enabled identifying some women with suspected fistula. As a result, most fistula surgeons are performing some other surgeries (including pelvic organ prolapse and other urogynecologic surgeries). What is lacking, probably to declare elimination of obstetric fistulae, is a national survey.

There is no doubt that the observed result is the success story of the government and partners' years' long all round interventions. In collaboration with its partners, UNFPA launched the global Campaign to End Obstetric Fistula in 2003. The UN declared May 23 to be an International Day to End Obstetric Fistula since 2012. Since 2015, UNFPA partnered with the MoH to eliminate obstetric fistula from Ethiopia. The obstetric fistula elimination strategy was developed with UNFPA financial and technical support.

Since Obstetric fistula cases are becoming rare, in collaboration with the central Hamlin Fistula Hospital, UNFPA launched a three-year joint project focusing on improving access to treat fistula and uterine prolapse, and screen and refer cervical cancer cases in 2019 [56]. In general, the progressive decline in maternal and neonatal mortality and the very rare occurrence of obstructed labor have contributed to the rare occurrence of obstetric fistula in the last decade. The next step for UNFPA is probably conducting a national survey for obstetric fistula.



## 4.2. ENDING UNMET NEED FOR FAMILY PLANNING

### 4.2.1. UNFPA SUPPORT TO THE FAMILY PLANNING PROGRAM

In Ethiopia, Family Guidance Association of Ethiopia (FGAE) pioneered the FP service in 1966. With the support of UNFPA, the MoH and Ministry of Industry and State Farms started the FP services in many public health facilities and industry clinics in late 1980s. After two decades contraceptive pills and intrauterine contraceptive devices (here in after IUD) were introduced into the global market (1960s) as modern contraceptive methods [57]. The outcome of the FP program was well observed in Ethiopia over the last three decades as TFR declined from 7.7 in 1990s to 3.8 in 2020 (urban areas near replacement level) [15,58-60]. As a result, Ethiopia is grouped among countries with the largest reductions in TFR for the period of 2010-2019 [61]. Of interest, the reduction in TFR in turn is attributed to the significant reduction of the global maternal and infant mortality [62-64].

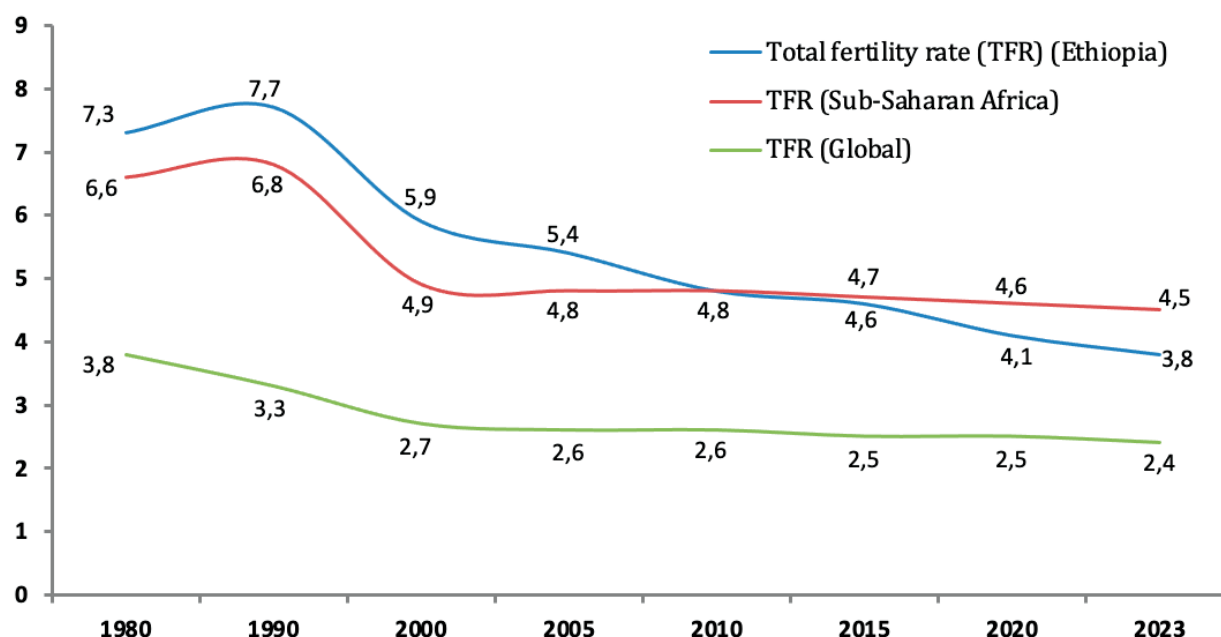


A young woman receiving care at the UNFPA-supported Youth-Friendly Space (YFS) in Haroresa health center, YFS, Dilla City, Gedeo Zone, SNNP Region.

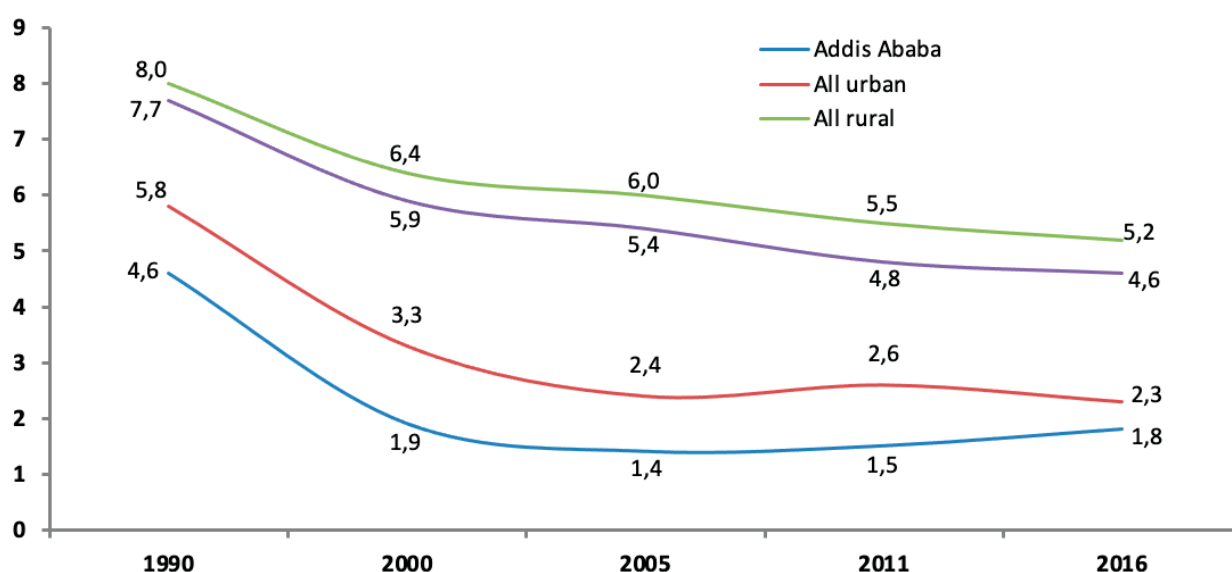
However, the TFR of Ethiopia (Figure 11) is still far from the global average and predicted to continue in high range largely contributing to the global population for several more decades, and convergence may not be possible before the end the current millennium [65] unless urbanization and industrialization are accelerated; universal girls' education is sustainably assured; and the urban-rural divide is narrowed down by ensuring service equity and gender equality. Earlier convergence in demand for FP and contraceptives use may not necessarily be a far-fetched possibility for countries with the majority of their population educated and have access to FP. Convergence in FP demand and use was noted in 185 countries globally since mid-1990s [66], which was also noted in urban areas in Ethiopia as described below with other indicators.

As shown in Figure 12, the urban-rural gap is very wide; after 2000, the TFR of rural areas was more than 2-fold higher than urban areas. In the same period, the TFR of urban areas was near replacement rate (TFR of 2.1), which is ideal as both high and low TFRs are not desirable. The TFR in Addis Ababa continued being below replacement rate for two decades (1995-2016). The achievement in TFR reduction in urban areas for more than a decade passes a message that it is possible to bring about proximate result in rural areas.

**Figure 11. Trends of total fertility rate (TFR) of Ethiopia, Sub-Saharan Africa, and Global between 1980 and 2023.**



**Figure 12. Total fertility rate trends of Ethiopia disaggregated as the whole country, rural, all urban, and Addis Ababa. Data sources: Family Fertility Survey 1990, EDHS 2000, 2005, 2011, and 2016.**



There are other indicators for the successful accomplishment of the FP program in Ethiopia, for which UNFPA takes the lion's share of the credit. Among others, the increased contraceptive prevalence rate (CPR) by 5-fold increased contraceptive demand, increased postpartum and postabortion contraceptive uptake, reduction in TFR, reduction in maternal mortality, increased child survival, and change in population pyramid.

By 1990, 94% of urban and 57% of rural women aged 15-49 years knew at least one type of contraceptive method. In 2016, contraceptive knowledge became near universal (99%). As shown in Figure 13, women in the reproductive age (15-49 years) had good knowledge about pills and injectables and somehow about implants. Little knowledge improvement was seen after 25 years in IUD and sterilization methods, which has probably been reflected on the utilization of the methods (Figure 14). Interestingly, despite good knowledge about contraceptive pills, there was almost no change in the proportion of pills used between 1990 and 2016. To the contrary, two-third (65%) of modern contraceptive method users used injectables and nearly a quarter (22%) of women used implants. The focus of the UNFPA's 6th CP was on long-acting contraceptive methods to increase the CPR [67]. Sterilization methods were the least preferred, probably due to lack of awareness, poor counseling, lack of experts and set up for the service, or due to high fertility desire.

Similar trends were observed in many other Sub Saharan African countries; the proportion of female and male sterilization, IUD (with exception of West Africa), and pill utilization remained flat between 1994 and 2019. Female sterilization is the most common method in Asia, Europe, North and South America, which has probably contributed to the below replacement rate for half of the global population. IUD is widely used in North and West Africa and Asian countries [68], but not in Ethiopia. The big difference in contraceptive methods' use between Sub-Saharan African countries and other parts of the world may interest researchers to draw several hypotheses. One factor for low preference to sterilization is probably the still high need to have many children in Sub-Saharan Africa as the majority is influenced by religious doctrine, cultural beliefs, and concerns over side effects, and patriarchal society/husbands disapproval. From practice, it is known that shortages of set up, commodities, and providers for sterilization and IUD use, and fear of invasive procedures (male and female sterilization) are common factors contributing to the high unmet needs.

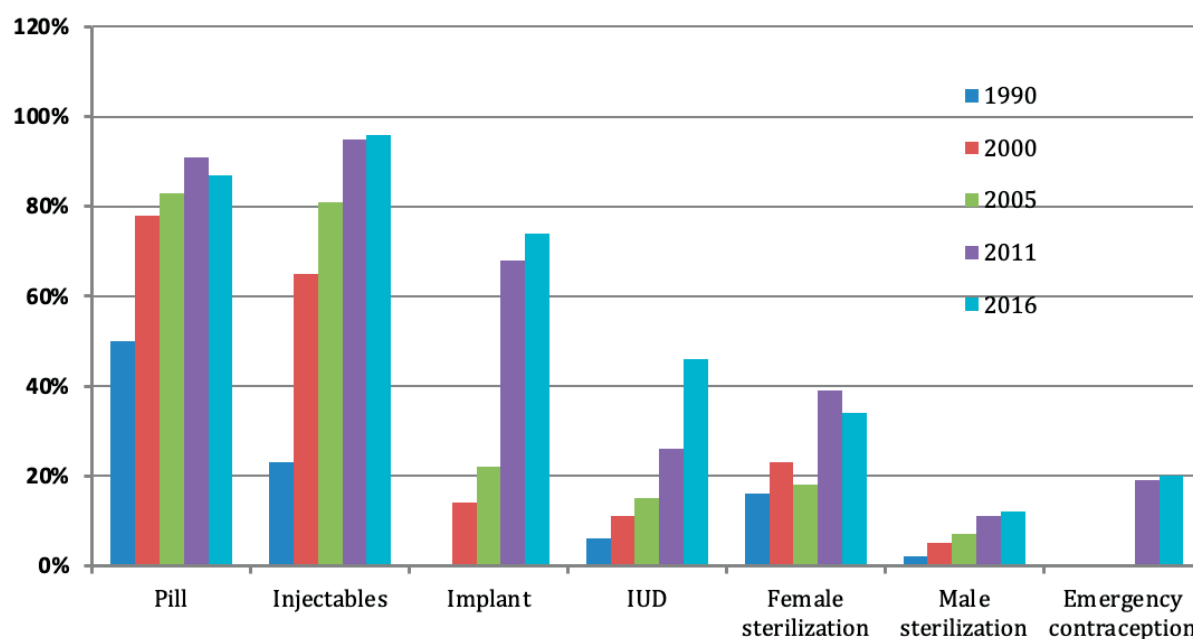
Effectiveness of method, recommendation from peer users, low incidence of forgetfulness, and the relatively longer intervals for administration were common reasons for preferring injectable contraceptive to others in Ghana [69]. Another study has noted that longer protection, better child-spacing, and method effectiveness are the most common reasons for choosing long acting reversible contraceptive methods [70]. A robust analysis of available quantitative and qualitative data from all regions in the globe has concluded that contraceptive users have diverse values and preferences [71]. The long fasting seasons may be another factor for Ethiopian women not to prefer pills.

Some other contraceptive methods (like patch, vaginal ring, and quinacrine sterilization) are not available, which are presumed to be most preferred as their administration can be self (patch) or as such do not need highly skilled providers, and more than that they may reduce the unmet needs due to fear of adverse effects and invasiveness of some of the procedures. Probably incorporating such methods in the national guidelines and UNFPA CPs may guide for availing them in Ethiopia. With those limitations, as shown in Figure 15, the national modern CPR has

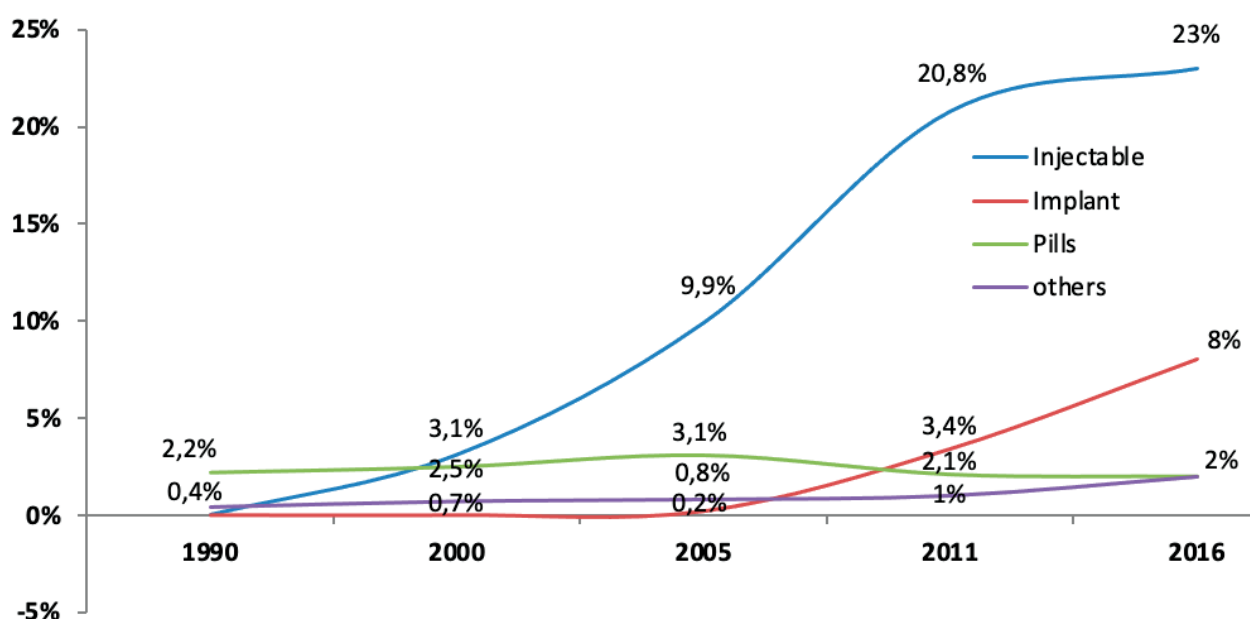


increased from 1.25% in 1980, 2.9% in 1990, 6% in 2000, and to 41% in 2019 [15,72,73]. Unmet contraceptive need (as one of universal RH coverage indicators) showed a significant reduction, but it is still among the poor performance indicators (Figure 16). The 2016 unmet contraceptive need report (22.3%) of Ethiopia was comparable with FP2020 initiative focus countries (21.6%) and Eastern and Southern African countries (21.5%) [74-76].

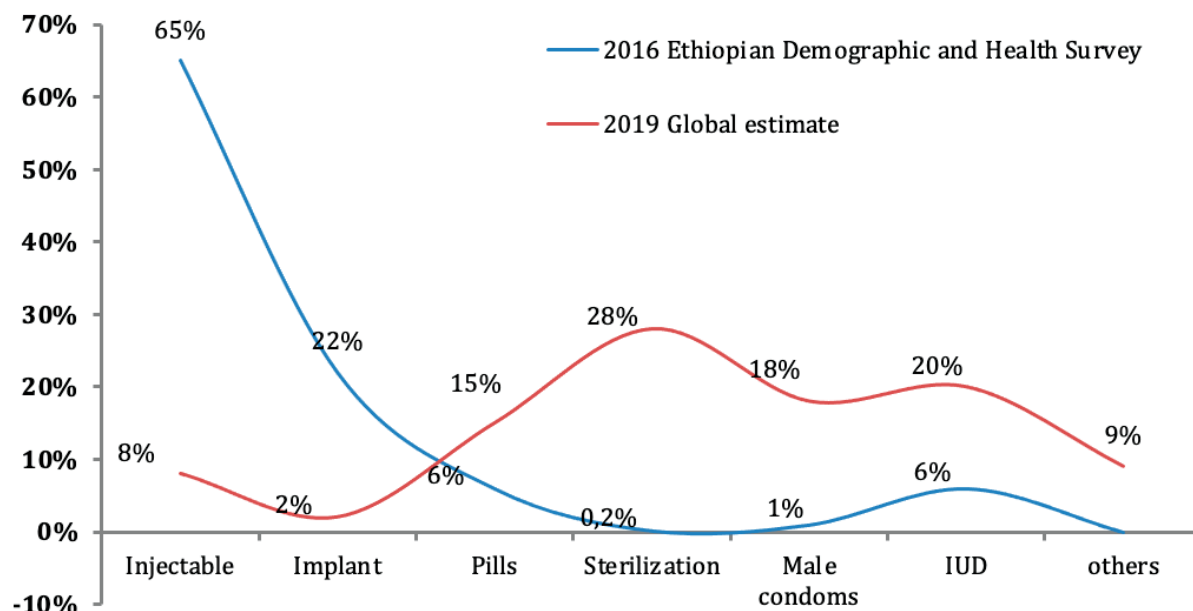
**Figure 13. Trends of all women aged 15-49 years contraceptive knowledge of any method, 1990-2016. Data sources: Family Fertility Survey 1990, EDHS 2000, 2005, 2011, and 2016.**



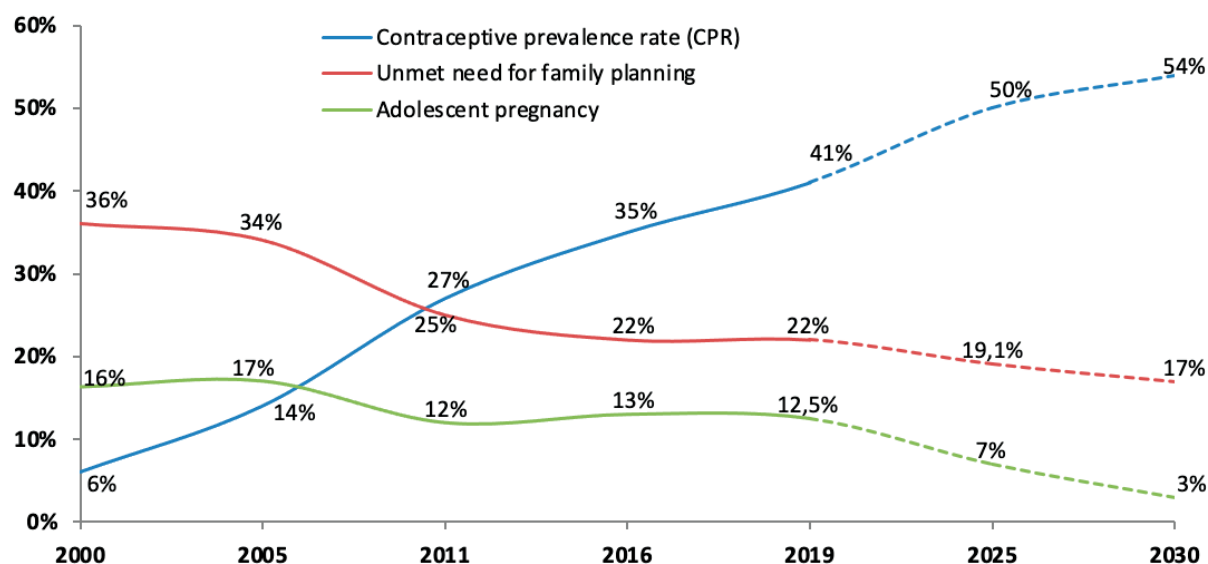
**Figure 14. Trends of contraceptive methods use prevalence in Ethiopia. Data sources: Family Fertility Survey 1990, EDHS 2000, 2005, 2011, and 2016.**



**Figure 15. Proportion of women of reproductive age (15-49 years) using various contraceptive methods, based on a comparison between the 2016 EDHS report with the 2019 global estimate. Take note that the 35% CPR of Ethiopia in 2016 was considered as 100% and the proportion for each method was computed accordingly.**



**Figure 16: Trends in modern contraceptive use and unmet need among married women, as well as the proportion of teenage/adolescent pregnancy over the last 20 years, with projections to 2029.**



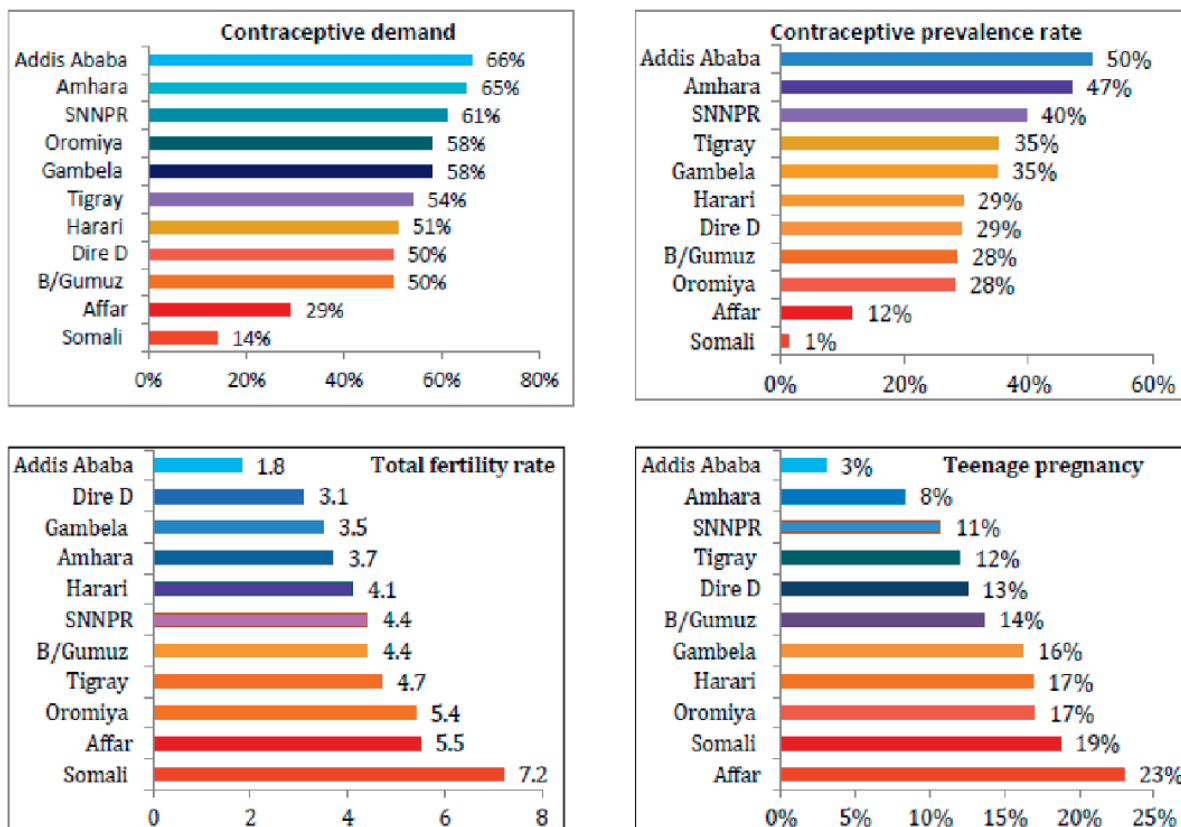
In 2016, the percentage of married women with no demand for contraception was equal to the global estimate in 2019 (42% each) [77]. Further, the FP demand and utilization of Ethiopia over the last two decades have been following the global trend in low-income countries. However, the discontinuation of contraceptive methods within 12 months by Ethiopian women was unacceptably high (35%). Pills (70%) and injectables (38%) were the most commonly discontinued methods. As

more than half (23% of the total 41%) modern contraceptive users were on injectables [15], the reason behind warrants investigation and revisiting the counseling service.

In Ethiopia, despite good progress at the national level, there was substantial variation at the subnational level (Figure 17). The regional disparity in contraceptive demand, contraceptive use, teenage/adolescent pregnancy, and fertility rate, among others, was remarkable in 2016. The CPR was approximately a mirror reflection of contraceptive demand, implying how powerful demand creation is for the utilization of the service. In other words, contraceptive demand and CPR have a positive correlation with each other and a negative correlation with TFR and teenage pregnancy. The top three regions with the highest teenage pregnancy (Somali, Afar, and Oromiya regions) had also the highest TFRs.

There is a large body of data showing a positive correlation between early initiation of pregnancy and increased TFR [78,79]. Despite the high proportion of child marriage because the Amhara Region ranks top in that area as attested by the series of Demographic and Health Surveys, teenage pregnancy was the second lowest in the Amhara region, which is another good evidence to ascribe low use of contraceptive methods to the high fertility rate in the Afar, Somali, and Oromiya regions. A study on adolescents' access to and uptake of contraceptive information concluded that supplies and services are highly variable among regions, with adolescents in Amhara region faring better than their counterparts in Afar and Oromia [80]. That is why the TFR of the Amhara region was the lowest among the bigger regions. At the regional level, a positive correlation between contraceptive demand and use, and a negative correlation with unmet need for FP, TFR, and adolescent pregnancy were observed in the Amhara region.

**Figure 17. Regional comparison of contraceptive demand, contraceptive prevalence rate, teenage pregnancy, and total fertility rate, 2016. Data source: 2016 EDHS.**

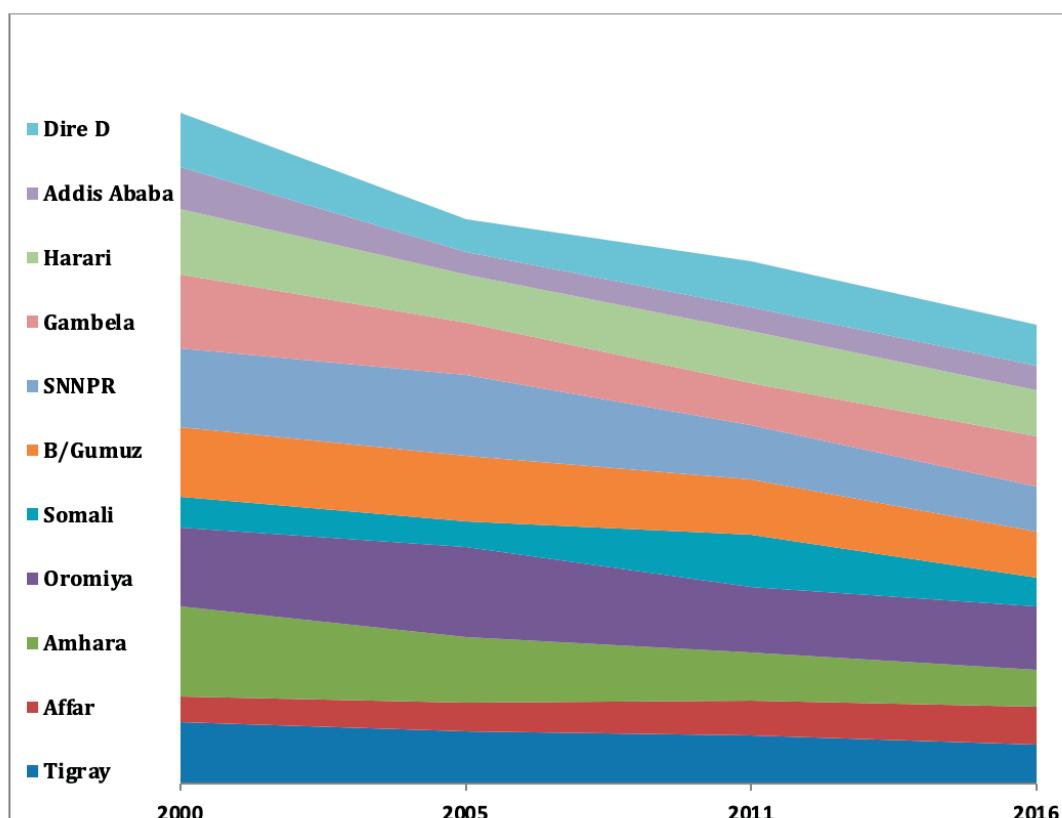




As shown in Figure 18, convergence in contraceptive demand and use could not be achieved in any of the regions. As noted earlier, the unmet contraceptive need declined by 39% in less than two decades; however, the regional discrepancy has three faces. The first is that the Afar and Somali regions had low demand, low use, and low unmet need earlier, with some increment later. Basically, in these two regions, contraceptive demand was not yet created. The other face is that in almost all other regions, unmet need was relatively higher earlier, but with time, some have shown good progress in fulfilling the demand as the trends show down going and somehow narrowing.

Exceptionally, the Amhara region reduced the unmet need by 59% and the second best achiever was SNNPR (42%). In Oromiya, the contraceptive demand was among the highest (even in 2016), but the use was low because of the high unmet need (29% in 2016, and the change in fulfilling the demand from 2000 was only 19%). The third category is moderate demand, moderate use, and low to moderate unmet need (Tigray, Diredawa, and Addis Ababa). The rural-urban contraceptive unmet need gap remained wide throughout the study period, which probably contributed to the wide gap in CPR (Figure 19) and TFR (Figure 12). Until proven otherwise, one can conclude that the unmet need (probably due to low access to FP services) has contributed to the low use of modern contraceptive methods by married women in rural areas.

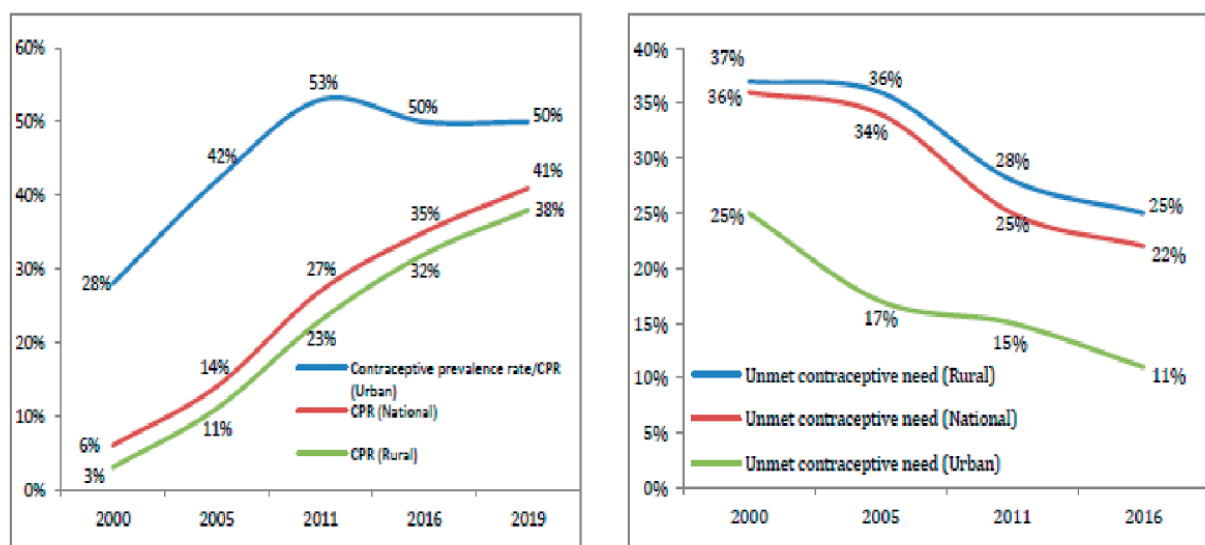
**Figure 18. Trends of contraceptive unmet need across regions. Data sources: EDHS 2000-2016.**



Interestingly, equity in use of modern contraception (CPR in the lowest wealth quintile/CPR in the highest wealth quintile) [81] between 2005 and 2019 has shown more than a 4-fold improvement; from the 2005 baseline (0.12), a progressive improvement was observed (0.27 in 2011, 0.41 in 2016, and 0.53 in 2019). Apart from the earlier cited factors, it is worth noting that evidence is

emerging on the line of missed opportunities. A longitudinal study in Ethiopia by social scientists over the last two decades identified that unmarried girls have less access to contraception, primarily due to limited knowledge and social stigma. Notably, health extension workers (HEWs) are not confident enough to provide contraception to adolescent girls, as they had a concern about community disapproval and fear of encouraging sexual activity. Not surprisingly, the unmarried but sexually active adolescent girls with limited access to contraception were at increased risk of unplanned pregnancies, pressurizing them to enter early marriage, unsafe abortions, or single motherhood. Similarly, newly married women were found to have limited access to contraception [36].

**Figure 19. Trends of modern contraceptive prevalence rate (2000-2019) and contraceptive unmet need (2000-2016) among married women in rural and urban areas, Ethiopia. Data sources: EDHS 2000, 2005, 2011, and 2016, and Mini-EDHS 2019.**



Other untapped opportunities to scale up some of the least preferred contraceptive methods are postpartum and postabortion periods in health facilities. A systematic review and meta-analysis of 19 primary studies from Ethiopia has shown that postpartum modern contraception uptake was nearly 46%, which was superior to the national average for 2019 (41%), still with remarkable subnational level variation (65% in Addis Ababa and 12% in the Somali region) [82]. The pooled estimate in this study was higher than another meta-analysis for low-income countries in Sub-Saharan Africa (37%) [83]. A meta-analysis of 12 primary studies from Ethiopia showed that postpartum IUD use was 22% [84], which was more than 20-fold higher than the national IUD use prevalence in 2016. As an indicator for the importance of service integration and education, postpartum modern contraception utilization was strongly associated with antenatal care visits, postnatal care visits, formal education, and the history of FP counseling and use. Postabortion contraceptive uptake in Ethiopia was reported as ranging from 67% to 75% [85-87].

Another important programmatic implication is that since women and adolescents with a history of abortion are at increased risk of having another unintended pregnancy, they are also at higher risk of experiencing another abortion and probably life-threatening complications, which could be avoided by providing proper counseling and contraception. Therefore, increasing health facility delivery and safe abortion service as per the 2005 revised abortion law is not only an action to reduce immediate maternal morbidity and mortality but also to increase contraception uptake and break the pregnancy-abortion-pregnancy cycle [88].

#### 4.2.2. UNFPA SUPPORT TO PREVENTING UNWANTED AND/OR UNINTENDED PREGNANCIES

Based on existing literature and empirical evidence, it is well acknowledged that unwanted pregnancies might contribute to an increased likelihood of resorting to unsafe abortion and can also lead to socioeconomic hardships. Unsafe abortion was the leading cause of maternal mortality in Ethiopia until the liberalized abortion law came into effect in 2005 and access to contraceptive methods was improved [89]. The WHO reviewed nearly two decades of data on global unsafe abortion incidence and mortality and concluded that the incidence of unwanted pregnancies and unsafe abortions is likely to continue increasing until the contraceptive need is met [90]. In Ethiopia, unintended pregnancy ranged from 19%-37%; in one community-based study, 42% and 25% of unintended pregnancies were due to lack and failure of contraceptive methods, respectively [91]. Lack of access and knowledge about contraceptive methods (particularly emergency contraception) are also identified as contributing factors to the high incidence of unintended pregnancies. According to the 2016 EDHS report, the proportion of unintended pregnancy was more than 26%, which was a bit lower than two systematic reviews and meta-analyses that pooled estimates of twenty-eight and twenty-four studies from Ethiopia by including data from 1990 to 2020 (28% and 30%, respectively) [92,93].

UNFPA has been applying different approaches to reduce unwanted and/or unintended pregnancies. Since the majority of unwanted pregnancies occur among adolescent and unmarried girls, the first and foremost approach that UNFPA has been applying is to create awareness for them to delay their sexual debut and enhance their life-skills to avoid potential risks of sexual violence, including rape, abduction, and forced marriage. The second was to promote regular contraception use for planned and consensual sexual intercourse and emergency contraception for unplanned intercourse and accidental sexual violence. However, the high prevalence of unintended pregnancies in Ethiopia still highlights the urgent need for increased public awareness and enhanced accessibility to contraceptive options.



In Benishangul-Gumuz, UNFPA works with Mujejegua Loka Women Development Association (MLWDA) to support young girls to stay in school and be protected from early marriage and GBV. MLWDA runs a safe house providing protection, legal, and psychosocial services.



### 4.3. ENDING GENDER-BASED VIOLENCE AND ALL HARMFUL PRACTICES

#### 4.3.1. UNFPA SUPPORT TO ENSURING GENDER EQUALITY, PREVENTING AND RESPONDING TO GBV AND HARMFUL PRACTICES

Gender equality, preventing GBV, and harmful practices have been UNFPA priorities for decades but could not bring maximum impact like the FP and maternal and newborn health, mainly due to the deep-rooted tradition and weak law enforcement by the government. Ethiopia appears to be making limited progress towards attaining SDG Target 5.2: “Eliminate all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation” and SDG Target 5.3: “Eliminate all harmful practices, such as child, early, and forced marriage, and female genital mutilation,” seems a long way for Ethiopia. The health condition of women, children, and girls has shown good progress of improvement, but the gender gap in decision-making and economic power of women in the household, in the community, and at a higher level is still low.

UNFPA support to the prevention and treatment of GBV and harmful practices has been multifaceted, including serving as chair at the UN Gender Technical Working Group to ensure gender mainstreaming into the UNDAF before the 9th CP, training medical staff on the use of clinical management of rape, administration of post-exposure prophylaxis against HIV, distribution of emergency contraceptive commodities, providing reproductive health kits and antibiotics for STI prophylaxis, and supporting one-stop centers’ establishment in public hospitals. By mid-2022, more than 50 one-stop centers had been established in public hospitals across the country with the support of UNFPA. ‘Safe houses’ that were able to accommodate as many as 80 GBV survivors were also supported by UNFPA.

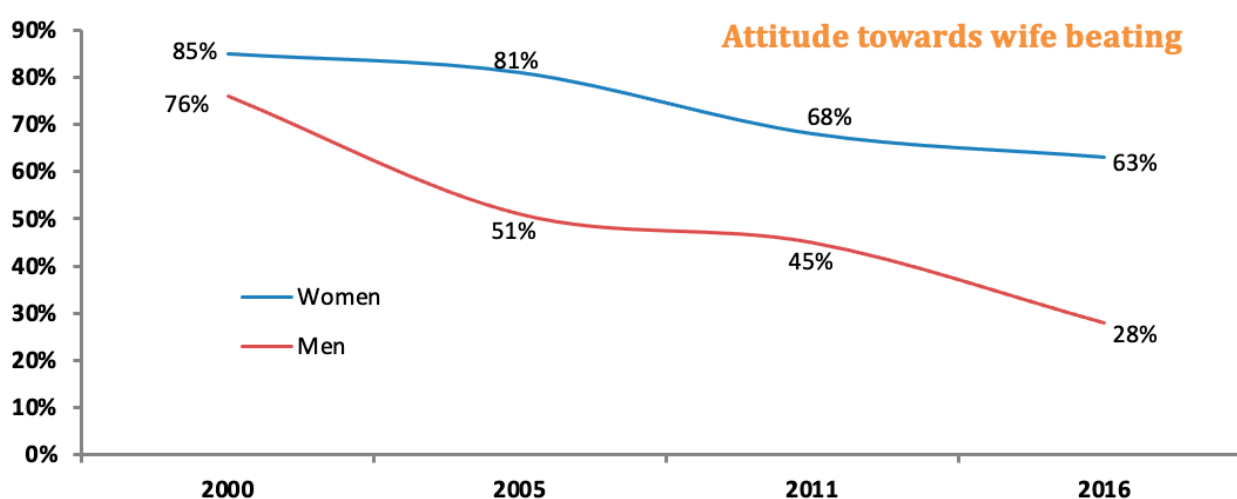
For decades, UNFPA has been providing technical and financial support to line ministries in developing policies, strategies, and guidelines and building their capacity to implement and mainstream national policy directions. UNFPA, in collaboration with implementing partners, has supported community-based gender-based programmes that strive to promote the rights of women and girls and combat detrimental practices such as FGM, child marriage, and abduction. The prevention of GBV and harmful practices has been a priority for the UNFPA in both its regular programme and humanitarian settings.

As noted earlier, the GoE has enacted several laws against violations of human rights and developed policy frameworks for actions (plus endorsement of the International Convention on the Elimination of Discrimination against Women and the Protocol to the African Charter on the Rights of Women in Africa); empowerment of youth and women, as well as ending violence against women, were prioritized in the Growth and Transformation Plan (GTP) of the GoE, however, GBV and harmful traditional practices are still highly prevalent. Putting laws and policy frameworks (including strategies, directives, guidelines, and action plans) in place that are aligned with international human rights and standards are important developments, but they cannot be an end by themselves unless much work is done to allow the laws and policies to touch ground and bring about community behavioural change.

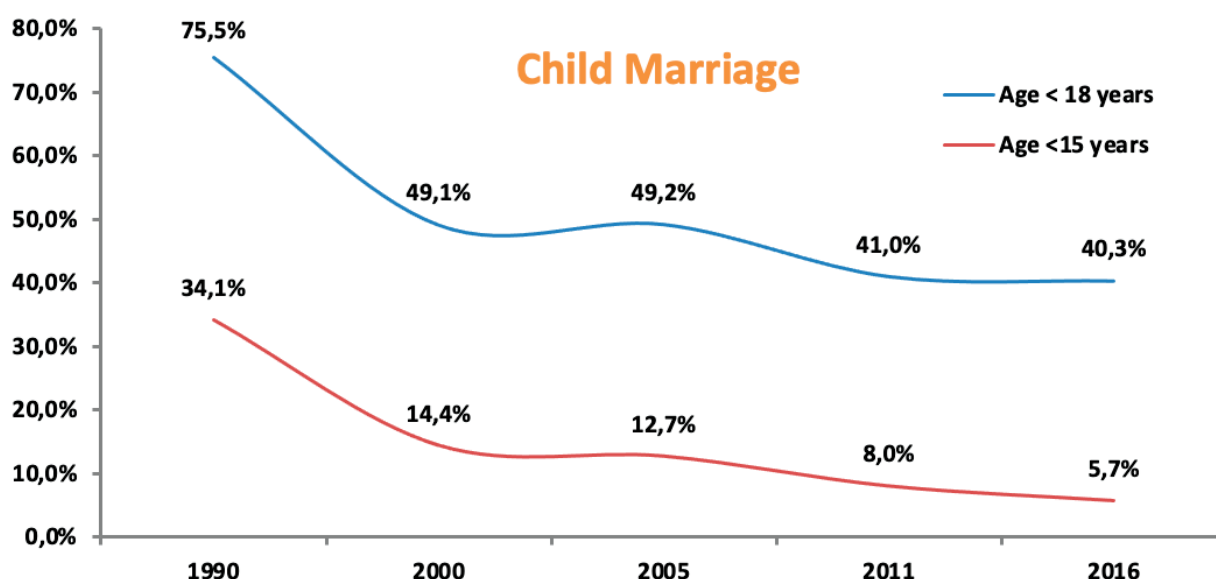
Ethiopia is a patriarchal society, and therefore women and girls are severely disadvantaged and underprivileged as the tradition favours male dominance and decision-making. GBV against girls

and women in the form of rape, abduction, and sexual harassment is the most prevalent human rights violation globally [94], and the Ethiopian situation is not different [95,96]. A meta-analysis pooled estimate has shown that nearly half of Ethiopian women experience GBV in their lifetime [97]. According to the 2016 EDHS, 23% of women aged 15-49 years have experienced physical violence, and 10% have experienced sexual violence since the age of 15. Unfortunately, a large number of Ethiopian women aged 15-49 years believed that wife beating is justified for at least one reason; a progressive attitude change has been observed since 2000 although it remains high. It looks paradoxical that women have a higher attitude towards wife beating than men (Figure 20). In addition, Ethiopia was cited several times, stating that 25 million girls and women have experienced FGM.

**Figure 20. Trends of women's and men's attitude towards wife beating. Data source: EDHS.**



**Figure 21. Trends in proportion of child marriage aged < 15 years and < 18 years, 1990-2016, Ethiopia. Data sources: 1990 Family Fertility Survey report and EDHS 2000, 2005, 2010, and 2016.**

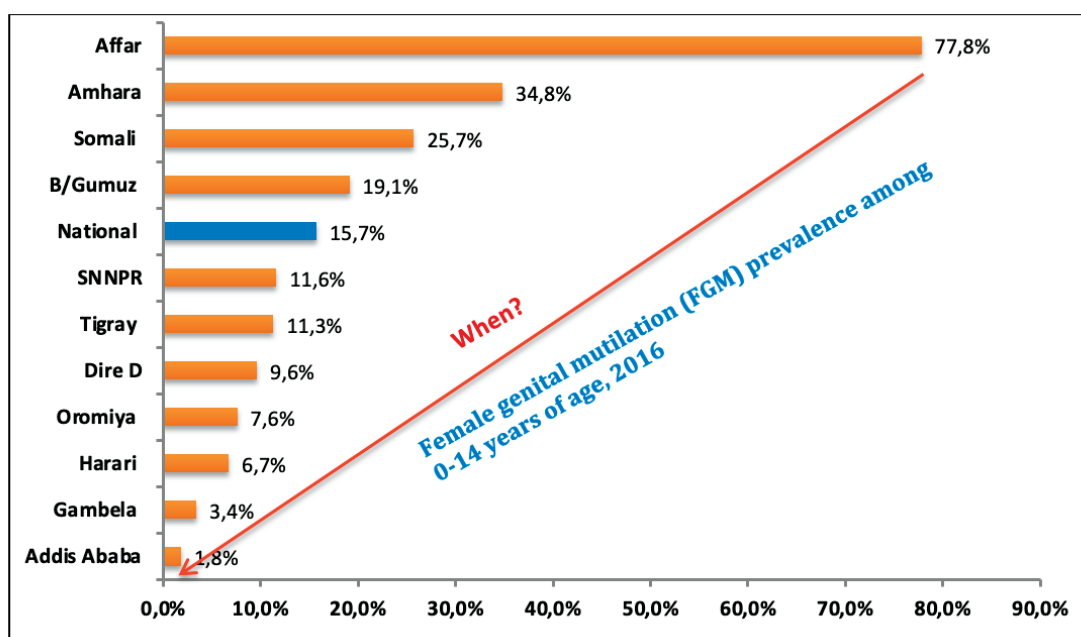


Another harmful practice (child/early marriage before the age of 18 years and forced marriage by abduction or without requesting the girl's consent) remains a huge socio-economic and health burden in Ethiopia, as partly noted earlier along with TFR and unintended pregnancy and to be noted further below. According to the Pankhurst and Espinoza study, "poverty and discriminatory gender norms continue to push girls into child marriage, particularly in rural areas; similarly, girls who have dropped out of school are at increased risk of child marriage" [36]. They concluded that poverty remains a main underlying driver of early marriage in Ethiopia (42% vs. 19% among poor and least-poor households, respectively), pushing many adolescent girls into child marriages.

Another psychosocial trauma of child marriage is the increased probability of early divorce. The SWOT analysis of the UNFPA 9th CP (qualitative study) has also identified that poverty was one of the driving factors for child marriage during the conflict. "Child marriage was used as a negative coping mechanism for the child girl to be better cared and parents to get some return from the husband." Nevertheless, slow but progressive changes were observed in many of the indicators. According to the World Economic Forum, the Gender Gap rank of Ethiopia (assessed by economic participation and opportunity, educational attainment, health and survival, and political empowerment) was 121 out of 134 countries in 2010 and 74 out of 146 in 2022 (scored 0.71 out of 1) [98]. Child marriage sharply declined by 25% between 1990 and 2000, but after that the decline was less than 10%. The decline in child marriage among girls aged <15 years was a green light to hope, making child marriage a history (Figure 21).

The national FGM prevalence among 15-49 year-old women declined from 80% in 2000 to 65% in 2016. Furthermore, FGM disaggregated by age in 2016 indicated the progressive decline across generations (59% among 20-24 years, 47% among 15-19 years and 16% among 0-14%). As shown in Figure 23, the high prevalence of FGM among children aged 0-14 years in Afar, Amhara, and Somali regional states is very worrying. A very significant decline in many other regions, which has resulted in the national FGM rate of approximately 16% is highly encouraging for the continued effort to eradicate FGM. The extremely high prevalence of FGM in the Afar region indicates where more resources and collective efforts are required.

**Figure 22. Prevalence of female genital mutilation (FGM) among children aged 0-14 years, disaggregated by regional states, 2016. Data source: EDHS 2016.**



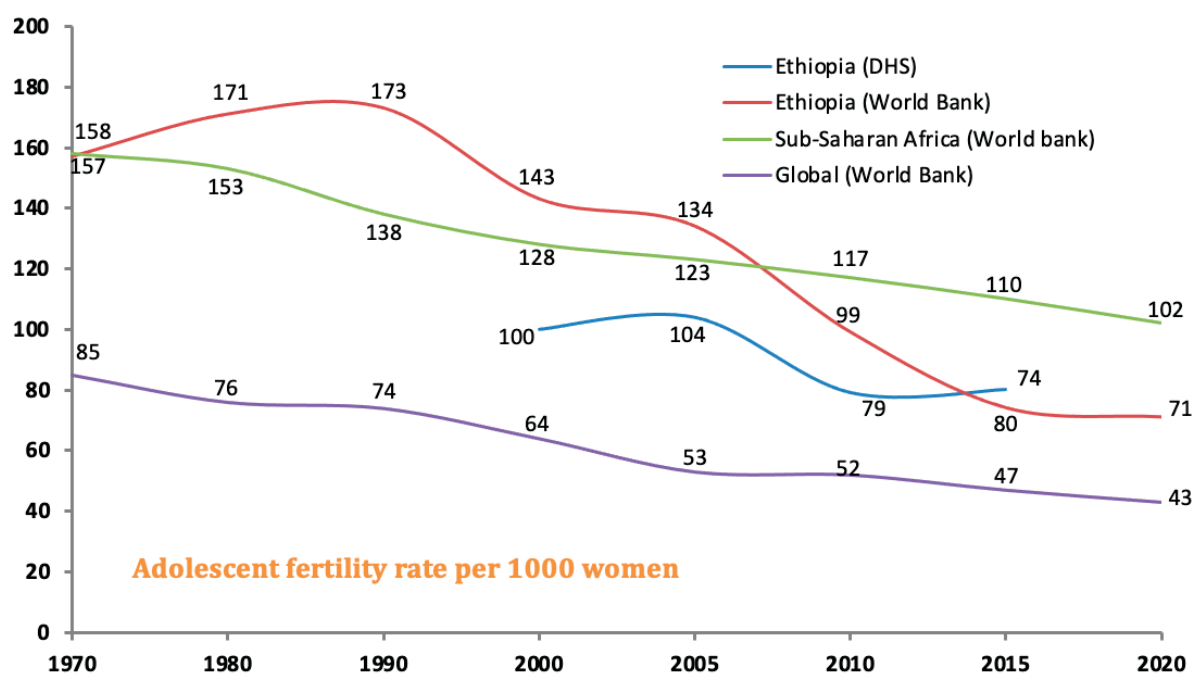


### 4.3.2. UNFPA SUPPORT TO ADOLESCENT AND YOUTH HEALTH AND DEVELOPMENT

As noted above, Ethiopia is a nation of young people who have faced several SRH problems, including GBV, gender inequality, early and forced marriage, FGM, unplanned pregnancies, abortion, and STI/HIV. Relatedly, Ethiopian youths (especially young women) also face conflict-related displacement, rights' violations, lack of quality education, unemployment, and lack of quality health services [99]. During and in the aftermath of the northern conflict, violations of young women's rights (including gang rapes) were common, as UNFPA unpublished study showed. Substance use and abuse/addiction (mainly khat, tobacco, and alcohol) is a huge health issue among youths. It is as high as 38% among high school students, and it is strongly associated with risky behaviour, including risky sexual practice, use of additional substances, "betting", and vandalism [100,101].

In collaboration with implementing partners, UNFPA has been supporting multiple initiatives in different areas to improve the health and rights' condition of adolescents and youth. Major achievements were made in some areas, including awareness creation and life skills development, preventing child marriage, preventing HIV transmission, improving access to contraception, and safe abortion services. For instance, an integrated interventional project on vulnerabilities of adolescent girls supported by UNFPA between 2006 and 2011 in Amhara Regional State directly targeting 697 adolescent girls has demonstrated that early marriage (aged 10-14 years) can be eliminated, and educating girls can be valued by the community [102].

**Figure 23. Trends in adolescent fertility rate per 1000 women in Ethiopia, Sub-Saharan Africa, and the world over 50 years (1970-2020). Data sources: World Bank and EDHS 2000, 2005, 2011, and 2016.**

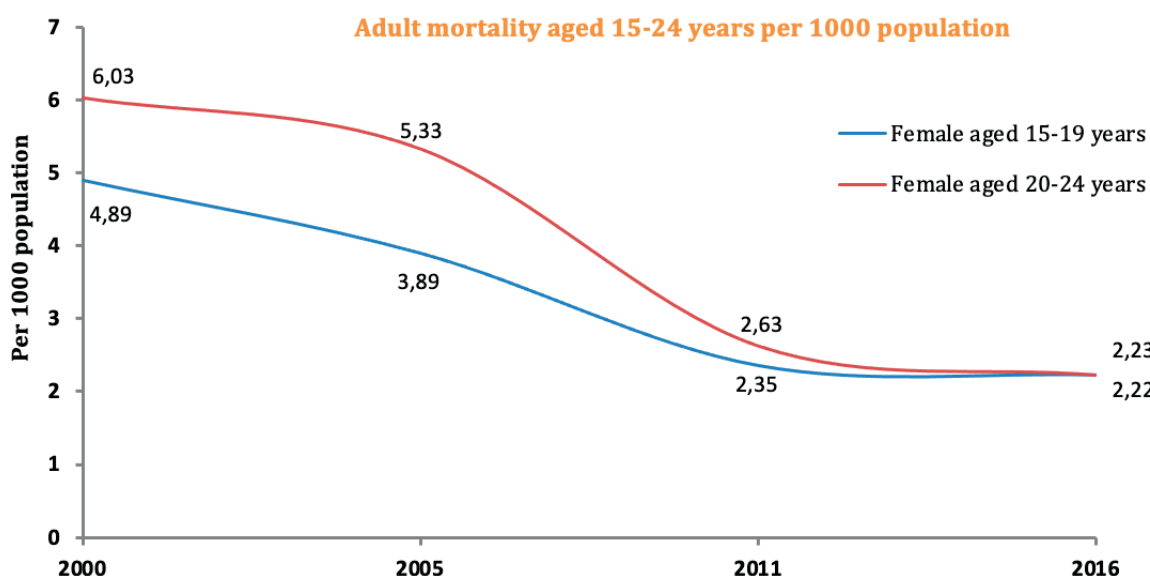


As the 50-year trend analysis (Figure 23) showed, the adolescent fertility rate in Ethiopia was one of the highest in the world. In the new millennium, however, the rate has declined by nearly two and half-fold and reached halfway between the global and Sub-Saharan Africa averages. The

World Bank estimate is a bit higher than the DHS survey findings. According to both estimates, Ethiopia's recent adolescent pregnancy rate was lower than that of Nigeria (106 per 1000 teenage women, the largest economy in Africa) and higher than Burundi (58 per 1000 teenage women, the country with the lowest gross domestic product per capita in Africa) [103]. This may imply that the rate of adolescent pregnancy may be influenced by multiple factors, including education, law enactment and enforcement, household-level poverty (rather than country-level economy), prevalence of child marriage, CPR, and other sociocultural and religious factors.

As another impact indicator of the UNFPA programs on adolescents and youths health, female youth mortality has significantly declined between 2000 and 2016 (Figure 24), to which maternal mortality reduction, prevention of unplanned pregnancy, and safe abortion services are attributed. The female youth mortality rates of all causes per 1000 population have declined by more than two-fold among aged 15-19 years (from 4.89 to 2.22), and nearly three-fold among aged 20-24 (6.03 to 2.23) [15]. Further, the inclusion of maternal care, comprehensive abortion care, and FP services in the UHC benefit package has probably contributed to the improvement in reproductive health performance and thereby the reduction in female youths' mortality. Globally, female mortality rates are lower than male mortality rates in these age group [104], which was consistently the case in Ethiopia.

**Figure 24. Trends in adult mortality aged 15-24 years, 2000-2016 (1993-2016). Data source: EDHS 2000, 2005, 2011, and 2016.**



Although some are not functional as intended (as detailed in the SWOT analysis), partly because of poor governance, UNFPA has hugely invested in youth centers' establishment in Ethiopia to improve youth access to SRH services and develop their life skills. In 2010, UNFPA and UNICEF jointly launched the Rights-Based Approach to Adolescent and Youth Development in Ethiopia [105]; however, because of lack of legal backing, the approach could not get a buy-in.

It is good that the Minimum Service Package for Adolescents and Youth Health was developed with the support of UNFPA in 2022. The youth centers and "safe houses" are intended to serve young people in urban areas. However, as the majority of the young people are in rural areas and a huge chunk of the trauma occurs in rural areas (abduction/forced marriage, rape, beating), equity and fairness should be considered to improve the quality and accessibility of SRH services to adolescent girls and young women in rural areas.

## 4.4. ENDING SEXUAL TRANSMISSION OF HIV

### 4.4.1. UNFPA SUPPORT TO PREVENTING HIV TRANSMISSION

HIV infection transmission prevention, the most “cross-cutting concern” among many actors, is one of the areas of advocacy and intervention of UNFPA, especially while dealing with adolescent and youth SRH matters. According to Robinson, HIV/AIDS and MDG were additional challenges for UNFPA SRH and population programs, primarily because RH was contentious during MDG consensus building and HIV/AIDS has got the attention of many competitors [106], while the disease is mainly acquired through risky sexual behavior. Without going into the details of the conflict of interest, there is no doubt that UNFPA has been contributing substantially to the fight against HIV vertical and sexual transmission in Ethiopia.

UNFPA contribution to HIV transmission prevention has been through the area of condom programming and supporting adolescents, youth, and women in emergency situations from sexual violence and unprotected sex. UNFPA has done all it can to link HIV transmission with SRH programs, as the majority of HIV transmission in Ethiopia is sexual. Although the interventions to reduce the vertical transmission of HIV from mothers to children are across the continuum of care, preventing HIV acquisition by the parents is the primary interest of UNFPA. Overall, UNFPA has played its part in reducing the national HIV prevalence from 2.3% in 2002 to 0.8% in 2021.



At 14, Ms. Alemtsehay had her life and education disrupted by conflict in northwestern Ethiopia. An older man who wanted to wed her began harassing her until she found security at a safe house supported by UNFPA. The safe house in Ethiopia's Benishangul Gumuz region is a sanctuary for up to 100 survivors of gender-based violence. The centre offers counselling, medical care and training courses, as well as a safe space to take refuge.





# **5. UNFPA SUPPORT TO SRHR AND RESPONSE IN HUMANITARIAN SETTINGS**



In Ethiopia, UNFPA's presence in humanitarian settings has intensified since 2007, aiming to mainstream RH, GBV, and maternity care in emergency preparedness and response. UNFPA is praised for its humanitarian work in maternity and reproductive health services, GBV prevention and management, and HIV prevention. At the policy level, UNFPA has supported the development of the Ethiopian Disaster Risk Management Strategy and the development of the GBV standard operating procedures (SOP). UNFPA has been taking the lead in providing commodities and related training to improve access to services for most vulnerable groups in regions affected by humanitarian emergencies [19].

Although the MoH took a long time to recognize its importance (more than 20 years since IAWG recommended it in 1996), UNFPA has been steadfast in its support for the availability of the Minimum Initial Service Package (MISP) for RH in humanitarian settings for more than a decade. Since 2022, UNFPA has influenced the inclusion of MISP for RH objectives in the emergency preparedness and response guidelines in humanitarian settings, which have taken into account: SRH in emergency preparedness, response, and recovery plans; providing quality EmONC and STI/HIV services; and ensuring a coordinated delivery of RH commodities in emergency and conflict situations.



The UNFPA-supported Toll-free Hotline (7711) for GBV survivors receives up to 15 calls daily in three languages, Amharic, Oromiffa, and Tigrigna. The calls come primarily from women who are victims of violence, including GBV. The Ethiopian Woman Lawyers Association (EWLA) runs the call center to provide quick access to legal aid services.

UNFPA has also been the lead partner to support the GoE in a stock of emergency RH kits since 2007. Additionally, UNFPA has provided training to medical staff on handling maternal care, treatment for GBV survivors, and FP services in humanitarian settings. UNFPA's partnership with international humanitarian agencies and donors to strengthen emergency preparedness in SRH in humanitarian crises has been growing year over year, with a serious concern about the likely compromise of the regular development programs. UNFPA's engagement with the humanitarian crisis response was not limited to conflict-affected areas but also to drought and flood-affected regions. The protracted drought in East and South-East Ethiopia and intercommunal conflicts

covering many of the regions had internally displaced millions of people with pressing humanitarian needs before the eruption of the large-scale conflict in the north of Ethiopia.

Given the large-scale armed conflicts and other causes of humanitarian crises in Ethiopia, UNFPA's mission in humanitarian settings has been critical (probably more than ever) for the continuity of the progress made earlier in maternal and newborn health. The UNFPA's humanitarian response presence in Addis Ababa and in severely conflict-affected regional states (Tigray, Amhara, and Afar) was set up and put into action as soon as the conflict in Northern Ethiopia started to oversee activities and responses for both SRHR and GBV. In parallel, the deployment of midwives and mental health and psychosocial support specialists to the conflict-affected areas, and emergency RH and dignity kits' distributions were carried out for the purpose of clean and safe delivery (both at the community and health facility levels), personal hygiene, and the provision of postabortion care and treatment for GBV survivors.

UNFPA also works on comprehensive abortion care, Maternal and Perinatal Death Surveillance and Response (MPDSR), procurement and distribution of RH commodities (contraceptive methods, medical equipment, medicines, and medical supplies), ambulance donation, maternal health quality improvement, cervical cancer prevention, pelvic organ prolapse treatment, vulnerable adolescents and youth, resource mobilization, and assisting the MoH and regional health bureaus by assigning technical experts.



An internally displaced woman receives a long-term family planning method by one midwife deployed by UNFPA in Shire, Tigray.



6.

# UNFPA SUPPORT FOR DATA FOR DEVELOPMENT



At its inception, UNFPA's support to the Government of Ethiopia was in population dynamics, specifically in the collection and use of data for economic planning, programme implementation, monitoring, and evaluation. In the early 1980s, UNFPA supported the country in preparing for and conducting the first modern population census in history, which took place in 1984. Since then, the country has been assisted by UNFPA in conducting two additional censuses in 1994 and 2007. Preparation for the 4th national population and housing census is underway with UNFPA support. Additionally, UNFPA has supported the country to conduct four national demographic and health surveys, and two health facility-based emergency obstetric and newborn care surveys. This has resulted in the availability of benchmark and baseline data for policy, programme implementation, monitoring, and evaluation.

In 1993, UNFPA supported the government of Ethiopia to develop an effective and realistic population policy aimed at ensuring that the rate of economic and social development is ahead of the rate of population growth. The implementation strategy of the policy was also supported by UNFPA. The process of revising the policy is currently underway with the support of UNFPA.

The UNFPA's development mission is to facilitate demographic transition through the promotion of reproductive health for adolescent girls and women, so as to contribute to the realisation of the demographic dividend. Beyond its initiatives promoting the empowerment of girls, women, and youth, increasing the CPR, and addressing unmet family planning needs, UNFPA is offering the Ethiopian government financial and technical support to assist in the compilation of a demographic and socioeconomic profile. This profile will serve as a framework for evaluating the country's efforts to capitalise on the demographic dividend. UNFPA is also supporting the development of a road map for harnessing the demographic dividend in Ethiopia.



A close-up photograph of a young child with dark, curly hair, smiling broadly and showing their teeth. A hand is visible near the child's mouth, with fingers slightly curled. The child is wearing a dark garment with a yellow and black striped collar. The background is a textured, light-colored wall.

# CONCLUSIONS



The UNFPA contribution to the Ethiopian Reproductive Health (exceptionally on capacity development in FP and EmONC services) was immense and impactful. Multiple indicators of FP services and maternal and newborn health at the national level are gearing towards the global average. However, disparities in access and utilization of FP services and the continuum of maternity care between urban and rural areas are wide. The prevailing GBV and harmful traditional practices -mainly stemming from a range of cultural, socio-economic, and religious factors- indicate that UNFPA interventions in these areas were not as effective as FP and maternal health interventions. UNFPA interventions in humanitarian settings and budget flexibility are highly commendable. UNFPA has been at the forefront of building capacity and supporting data collection, analysis, and advocacy for evidence-based programming through the use of timely and up-to-date data. However, the postponement of the 4th Population and Housing Census and the 5th Ethiopia Demographic and Health Survey (EDHS) due to security reasons, has resulted in a dearth of up-to-date data for programming.

**Therefore, what went well?** At national level, because of collective efforts (with UNFPA exceptional support), there has been a significant increase in ANC, SBA, CPR, and reduction in TFR, maternal and early childhood deaths, obstetric fistula, as well as increasing BEmONC and CEmONC in health facilities. Similarly, the inclusion of maternal and neonatal health services, FP, and abortion care in the essential health service package (free of charge), the commitment, and some movement towards EPMD, UHC, and SDG targets are also some of the advances worth noting. With UNFPA support, the capacity of government planners and statisticians has improved considerably over the years.

**What did not go well?** Little change in inter-regional and rural-urban disparity in the uptake and coverage of RH services, high rural TFR and unmet need for FP, including high child marriage and adolescent pregnancy; high FGM in some regions; 50% home delivery; high prevalence of gender inequality; lack of mixed contraceptive methods in rural areas; and high unintended pregnancies. The inability of the government, with UNFPA support, to conduct the Population and Housing census and the EDHS in a timely manner are some of the areas that would require close attention and a possible change in the strategies in the years ahead.

**What opportunities are potentially supportive of UNFPA programs?** The progressive policy environment and government commitments (inclusion of most RH programs in the essential health service package, Supplies Partnership Compact Agreement for FP/RH commodities, commitment for FP 2030, aspirations towards demographic dividend, development of gender equality and women's empowerment policy and GBV policy by the Ministry of Women and Social Affairs), technology advancement (MoH blue print for digitalized health, increasing interest in digital learning, and probably artificial intelligence, including virtual reality and augmented reality applications development), and the growing donation to humanitarian crises. The availability of technology to estimate the population of the country (Hybrid census), especially the population of the hard-to-reach areas, is an opportunity that UNFPA is exploring with the government to provide up-to-date data in light of the current security situation.

**What should be done?** Keeping the momentum on the continuum of maternity care and FP services in both regular and humanitarian settings, giving emphasis to the rural-urban and inter-regional disparities, maximum effort in the Afar, Amhara, and Somali regions (to bring change in FGM practice) and Oromiya region (to reduce the high unmet contraceptive need), ensuring

contraceptive methods mix and reaching the unreachable areas, introducing quality improvement technologies (such as digitalization and equipping ambulances with lifesaving apparatuses), promoting law enforcement against GBV and harmful practices, and conducting sub-national level surveys. The low demand, low utilization, and low unmet contraceptive need in the Afar and Somali regions deserve investigation and special consideration. There should be continuous capacity-building and advocacy for the collection and use of up-to-date data for development.

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**For more information:**

**Koffi Kouame**

**UNFPA Country Representative**

[kouame@unfpa.org](mailto:kouame@unfpa.org)

**Taiwo Oluyomi**

**Deputy Representative**

[oluyomi@unfpa.org](mailto:oluyomi@unfpa.org)









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