ASSESSING PROGRESS TOWARDS THE

# MILLENIUM DEVELOPMENT GOALS

ETHIOPIA MDGs REPORT 2012

Ministry of Finance and Economic Development Federal Democratic Republic of Ethiopia

ETHIOPIA Delivering as one

United Nations Country Team Ethiopia

ASSESSING PROGRESS TOWARDS THE

# MILLENIUM DEVELOPMENT GOALS

## ETHIOPIA MDGs REPORT 2012

December 2012 - Addis Ababa, Ethiopia

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# Acronyms

| | |
|---|---|
| **AfDB** | African Development Bank |
| **ART** | Anti-Retroviral Treatment |
| **DAG** | Development Assistance Group |
| **CSA** | Central Statistical Agency |
| **CMR** | Child Mortality Rate |
| **EDHS** | Ethiopian Demographic and Health Survey |
| **EPA** | Environmental Protection Authority |
| **EHSDP** | Ethiopia Health Sector Development Programme |
| **EOC** | Emergency Obstetric Care |
| **ESDP** | Education Sector Development Programme |
| **GER** | Gross Enrolment Rate |
| **GHG** | Green House Gases |
| **GHI** | Global Hunger Index |
| **GTP** | Growth and Transformation Plan |
| **HEP** | Health Extension Programme |
| **HAPCO** | HIV/AIDS Prevention and Control Office |
| **HICES** | Household Income Consumption and Expenditure Survey |
| **HIPC** | Heavily Indebted Poor Countries |
| **HSDP** | Health Sector Development Plan |
| **IMR** | Infant Mortality Rate |
| **LLIN** | Long Lasting Impregnated Net |
| **MDGs** | Millennium Development Goals |
| **MDRI** | Multilateral Debt Relief Initiative |
| **MIS** | Malaria Indicator Survey |
| **MMR** | Maternal Mortality Rate |
| **MoFED** | Ministry of Finance and Economic Development |
| **MoE** | Ministry of Education |
| **MoWCYA** | Ministry of Women, Children and Youth Affairs |
| **MoH** | Ministry of Health |
| **MoLSA** | Ministry of Labour and Social Affairs |
| **NAP** | National Action Plan |
| **NER** | Net Enrolment Rate |
| **ODA** | Official Development Assistance |
| **PASDEP** | Plan for Accelerated and Sustained Development to End Poverty |
| **PHEM** | Public Health Emergency Management |
| **PMTCT** | Prevent of Mother-to-Child Transmission |
| **PSNP** | Productive Safety Net Programme |
| **UNECA** | United Nations Economic Commission for Africa |
| **UNDP** | United Nations Development Programme |
| **UNFPA** | United Nations Population Fund |
| **UNICEF** | United Nations Children's Fund |
| **WB** | World Bank |
| **WHO** | World Health Organization |
| **WMS** | Welfare Monitoring Survey |

# I. Acknowledgements

This report on Ethiopia's progress towards meeting the Millennium Development Goals is jointly prepared by the Government of Federal Democratic Republic of Ethiopia and the United Nations Country Team (UNCT). The preparation of this report was coordinated by Ministry of Finance and Economic Development (MoFED) and United Nations Development Programme (UNDP). The report benefited from the substantive and strategic guidance and supervision of the report preparation committee, which comprised Mr Temesgen Walelign, the Director of Development Planning and Research at the MoFED, Mr Girma Hailu, MDG Policy Analyst, and Mr Samuel Bwalya, Economic Advisor. The committee is grateful to Mr Roger Pearson, the Chief of Research, Evaluation, Policy and Monitoring(UNICEF) and Ms Yumi Matsuda, the Monitoring and Evaluation Specialist(UNICEF) for their technical inputs and comments, which substantially enriched the content and quality of this report. The Committee also extends its appreciation to the UNDP Communications Unit for its editorial support. The committee is grateful to members of staff of the Development Planning and Research Directorate at MoFED and the UNCT, especially UNDP UNFPA, UNICEF, WHO, UNAIDS and the UN Resident Coordinator's Office for their invaluable technical and financial support. The committee also thanks the consultant Mr Zewdu Belete who compiled and drafted the initial report for his hard work, insights and commitment. This report also benefited from a wide range of consultations held with internal and external partners and the Committee wishes to extend its sincere thanks and appreciation to all those consulted for their constructive comments.

Addis Ababa, Ethiopia

# II. Executive Summary

Ethiopia has made significant progress towards achieving the Millennium Development Goals (MDGs). Six of the eight MDGs are already on track and strong efforts are being made to ensure that the remaining two are brought on track by the 2015 deadline. The country has registered an annual economic growth of 11% over the past eight years. More than 65% of the public expenditure has been spent on pro-poor sectors such as education, water, health, agriculture, roads and energy. The progress so far recorded is attributed to strong commitment by Government and its development partners' to the MDGs and to the overarching national development plans, PASDEP and GTP. Mainstreaming the MDGs into Ethiopia's medium-term development process has helped the Government to channel resources to the critical sectors. The Government's development plan has prioritised interventions that generate positive impact on the MDGs and the country's overall transformation agenda. This summary highlights the country's performance and progress on the MDGs. Data from the recent Household Income, Consumption and Expenditure and the Welfare Monitoring Surveys, the Demographic and Health Survey (DHS) and the annual (Growth and Transformation Plan) GTP progress review reports have been used to analyze trends in human development and MDGs in particular. Other administrative datasets were also collated and used in this report. The summary of the performance on each of the eight MDGs is given below.

## Goal 1: Eradicate Extreme Poverty and Hunger.

Recent data shows that the proportion of people living below the poverty line in Ethiopia has declined from 45.5 % in 1995/96 to 27.8 in 2011/12 (GTP-APR MoFED, 2011/12). This represents a significant reduction of 38.9% over the last sixteen years. With this performance, the country needs to reduce poverty by 3.8 percentage points over the remaining three year period in order to meet the target of 24% headcount poverty by 2015. While poverty in the rural areas is higher than the urban areas, the gap has narrowed down quite significantly over the last sixteen years (1995/96 – 2011/12). The number of people living below the poverty line (measured by poverty incidence), the distance from the poverty line (measured by poverty gap) and the level of inequality among the poor (measured by poverty severity) have declined by 34.9%,39.5,and 39.2%. Over the last fifteen years, however, income inequality (measured by the Gini coefficient[1]) or less constant at 0.30 at national level, while it increased to 0.371 from

1 The Gini coefficient is a number between 0 and 1, where 0 corresponds with perfect equality (where everyone has the same income) and 1 corresponds with perfect inequality (where one person has all the income—and everyone else has zero income).

0.34 in urban and slightly increased to 0.274 from 0.27 in rural areas. With respect to urban unemployment, the data shows that 16.1% of male and 29.6 of female young people (aged between 15-29 years) were unemployed in 2011/12 (GTP-APR MoFED, 2011/12), although overall, urban unemployment marginally reduced to 17.5% in 2011/12 from 18% in 2010/11, urban youth unemployment fell only from 23.7% to 23.3% for the same period (GTP APR MoFED, 2011/12).

Food poverty is also declining in Ethiopia. The hunger index, weighted equally on three indicators consisting of malnourishment, children's underweight and child mortality, declined from 43.2% in 1990 to 28.7% in 2010/11. The 33.6% decline recorded during this period is above the 26% and 18% decline recorded globally and in Sub-Saharan Africa respectively. In addition, the number of stunted children (under the age of five) declined from 57.8% in 2000/01 to 44.4% in 2010/11 (EDHS, 2011). In 2010/11, the percentage of stunted children was only 29.7% in the richest quintile compared to 49.2% among children in the poorest quintile. The number of underweight children declined from 41% to 28.7% during the same period. This analysis indicates that significant progress has been made to reduce hunger and malnourishment in Ethiopia following the adoption of MDGs in 2000.

## Goal 2: Achieve Universal Primary Education.

Ethiopia has done quite well in terms of meeting university primary education targets over the last decade and is on track to achieve this goal. The Net Enrolment Ratio (NER) in the lower primary school cycle (grade 1 – 4) increased from 77.5% in 2004/05 to 92.2% in 2011/12 and in the upper cycle of primary education (grade 5 – 8) from 37.6% to 48.1% during the same period. Overall, the NER for primary education (Grade 1–8) increased from 77.5% in 2005/06 to 85.4% in 2011/12. The primary school attendance ratio has risen from 30.2% in 2000/01 to 64.5% in 2010/11. The increase in attendance was disproportionately higher for children from rich families at 70% compared to 52% for children from poor families. Most of these children dropout of school after grade five although dropout rates have been declining. For example, the completion rate in lower primary education rose from 69.1% in 2010/11 to 73.8% in 2011/12 and is expected to increase further as government accelerates implementation of interventions aimed at increasing enrolment and educational progression of children from poor families and thereby helping to break the yoke of inter-generational poverty among poor households. To be effective, these programs also need to focus on improving the quality and standards of education at all levels and across the country.





## Goal 3: Promote Gender Equality and Empower Women.

The progress of Ethiopia's performance on this goal has been significant given its low baseline. The gender disparity (ratio of girls to boys) in primary education has improved from 0.85 in 2006/07 to 0.93 in 2011/12 and from 0.59 in 2006/07 to 0.83 in 2011/12 in secondary education. Gender disparity gets broadened as it goes to the higher education level. Gender disparities stand at 0.88 and 0.76 in secondary education first cycle (grade 9 – 10) and second cycle (grade 11 – 12), respectively in 2011/12.

The country is on course to eliminate gender disparities in primary education but more effort is required to raise progression from primary to secondary schools among girls in order to eliminate gender disparities at secondary and tertiary levels by 2015. Early marriages, especially among children from rural and poor households, tend to inhibit educational progression among girls from primary to secondary level. The median age at first marriage increased marginally from 16.1 years in 2005 to 16.5 years in 2010/11 (EDHS, 2011). The number of girls being married by the age of 18 varies across regions, ranging from 12% in Addis Ababa to 58% in Beninshangul-Gumuz. Similarly, the Total Fertility Rate (TFR) has declined from 5.9 in 2000 to 4.8 in 2011, but this too varies significantly across regions. For example, fertility rates are lowest at 1.5 in Addis Ababa and highest at 7.1 in the Somali Region. Fertility rates are highly correlated with educational attainment by women, where women without formal education have higher TFR of about 5.8 compared to 1.9 and 1.3 among women with secondary education and post-secondary education, respectively.

## Goal 4: Reduce Child Mortality.

The MDG target on child health is to reduce child mortality by two-third between 1990 and 2015. In Ethiopia, under-five child mortality has substantially declined to 88 per 1,000 live births in 2010/11 from 123 per 1000 live births in 2004/05, registering a 28.4% reduction over the period of five years (EDHS, 2011). However, the level of decline varies by household wealth category, level of mother's education and place of residence. According to the result of EDHS conducted in 2010, the under-five mortality rates are higher among children from poor families than those from more prosperous families. For example, under-five mortality rate amongst the children from the richest quintile is only 86/1000 live birth compared to 137/1000 lives for children from the poorest quintile. Similarly, children whose mothers completed higher education had the lowest under-five mortality rate 24/1000 live births compared to children whose mothers had no formal education 121/1000 live births. There are significant variations between rural and urban settings with UMR in urban area estimated at 83/1000

compared to 114 in rural areas. Infant mortality has declined from 97 in 2000/01 to 59 in 2010/11. The health extension programmes and the expansion of health facilities have played a significant part in reducing child mortality rates in Ethiopia over the last decade.

## Goal 5: Improve Maternal Health.

Ethiopia has one of the highest rates of maternal mortality in Africa. Progress on reducing maternal mortality has stalled since 2005 when the country managed to reduce maternal mortality rate (MMR) to 676 per 100,000 births in 2010/11 from 871 in 2000/01. This means that with the MDG target of 267 per 100,000 births by 2015, the country is clearly off-track on goal five. There are a number of factors behind this dismal performance, namely: delays in seeking skilled emergency obstetric care; delays in reaching the health facility, and delays in receiving a timely intervention after reaching the facility and large proportions of unmet family planning needs among girls in child-bearing ages. For example, although the percentage of women (aged between 15 and 49) using modern contraception increased from 6.3% in 2000 to 18.7% in 2011 and contraceptive use prevalence rate for the same age group increased from 6% in 2000 to 29% 2010/2011 (EDHS, 2011), performance on these indicators is still very low compared to many African countries. In addition, the percentage of deliveries attended by skilled birth attendants was only 20.4% in 2011/12, much lower than skilled delivery of 74% and 44% respectively for urban and rural communities in the Southern and Eastern African region. The UN Country Team is working with the Government of Ethiopia to apply the MDGs Acceleration Framework (MAF) and develop an action plan for accelerating progress on maternal health.

## Goal 6: Combat HIV/AIDS, Malaria and Other Diseases.

The MDG on combating HIV/AIDS, Malaria and Tuberculosis has three specific targets. Two targets on HIV/AIDS aims at halting and beginning to reverse the spread of HIV/AIDS and to ensure universal access to treatment of HIV/AIDS for those who need treatment. The third target seeks to halt and begin to reverse the spread of malaria and tuberculosis by 2015. Ethiopia has achieved significant progress towards meeting these targets and it is estimated that HIV/AIDS prevalence amongst the adult population has dropped to 1.5% in 2010/11 (EDHS, 2011) against the MDG target of 2.5%, indicating that the country has more than achieved this target[2]. Malaria control and prevention is one of the core interventions of the country's primary health care

2 Antenatal sentinel surveillance data also shows that HIV/AIDS prevalence of new infections amongst pregnant women (aged between 15 to 24 years) has declined from 5.6% in 2005, to 3.5% in 2007, and 2.6% in 2011 (HAPCO, 2012). Prevention from mother to child transmission coverage increased from 9.3% in 2010 to 25.5% in 2011. Close to 274,708 people, living with HIV/AIDS, were on anti-retroviral treatment at the end of June 2012.





system. The percentage of children under the age of five that sleep under insecticide treated nets increased from 3% in 2005 to 33% in 2010/11 (Malaria Indicator Survey, 2011). The distribution of insecticide treated bed-nets has been a major factor in reducing malaria deaths, where have fallen by over 50% since 2007/08 (Banteyarga etal, 2011). The national tuberculosis detection and treatment success rates is estimated to have reached 63% and 88% in 2011/12 respectively, placing the country on track towards achieving the national target of 90% detection and cure rate by 2015.

## Goal 7: Ensure Environmental Sustainability.

The MDG 7 has four specific targets. The first of these targets requires the country to integrate the principles of sustainable development into national policies and programmes and to reverse the loss of environmental resources. Through the medium term strategy (GTP) and Climate Resilient Green Economy (CRGE) strategy, Ethiopia has made important steps towards mainstreaming principles of sustainable development in its development process. The second target on goal 7 relates to the need to reduce biodiversity loss and the third and fourth targets seek to half the proportion of people without access to safe drinking water and basic sanitation and to improve the lives of slum dwellers by 2015.

With respect to access to safe drinking water, the review shows that the percentage of households with access to improved and safe drinking water has more than doubled over the last five years and reached 58.25% in 2011/12 (GTP APR MoFED, 2011/12). Rural and urban sanitation coverage improved from 60% and 80% in 2010/11 to 64% and 86% in 2011/12, respectively. Likewise, the national sanitation coverage has increased from 63% in 2010/11 to 67% in 2011/12. Though the country is on track to meet the MDG targets, existing evidence suggests that the country should do a lot more to improve access to safe drinking water and sanitation services in the remaining years. Similar improvements have been made in construction of housing units in urban areas of the country. The review of country progress against set targets suggests that the country has the lowest carbon emission rates per capita in the world at less than 2t in 2011. Overall, total emissions of around 150 Mt $CO_2$ represent less than 0.3% of global emissions target.

## Goal 8: Developing a Global Partnership for Development.

The objective of MDG eight has been to rally and foster global partnerships to address global development challenges and mobilize resources to finance interventions aimed at achieving the Millennium Development Goals (MDGs). Significant progress has been made in creating, maintaining and expanding global partnerships for development;

especially in the context of securing debt relief and ensuring debt sustainability, as well as expanding access to information and communication technologies. The flow of Official Development Assistance (ODA) to Ethiopia reached US$ 2,617.9 million and accounted for approximately 11% of the country's national budget in 2011/12. While this amount of ODA appears to be large in absolute terms and in comparison to many countries in sub-Saharan Africa, Ethiopia's per-capita ODA is only US$31.5 compared to US$52.16 average for Sub-Saharan Africa. Ethiopia's export earnings have increased quite significantly over the last decade, accounting for 17% and 14% of GDP in 2010/11 and 2011/12, respectively compared to 6.8% of GDP in 2005/06 (National Account Estimates, MoFED 2011/12).

On the overall, Ethiopia has managed to register a remarkable broad-based economic growth over the past years. The consistent focus on poverty reduction programmes and the political commitment to achieving all the MDGs has resulted in significant gains on six of the eight MDGs targets. Nonetheless, additional efforts are required to advance and accelerate progress on achieving the MDG targets on gender equality, women's empowerment, and improved maternal health where progress is less satisfactory.

## III. Highlights of Macroeconomic and Development Context

Ethiopia's economy is undergoing a rapid growth and transformation. It has recorded significant and sustained progress in both economic and social development as well as in building necessary physical infrastructure. Over the past decade, the country has recorded double-digit economic growth rate (averaging at 11% annually) and is rated one of the fastest growing non-oil exporting economy in the world. This growth has been propelled largely by huge public investments in social and economic infrastructure and by a relatively high growth in the agricultural sector. The industrial sector accounts for 11% of the country's GDP and has posted double-digit growth rates since 2008/9. The service sector which accounts for 54% of Ethiopia's GDP and has been a major driver of economic growth, posting annual average growth rates of about 14% since 2006/7. The expansion of the service sector has mainly been attributed to the increase in government spending on public service delivery, public infrastructural development (education, heath, and roads) and enhancing the capacity of the public service to deliver social services.

Ethiopia has implemented prudent monetary and fiscal policies and inflation for the most part been kept at single digit. However, in 2011/12 slippages in macroeconomic management and external shocks induced a significant rise in food and non-food





inflation, increasing the overall inflation to 34.3%. Fiscal deficits and debt positions are within sustainable limits and external balances are fairly favourable but need to be strengthened. Maintaining macroeconomic stability is an important imperative for enhancing Ethiopia's sustainable economic growth and poverty reduction efforts. It is however noted that prolonged slippages in macroeconomic stability can potentially erode economic gains the country has so far recorded and reverse progress in human development.

There has been a clear vision and political commitment to accelerate growth and reduce poverty. Clear policy commitments have been demonstrated both in macroeconomic management. This is also true of efforts to boost domestic resource mobilization to create the fiscal space needed to scale up pro-poor public expenditures including on social protection and building economic and social infrastructure. In 2011/12, the government budget allocation to pro-poor programmes (including MDGs) was increased by 40% to reach 87.6 billion Ethiopian Birr (a sum equivalent to 70.4% of the federal budget). An additional 15 billion Ethiopian Birr was allocated in 2011/12 to finance interventions aimed at accelerating progress towards MDGs that have either recorded slow progress or are off-track. Government's commitment to achieve MDGs and enhance human development is now yielding positive development outcomes. Human progress as measured by the Human Development Index (HDI) has increased by 3.1% annually growth over the last decade, placing Ethiopia as the third fastest mover of human development in the world (UNDP, Human Development Report, 2013).

## IV. Tracking Progress in Achieving the MDGs by 2015

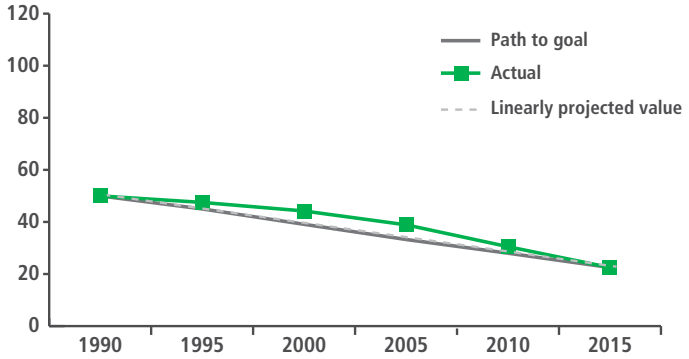
The MDGs are fully mainstreamed into Ethiopia's medium-term development strategy, the Growth and Transformation Plan (GTP), and development benchmarks have been integrated into a single GTP monitoring and evaluation framework. Accordingly, the Government decided to prioritize and increase public expenditures on pro-poor and MDG sectors to further accelerate progress and to ensure that the MDGs are attained by 2015. The Government also introduced an additional budget (of 15 and 20 billion Ethiopian Birr in 2011/12 and 2012/13 respectively) for accelerating progress on slow and off-track MDGs. The cautious macroeconomic management jointly with a robust and sustained economic growth (recorded over the past eight years) has created a solid platform for transforming and accelerating progress on six of the eight MDGs.

# 1 Eradicate Extreme Poverty and Hunger

## Target 1A: Halve between 1990 and 2015 the proportion of people whose income is below poverty line.

45.5% of the population was living below the national poverty line in 1995/96 and rural poverty (47.5%) was significantly higher than urban poverty (33.2%). The poverty gap and the severity of poverty were high, reaching levels of 11.9% and 4.5% respectively in 1999/2000. The proportion of people living below the poverty line declined from 45.5% in 1995/96 to 38.7% in 2004/05. By 2010/11, the number of people living below the poverty line (measured by incidence of poverty) had further declined to 29.6% (25.7 % of urban and 30.4% of rural people live below the poverty line). Furthermore, a recent report has further confirmed that poverty in Ethiopia has declined to 27.8% in 2011/12 (GTP APR MoFED, 2011/12). Ethiopia has managed to reduce the number of people living in poverty from 27.5 million in 2004/5 to 23 million[3] in 2011/12. High population growth has dampened some of the positive impacts of high and sustained economic growth. The national average of population growth is 2.6% per year, and is higher amongst the poorest segments of the population.

### Figure 3:1: Proportion of Population below the Poverty Line




The gap between the rich and the poor, as measured by Gini Coefficient, declined marginally from 0.30 in 2004/5 to 0.298 in 2010/11. The incidence of poverty, poverty gap and severity of poverty amongst rural households declined by 36% and 40.3% and 39.6% respectively between 1995/6 and 2010/11. Poverty levels fell at a faster rate during the past six years. This suggests that the consolidation of economic gains and prioritized public investments in physical and social infrastructure (schools, health, and road) are beginning to generate significant development dividends. In this context, growth should be sustained to further reduce and even eradicate poverty in the country in the coming years. Over the last decade, however, Ethiopia has been reducing poverty by 2.3% annually, which is quite high compared to 0.5% for Africa, excluding North Africa (Africa MDG Report, 2012). At this rate, Ethiopia now needs to reduce poverty by only 1.2 - 1.6% annually over the coming years to achieve the first MDG target of eradicating extreme poverty and hunger by 2015.[4]

MDG 1 also calls for progress on reducing food poverty, as it is an important indicator of hunger and nutrition status of the population in the country. The proportion of households in food poverty in Ethiopia has declined from 49.5% in 1995/96 to 33.6% and 32.7% in 2010/11 and 2011/12 respectively. The rate of decline was modest between the period 2005/6 and 2010/11 for food poverty (11.6%), food gap (12.5%) and severity of food poverty (6.1%).

Reducing poverty is important in advancing human development, but not sufficient to generate broad-based and inclusive development outcomes. There are significant regional disparities in the level of poverty. In 2005/6, Benishangul-Gumuz, Southern Nations and Nationalities and People's Region and Tigray, Amhara, Somalia and Beninshangul Gumuz regional states reported levels of poverty that exceeded the national average of 38.7% in 2004/05. By 2010/11, these regions managed to drastically reduce poverty levels to close to and below the national level. Trends in poverty reduction in Afar, Gambella and Somali regions do not depict any systematic pattern, but rather shows significant reversals in progress over the assessment period. This indicates a need to further cater for a regional specific focus in terms of designing and implementing robust poverty reduction measures. The figures also show that poverty levels are generally higher in emerging regional states (Afar, Somali, and Gambella) and in the Tigray region. Overall, the regional disparities in poverty have steadily declined over the last decade and are expected to level out during the upcoming years.

Disparities in poverty levels between rural and urban are modest. Rural and urban poverty declined respectively, from 38.5% and 35.3% in 2004/05 to 34.7% and 27.9% in 2010/11. Disparities among the rural and urban households are generally small, but significant difference exists in the regional states of Tigray, Afar, Somalia and Beninshangul-Gumuz where rural poverty(respectively 36.5%, 41.1%, 35.1% and 30.1%)was higher than urban poverty. In Dire Dawa, urban poverty was higher than rural poverty. In order to achieve more equitable development outcomes, government needs to implement robust regional specific poverty reduction strategies.

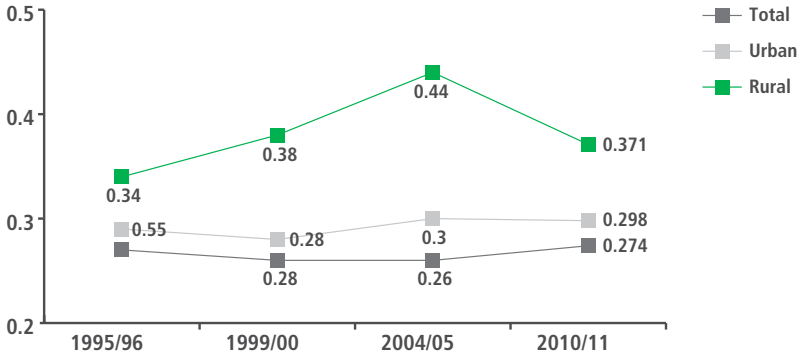
3 As per the 2011/12 National Accounts estimate, the 2011/12 mid-year Ethiopia's population is 83.2 million.

4 See, the GTP as well as MoFED and UNICEF. [2012]. Investing in Boys and Girls in Ethiopia: Past, Present and Future.

## Growth, Inequality and Poverty

Sound planned redistribution programs are needed to ensure that income generated through economic growth is equitably shared across various socio-economic groups. Ethiopia has registered high rates of economic growth over the past nine years, which now provides a solid basis for creating jobs and boosting income. The nominal per capita GDP increased from US$ 387 in 2010/11 to US$ 513 in 2011/12. Urban inequality steadily rose between 1995/96 to 2004/05 to reach a record high of 0.44 in 2004/5 before slowing down to 0.37 in 2010/11. The level of urban inequality is much higher and requires active public policy attention.

**Figure 3.2: Trends in Inequality in Ethiopia (1995/96—2010/11)**




*Source: Interim Report Poverty Analysis Study (2010/11)*

The alternative way of looking at the nature and pattern of inequality is to examine how wealth or income is distributed across different socio-economic groups in the country. In 1999/2000, the richest 10% of the Ethiopian population consumed 6.25 times more than the poorest 10% of the population. This ratio declined to 4 times in 2004/05, indicating that the poor were slowly catching up and indicates that inequality was declining. This further indicates that programs that have helped to reduce overall inequality within Ethiopia have strengthened the poverty reduction efforts.

In addition, empirical evidence suggests that the growth elasticity of poverty[5] in Ethiopia has increased from 0.9 in the 1990s to 2.0 in the 2000s. A study by Fosu (2011) shows that the growth elasticity of poverty and inequality were even higher standing

5 The growth elasticity of poverty refers to the percentage reduction in poverty rates associated with a percentage change in mean (per capita) income.





at 2.33 and -2.94 respectively in 2005. These development outcomes are commendable and should be sustained if the country has to achieve its bold ambition of becoming a middle-income status by 2025.

## Target 1B: Achieve full and productive employment and decent work for all including women and young people.

The 2005 Labour Survey conducted by the Ethiopian Central Statistics Agency (CSA) represents the most recent, available data on employment. It shows that the overall unemployment rate declined from 8.2% in 1999/00 to 5.2% in 2005. A recent labour survey captures pattern and trends in urban unemployment over the past five years. The data shows that urban employment increased from 42.6% in April 2004 to 48.2% in May 2010 whereas women's employment rate increased from 49.9% to 53.1%. A large part of the increase in employment figures for women is attributed to the increase in self-employment and unpaid family labour.

The urban unemployment rate has declined modestly from 18% in 2010/11 to 17.5% in 2011/12, and similarly the urban unemployment among the youth aged between 15 and 19 declined from 23.7% to 23.3% during the same period. The high unemployment levels, especially among the youth needs to be tackled by boosting the capacity of micro and small businesses to create jobs, by among other thing, enhancing the provision of targeted entrepreneurial skills training, business development advisory services, expanding access to credit market, and technology and innovation.

**Table 3.1: Urban Unemployment in Ethiopia**

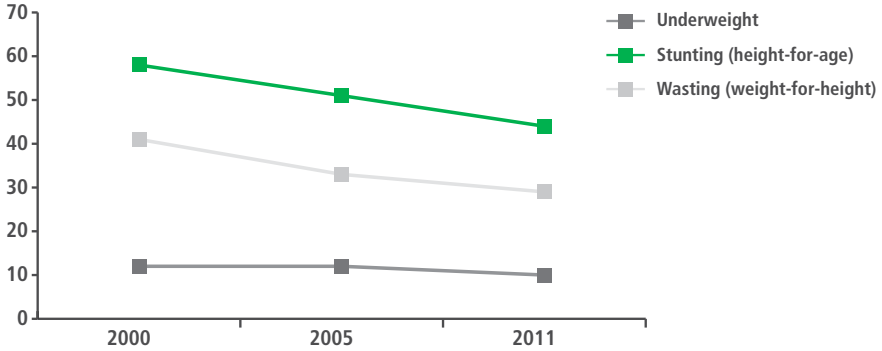
| | 2010/11 | | | 2011/12 | | |
|---|---|---|---|---|---|---|
| **Description** | **Male** | **Female** | **Total** | **Male** | **Female** | **Total** |
| **Economically active population (%)** | 67.9 | 53.5 | 60.3 | 69.7 | 56.2 | 62.5 |
| **Worker-population ratio (%)** | 60.2 | 40.0 | 49.4 | 61.7 | 42.6 | 51.5 |
| **People in the informal sector (%)** | 28.0 | 48.4 | 36.5 | 24.2 | 42.2 | 32.7 |
| **Unemployment rate** | 11.4 | 25.3 | 18.0 | 11.4 | 24.2 | 17.5 |
| **Unemployment among the educated** | 11.9 | 27.3 | 18.3 | 11.8 | 26.3 | 18.1 |
| **Unemployment among the uneducated** | 7.6 | 20.1 | 16.1 | 7.7 | 18.5 | 15.2 |
| **Unemployment among the youth (15-29)** | 16.5 | 30.3 | 23.7 | 16.1 | 29.6 | 23.3 |

*Source: Central Statistical Agency (CSA) and GTP-APR MoFED 2010/11 and 2011/12*

### Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

The 2011 Global Hunger Index by IFPRI ranks Ethiopia among the top seven countries that have recorded significant progress in reducing hunger between 1990 and 2011. Ethiopia's food poverty has declined from 49.5% in 1995/96 to 32.7% in 2011/12. Furthermore,

**Figure 3.3: Nutritional Status of Under-five Children**




According to Ethiopian Demographic and Health Survey (EDHS 2011), the proportion of stunted children under the age of five declined from 58% in 2000 to 44% in 2011. Stunting is more prevalent among rural children (46%) compared to 32% among urban children. There are also significant regional variation with highest rates of stunting recorded in the Amhara region (52%) and the lowest in Addis Ababa (22%). Mother's level of education and the household's wealth are seen to inversely relate with child stunting and wasting. This implies that interventions aimed at increasing maternal schooling and literacy and household income can significantly reduce child malnutrition and should be prioritized in Ethiopia medium term development strategy. While there has been a significant decline in stunting in the past five years, little or no progress has been made to reduce wasting and under-weight among children below the age of five. In an effort to reduce iodine deficiency, the Government in 2011 has passed a legislation prohibiting importation and selling of non-iodised salt in the country.





## Summary

Poverty has been declining at a rate that puts Ethiopia on track to achieve its target for MDG 1. The decline in poverty can be attributed to a number of factors including efficiency in implementing the Productive Safety Net Programme, a social protection program. Efforts to improve emergency preparedness and responses through the implementation of disaster risk management approach have enabled the country to respond to droughts and build household and community resilience to climate induced shocks. Production and marketing interventions in the agriculture sector have also helped to improve production and yields in the agricultural sector. These efforts have enhanced household and national food security and reduced hunger and poverty. The overall positive and impressive growth rate of the economy has provided a solid foundation for increasing household income and employment opportunities. The implementations of poverty reduction and redistribution programs have reduced poverty and inequality in the country. These programs need to be scaled-up and sustained to further reduce poverty and meet and even surpass the MDG target by 2015.

Food poverty and overall poverty levels and associated disparities across regions and socio-economic groups are still high and should be addressed in order to enhance inclusive human development. While economic growth has been robust during the last decade, the growth rates have been driven by high public investments (IMF Country Report, 2012). Therefore, growth will be hard to sustain unless rigorous efforts are made to dynamism the private sector, and manage risks and volatility. The Agricultural sector will also remain critical both in sustaining economic growth and poverty reduction in the medium term. It should, thus, be prioritized in terms of public policy and investment to further ensure food security and poverty reduction. Interventions that improve productivity and income of smallholder farmers by encouraging technology adoption, providing input support and investing in irrigation facilities to mitigate challenges with rain-fed agriculture, should to be prioritized. Building increasingly resilient food production systems to tackle climate change is also critical in creating household resilience and preventing the non-poor from falling back into poverty.

Furthermore, promoting production and consumption of more nutritious foods will be critical in reducing malnutrition especially among rural populations and children where the levels of stunting and wasting are still proportionately high. Policymakers should equally focus on reducing urban and rural inequality by further strengthening job and employment generation and social protection policies and strategies. Possible actions that have been discussed include scaling up of productive safety net programmes, creation of the institution of a modest non-contributory pension, social cash transfers to the most vulnerable households and the expansion of social insurance.

# Achieve Universal Primary Education 2

## Goal 2: Achieve Universal Primary Education

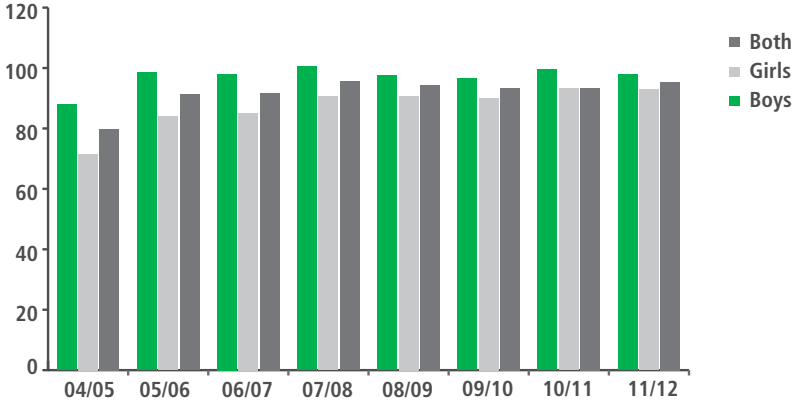
The Education Sector Development Programme (ESDP) is linked to the Education and Training Policy and was launched 15 years ago to drive the development of education in Ethiopia over 20 year period. The implementation of this programme started with the expansion of primary education, which resulted in a significant increase in access to primary education. In 2009/10, the education sector budget accounted for 25.9% of the total government budget. This figure dropped to 24.8% in 2010/11 and further to 23.9% in 2011/12. However, the number of primary schools increased from 16,513 in 2004/05 to 29,482 in 2011/12, while number of students enrolled in primary schools rose from 3.8 million in 1995/96 to 14 million in 2006/07, and reached 16.9 million in 2011/12. The number of teachers recruited also increased steadily to 393,723 in 2011/12 (GTP-APR MoFED, 2011/12). The current five-year education sector development programme (ESDP IV: 2010/11-2014/15) has shifted its focus to quality improvement as access to primary education has been more or less increased to enable the country achieve the MDG targets on primary education.

### Target 2A: Ensure that, by 2012, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

While significant number of children, both boys and girls, are in school, attendance, completion rates and quality of education are the key challenges that still need to be addressed.

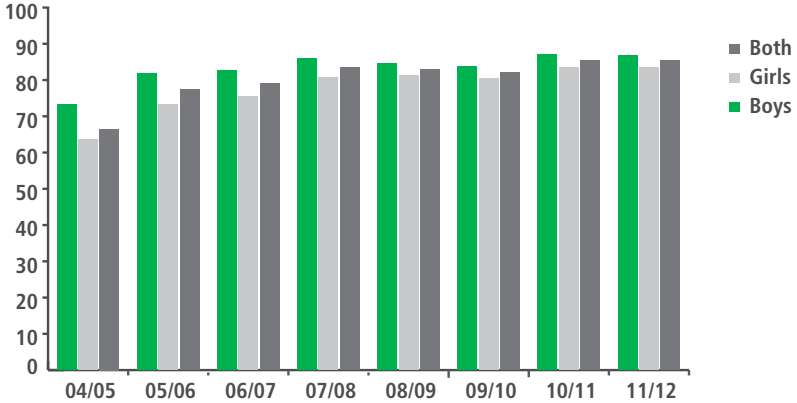
At the beginning of the 1990s, Gross Enrolment Rate (GER) in primary schools (Grades 1-8) was only 32%. This figure rose to 95.4 by 2011/12. Disaggregated data shows that good progress has been made in children's enrolment in grades one through four. The GER in early primary education has dramatically increased since 2005/06, and have reached 100% in recent years. However, GER for grades 5-8 is yet to reach such level. The Net Enrolment Rate (NER) for primary education has followed the same trend, increasing from 77.5% in 2005/06 to 92.2% in 2011/12 in the lower grades and from 37.6% to 48.1% in the higher grades during the same period. The NER for primary education (grade 1-8) reached 85.3% in 2010/11 and slightly increased to 85.4% in 2011/12.

**Figure 3.4: Trends of Gross Enrolment Rate (GER) at Primary School (Grade 1-8)**




*Source: MoE (2010/11 and 2011/12) Annual Abstracts*

**Figure 3.5: Primary Education Net Enrolment Rate [2005/06-2011/12]**




*Source: MoE (2010/11 and 2011/12) Annual Abstracts*

The gender gap in enrolment has also narrowed down, but gender disparities across the regions still exist. For example, while Addis Ababa, Tigray and Amhara regional states have already achieved gender parity, developing regional states of Somali, Gambella and Benishangul-Gumuz are significantly lagging behind on this indicator.

The Ethiopian Demographic and Health Survey (2011) shows that 65% of children attended primary school in 2010. However, attendance rates are still much lower in rural (61%) compared to urban areas (84%), with the lowest rates recorded in the Afar region (52%). The primary school completion rates for both boys and girls have been rising albeit far below the MDG target. Furthermore, the incidence of child labour is still high at 27%, with Tigray region recording the highest rate of 42.2% (EDHS, 2011).

**Table 3.2: Primary School Completion Rate by Sex**

| | Grade 5 (per cent) | | | Grade 8 (per cent) | | |
|---|---|---|---|---|---|---|
| **Years** | **Boys** | **Girls** | **Total** | **Boys** | **Girls** | **Total** |
| **2006/07** | 71.6 | 61.6 | 66.6 | 51.3 | 36.9 | 44.9 |
| **2007/08** | 71.1 | 67 | 69.4 | 49.4 | 39.9 | 44.7 |
| **2008/09** | 79.4 | 78.4 | 78.9 | 48.4 | 40.5 | 43.6 |
| **2009/10** | 77.5 | 73.7 | 75.6 | 51 | 44.5 | 47.8 |
| **2010/11** | 72 | 66.1 | 69.1 | 52.5 | 46.2 | 49.4 |
| **2011/12** | 74.1 | 73.4 | 73.8 | 52.4 | 51.9 | 52.1 |

*Source: MoE, Education Statistics Annual Abstract 2010/11 and 2011/12, GTP-APR MoFED 2011/12*

## Summary

As a result of measures taken by the Government, schools have been constructed; teachers have been trained and recruited (especially for rural areas); school feeding programmes have been implemented and provision of alternatives for basic education for children in remote areas and literacy programmes for adults have also been created. This has helped the country to increase net enrolment rates from 25% in the early 1990s to 85.4% in 2011/12. While sustaining these efforts, the country also needs to pay greater attention on improving the quality of primary education.

Girls are often pulled out of school to get married. Although the legal minimum age for marriage is 18 years nationwide, the median age at which a girl gets married is 17. In the Amhara region, the median age for women aged 20 - 49 is only 15. Government needs to do more enforce the law and ensure a large number of girls attain higher level of education before getting married.

The national literacy rate is still low at 36% in 2010/11. There are big regional differences in women's literacy levels that range from 80% in Addis Ababa and 20% in Somali and Afar regions. The Government plans to continue allocating more resources to the education sector and has started implementing the general education quality improvement programmes at all levels of the education system. Given the quality gaps across the education, standards, these investments should be prioritized and sustained over the medium to long term in order to raise standards and quality of education in the country.

# Promote Gender Equality and Empower Women 3

# Goal 3: Promote Gender Equality and Empower Women

Ethiopia has introduced policy reforms to promote gender mainstreaming and women's empowerment. Several policies and programmes have been undertaken. These include the development of women's policy, the revision of family and criminal laws, and development of the National Action Plan (NAP) on gender equality. In addition sectoral and national policies have included developing and mainstreaming of gender elements in health and education. The establishment of the Ministry of Women, Children and Youth Affairs (MoWCYA) and similar bureaus at federal, regional and sub-regional levels are also testimonies of the Government's commitment to addressing gender disparities and promoting women's empowerment in Ethiopia. Gender equality has increasingly become an integral dimension of the design, implementation, monitoring and evaluation of all national development programmes. These efforts notwithstanding, a number of complex challenges linked to historic power imbalances and deep-rooted traditional beliefs, attitudes and cultural values need to be addressed to promote the equal enjoyment of human rights by both genders in the country.

## Target 3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

Gender disparities have significantly narrowed in primary education. Multifaceted measures are still needed in secondary and higher levels of education to narrow the gap.

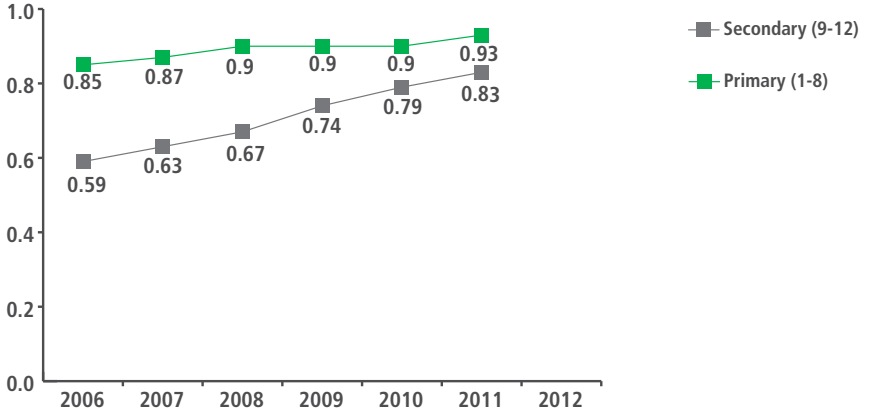
Ethiopia is making progress in addressing gender disparity at all levels of the education system. In the early nineties, the education infrastructure was considerably less developed. Moreover, human development stood at low levels and many deep-rooted harmful traditional practices and beliefs were eroding efforts to achieve gender equality. Bearing this in mind, the current level of gender equality in primary and secondary education is a remarkable achievement. The gender parity in primary and secondary education has continued to improve reaching 0.90 and 0.79 respectively in 2010/11. Furthermore, gender parities in primary education (grade 1 – 8) and the secondary education first cycle (grade 9 – 10) improved to 0.93 and 0.88 in 2011/12, respectively. Early marriage and household division of labour, with children performing numerous domestic chores and participating in livelihood activities, have led to many children especially girls to drop out of school.





Gender parity at tertiary education level has improved from 0.22 in 1991 to 0.39 in 2011/12, but still remains low and is even much lower at 0.25 in graduate school level. Ethiopia needs to design and implement policies aimed at increasing enrolment of women in tertiary education in order to promote women empowerment and effective participation and representation of women in decision-making and in the economy.

**Figure 3.6: Gender Parity Index in Primary and Secondary Education (2006/07 – 2010/11)**




*Source: Ministry of Education, Education statistics 2010/11.*

Bridging gender gaps requires that the Government commit to developing empowerment programs for women in political and economic arenas. In terms of economic empowerment, the Government has already implemented programs to encourage and promote women's entrepreneurship development by providing training to women involved in micro and small businesses and facilitating access to both credit and markets. In 2010/11, more than 101 micro and small-scale businesses owned and operated by women grew into medium-scale enterprises. Credit and saving services were extended to 1.5 million women in 2011/12 (GTP-APR MoFED, 2011/12).

Women's representation and participation in public decision-making has significantly increased during the past five years. Women's representation in the legislature (the House of Peoples Representatives) now stands at 27.9%, a rise from 2% in the 1990's, while women representation in the Judiciary is 30% and in the Executive is at 16.5%.

## Summary

Empowering women through access to education as well as providing them with physical and financial resources is crucial to the long-term development of the country. As women become more educated, they can influence resource allocation, delay marriage and reduce fertility rates and thereby positively influence the health and education of their children. However, despite the recent progress made in reducing gender parity in primary schools, there are still a large number of girls who lack adequate education and have little exposure to mass media. The percentage of women (aged 15-49) who listen to the radio doubled and reached the level of 22.2% in 2010/11. Community radios in rural areas have helped to increase the number of women that have access to information through the media. This percentage increased from 5.7% in 2005/06 to 17.2% in 2010/11. It is, however, very low compared to other countries in Sub-Saharan Africa. There are prospects for Ethiopia to further enhance dissemination of information to women by using community radios and modern ICT systems including the use of mobile phones and the internet.

The prevalence of Female Genital Mutilation and Circumcision (FGM/C) amongst children aged 0-14 remained high (at 23%) in 2011 (WMS, 2011). The level of female circumcision varies highly between regions, ranging from 7% in Gambella to 60% in Afar. The prevalence of FMG/C is high despite the Government's and non-state actors' interventions, the enactment of legislation and awareness creation on this harmful, cultural practice. Hence, measures to enhance gender equality need to confront all of the persistent and deep-rooted discriminatory socio-cultural attitudes, norms and practices that hinder progress on women empowerment.

Ethiopia has pledged to promote gender equality and uphold the convention on the Elimination of All forms of Discrimination against Women (CEDAW), the Beijing Platform of Action, the African Charter on Human and People's Rights, and the Convention on the Rights of the Child (UNICEF, 2012). Most of Ethiopia's national policies and instruments have been aligned to these international standards. Ethiopia's election to sit on the UN Human Rights Council is expected to further deepen its commitments to protect women's rights and promote gender equality in all aspects and tenets of sustainable human development.

# Reduce Child Mortality 4

# Goal 4: Reduce Child Mortality

Considerable progress has been made to improve the child health in the past one and half decades. Primary Health Care Service coverage reached 93% in 2011/12. The Pentavalent3 vaccine (DPT3) and full immunization of infant coverage has increased from 82% and 72.3% in 2009/10 to 84.9% and 79.5 in 2011/12, respectively. The infant and under five mortality rates have declined from 123/1000 and 184/1000 live births in 1990 to 59/1000 and 88/1000, respectively in 2010. Ethiopia is on track to achieve child health targets by 2015.

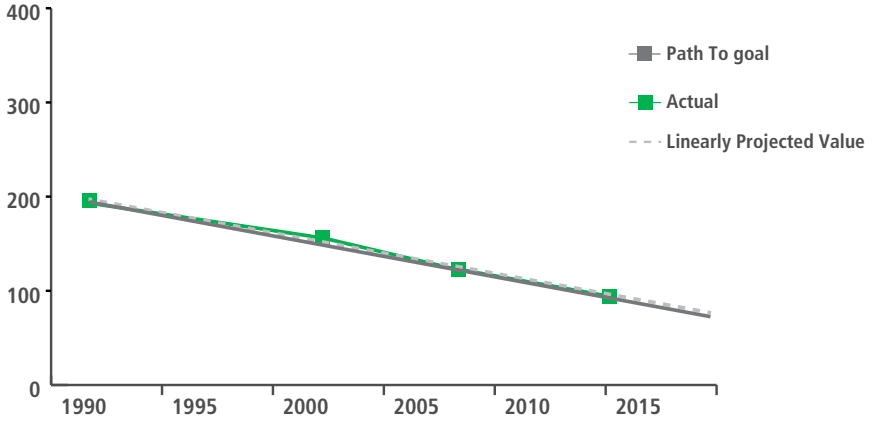
## Target 4A: reduce by two thirds, between 1990 and 2015, the under-five mortality rate.

Child survival rate has significantly improved and is on track to achieve the target set for under-five mortality.

Ethiopia has recorded significant reduction in childhood mortality. Improving the literacy of mothers, providing health education and expanding household income as well as availing access to primary health care services can significantly reduce childhood mortality rates in Ethiopia. In addition, increasing child immunization coverage can essentially reduce infant mortality rates. The DPT3 immunization coverage reached 84.9% in 2011/12 against the target of 90%. It is estimated that increasing immunization has the second highest impact (after access to clean water) on reducing child mortality and should be prioritized during the remaining few years in order for the country to reach the MDG target by 2015 (MOFED, 2012).

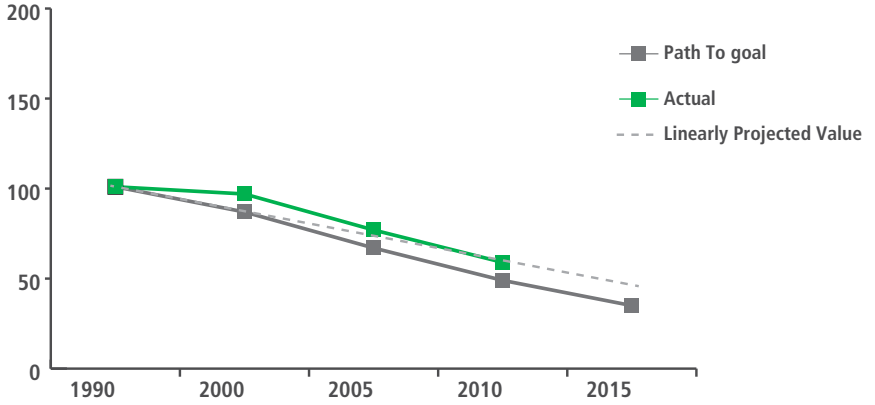
In 1990, under-five mortality rate (UMR) was one of the highest in Africa at 211 deaths per 1000 live births. However, UMR has steadily declined to 88 deaths per 1000 live births in 2010/11. Infant Mortality Rate (IMR) also declined from 97 in 2000/01 to 59 per 1000 live births in 2010/11, recording a 54.2% decline over the past decade. Neonatal mortality declined only marginally from 49 in 2000/01 to 37 per 1000 live births in 2010/11. If this progress is sustained, Ethiopia will certainly meet the MDG on child health by 2015.

**Figure 3.7: Trends in Under-Five Mortality Rate between 1990 and 2015**



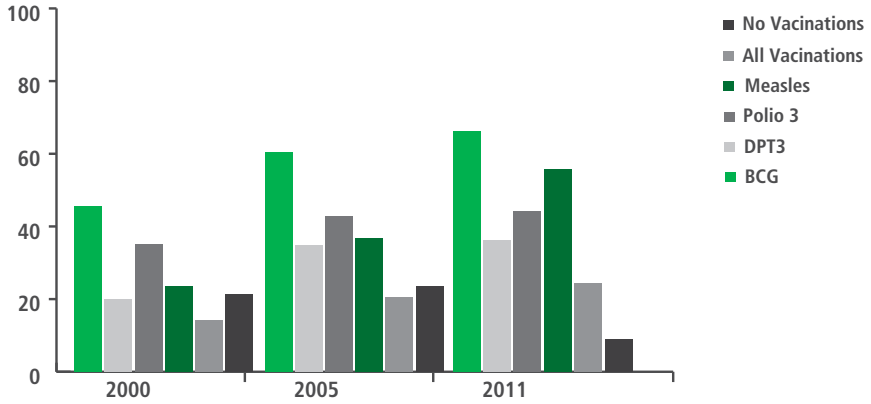

*Source: EDHS,2011*

**Figure 3.8 Infant Mortality Rate from 1990 to 2015 (Actual against Desired)**




*Source: EDHS,2011*

**Figure 3.9: The percentage of children age between 12 and 23 months vaccinated**




*Source: EDHS,2011*

## Summary

More attention is needed to bridge health inequality across regions and socio-economic groups. Efforts to expand investments in urban infrastructure development and amenities can help to narrow down development disparities across regional states. There are other determinants of child mortality such as poverty, high illiteracy rates especially among mothers and women in reproductive ages, inadequate access to health services, lack of safe drinking water and sanitation services, poor nutrition and acute malnutrition and high prevalence of preventable diseases such as malaria, respiratory infections (pneumonia), diarrhoea and measles6, all of which need to be addressed. Expanding immunization coverage, improving access to clean water and sanitation services and sustaining efforts to reduce food poverty and malnutrition should form part of the prioritized interventions for reducing child mortality rates in Ethiopia. These should be accompanied by efforts to improve maternal schooling, access to health services (including reproductive health care) and women's empowerment. It is important that the national nutrition program, health facility nutrition intervention, community–based nutrition, micronutrient interventions, and integrated community–based management of common childhood illnesses are all scaled-up and implemented more effectively to further reduce early child mortality and morbidity in Ethiopia.

6 See, EDHS reports and the Africa MDG Report, 2012.

# Improve Maternal Health 5

# Goal 5: Improve Maternal Health

At 871 deaths per 100,000 deliveries in 1990/91, Ethiopia was one of the countries with the highest rates of maternal deaths in the developing world. The country is expected to reduce maternal mortality by two-thirds from levels recorded in 1990 to reach the MDG target of 267 deaths per 100,000 deliveries by the end of 2015. To achieve this target, the Government needs to initiate targeted and quick-impact interventions to increase the proportion of deliveries attended by skilled health personnel, antenatal attendances and family planning service coverage. The GTP recent review report indicates that skilled health professionals attended only 20.4% of all deliveries and only 44.5% of mothers attended postnatal health services (GTP-APR MoFED, 2011/12). Ethiopia is unlikely to make much progress to reduce maternal mortality unless acceleration interventions are designed and implemented immediately. Complementary to the current set of initiatives, the Government and United National Country Team (UNCT) are working to accelerate the progress on maternal health by developing the MDG Acceleration Framework (MAF) action plan for implementation in developing regional states and pastoralist communities in Ethiopia.

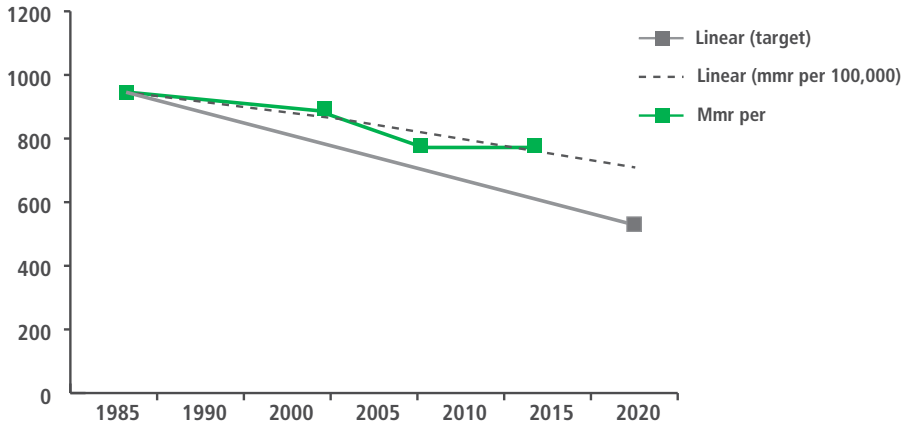
## Target 5A: Reduce by Three Quarters, between 1990 and 2015, the Maternal Mortality Ratio.

Maternal health is closely correlated with the health of the mother, the strength of the health care system and the quality and accessibility of maternal health care services. In the 1990 baseline, maternal mortality was estimated to have reached a level of 871 deaths per 100,000 live births. Maternal mortality fell to 871 in 2000/01 and to 673 in 2004/05. A modest reversal in progress was recorded in 2010/11 when the maternal mortality rate increased to 676 deaths per 100,000 live births (EDHS 2000, 2005 & 2011). Most maternal deaths occur during delivery and post-delivery period. This indicates that there are still significant obstacles in terms of access to and provision of antenatal and obstetric health care services, especially in rural areas. Women in urban areas are almost three times more likely to receive antenatal care from skilled health providers than women in rural areas. Maternal deaths can be reduced by expanding antenatal care coverage ensuring that deliveries are conducted by skilled people, providing increased access to basic and comprehensive emergency obstetric and new-born care and making family planning and basic post-natal care more available especially to mothers residing in rural areas.





Figure 3.10: Trend in Maternal Mortality in Ethiopia (1985-2010)




*Source: EDHS 2005 and 2011*

## Target 5B: Achieve Universal Access to Reproductive Health by 2015.

UNFPA (2009) estimates that one in three maternal deaths can be avoided if all women have access to contraceptive services. When women are able to control when and how many children they have, the health of the mother and child improves substantially.

Figure 3.11: Use of contraceptives amongst married women aged 15-49 (%)


*Source: EDHS 2005 and 2011*

According to the 2011 EDHS, the contraceptive prevalence rate for Ethiopian women (aged 15-49 old) increased from 6% in 2000 to 29% 2010/2011. The use of modern contraceptives increased from 11% in 2000/01 to 19% in 2010/2011.The increase in use of modern contraception is attributed primarily to the sharp increase (from 3% in 2000/01 to 21% in 2010/2011) in the use of injectable contraceptive methods. During the same period, the contraceptive prevalence amongst married women increased from 8% to 29% and amongst sexually active unmarried women from 4% to 57%. Usage of contraception is most prevalent in Addis Ababa (prevalence rate at 56%), followed by Gambella (33.2%) and Amhara (33%). The lowest rates (3.8%) were recorded in Somali.

There is a clear link between adolescent birth and maternal mortality rates. The adolescent birth rate is associated with high maternal mortality rates. Therefore, it is critical to reduce adolescent birth rates and to make post-abortion care available and accessible in order to reduce the maternal mortality rate in Ethiopia.

## Summary

The high maternal mortality in Ethiopia is primarily due to: (i) delay in seeking skilled emergency obstetric care; (ii) delay in reaching the health facility; and (iii) delay in receiving timely and effective intervention after reaching the facility. Therefore, it is crucial to address the cultural, social, and economic factors as well as the distance to functioning health centres and financial barriers that contribute to the delays and complicate deliveries.

Obstructed or prolonged labour, postpartum haemorrhage, infections, ruptured uterus, severe preeclampsia, and unsafe abortion are the major direct causes of maternal death. The supply side constraints which affect maternal health in Ethiopia include inadequate basic infrastructure of health facilities (such as water and electricity supplies), shortages of skilled midwives, weak referral systems at the health centre level, limited availability of equipment, limited financing for services, and weak management and staff motivation at facility level.

It is unlikely that the MDG target on maternal health will be met unless special efforts are undertaken. More needs to be done to improve access and quality of maternal health services. This will particularly require increasing the number of skilled attendants and providing emergency obstetric care. Furthermore, a broad set of factors such as increased awareness creation, demand for health care services and socio-economic issues (including household decision-making) should be addressed and effective community level actions implemented in order to accelerate progress on reducing maternal mortality in the remaining few years before 2015.

Ethiopia is one of the countries that have adopted the MDGs Acceleration Framework (MAF) and developed the MAF Action Plan to accelerate progress on maternal health in the four key regional states of Afar, Somali, Gambella and Beninshangul-Gumuz, including the pastoralist communities in Oromia and SNNP regional states. It is hoped that this will help to bring progress on track and towards meeting maternal mortality targets by 2015.


# Combat HIV/AIDS Pandemic, TB, Malaria and Other Diseases

# 6

# Goal 6: Combat HIV/AIDS, TB, Malaria and Other Diseases

The massive health sector programmes complemented with support from the international community have significantly reduced the incidence, morbidity and mortality caused by the HIV/AIDS, TB and malaria. Ethiopia's progress in the fight against HIV/AIDS, TB and malaria has been sustained for the past 15 years and the country is on course to achieve its MDG targets on HIV/AIDS, TB and malaria by 2015.

Ethiopia has endorsed the Health Sector Development Program (HSDP) IV that spans the period between 2010/11 and 2014/15 and focuses on prevention and mitigation of health problems such as HIV/AIDS, tuberculosis, malaria, diarrheal diseases and common childhood and maternal illnesses. The Federal HIV/AIDS Prevention and Control Office (HAPCO), in turn, has set ambitious targets for achieving universal access to treatment, testing, care and support for those living with HIV/AIDs and is implementing the second Strategic Plan for Intensifying the Multi-sectorial HIV and AIDS Response in Ethiopia (SPM II). The 'Millennium AIDS Campaign' designed by the federal government has also facilitated efforts to scale-up prevention and treatment programs.

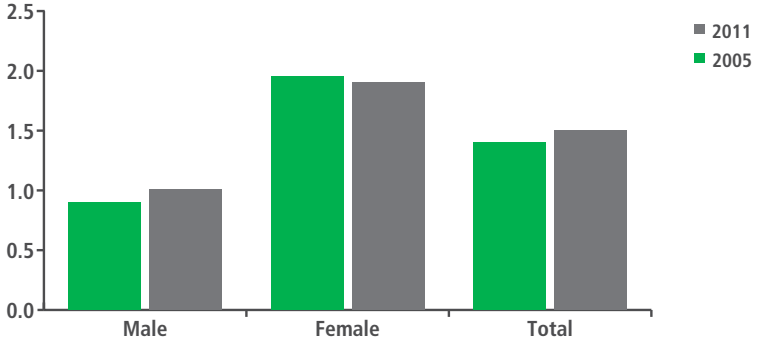
## Target 6A: have halted, by 2015, and begun to reverse the spread of HIV/AIDS.

The Ethiopian Demographic Health Survey (EDHS, 2011) indicates that HIV prevalence rate among the adult population is 1.5%. HIV prevalence has remained at this level since 2005. Antenatal surveillance data on HIV prevalence among 15 - 24 year old pregnant women also suggests a decline in prevalence from 12.4% in 2000/01 to 2.6% in 2010/11 a proxy indicator for declining incidence. Similarly a declining trend among pregnant women aged 15-49 was also observed from 12.4% in 2001/02 to 1.5% in 2010/11 (figure 3.13)



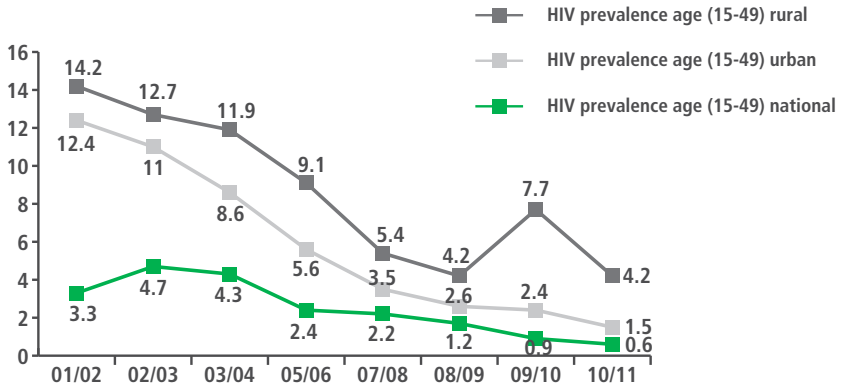


**Figure 3.12: HIV Prevalence among People Aged 15 – 49 (%)**




*Source: EDHS 2005, 2011*

**Figure 3.13:Trends in HIV Prevalence among Pregnant women aged 15-49 years**




*Source: EHNRI 2011, EDHS 2011.*

The decline in prevalence points to a combination of the rapid expansion of HIV counseling and testing sites, prevention of mother-to-child transmission (PMTCT), antiretroviral treatment services, increased awareness about HIV/AIDS, behavioral change, and the increase in psychosocial, educational and nutritional services provided for people living with HIV/AIDS.

AIDS prevention programs often emphasize the practice of safe sex, especially among non-cohabiting partners. Results from EDHS 2011 show that 47% of women and

15.5% of men between 15-49 years, who had more than one sexual partner in the past year, reported using a condom during their last intercourse. This could be attributed to increased awareness programmes on HIV/AIDS prevention and behavioral changes. The 2011 EDHS also shows that 97% of women and 99% of men are aware of HIV/AIDS. This suggests that Ethiopia is getting closer to attaining the universal HIV/AIDS awareness target by 2015.

## Target 6.B: achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

The HIV/AIDS Prevention and Control Office (HAPCO), together with the Ministry of Health, plays a central role in coordinating HIV/AIDS multi-sectorial response and collaborations with bilateral/multilateral partners as well as with civil society organizations, community based organizations and people living with HIV/AIDS.

According to HAPCO's and Ministry of Health's annual reports in 2011/12, there has been a steep increase in the number of facilities providing HIV counseling and testing, preventing mother-to-child transmission and providing antiretroviral treatment (ART) services. By June 2012 HIV/AIDS counseling was offered by 2,2881 fully operational sites, 1,901 sites provided preventative care for mother-to-child transmission, and 838 sites provided antiretroviral treatment. According to FHAPCO programmatic data by the end of December 2012, 288,137 people living with HIV/AIDS were on ART (FHAPCO, GARPR 2013). However, only, 43% of the expected eligible population needing preventative care for mother-to-child transmission services received care and 72% of the estimated number of people living with HIV/AIDS received treatment (FHAPCO, GARPR 2013). The coverage of children on ART was considerably low at 23% at the end of 2012. Cascading the interventions from HIV testing to treatment and care largely remains inadequate. The fact that 40% of patients enrolled on ART have discontinued the treatment in some regions also underlines that follow-up on people identified as HIV positive needs to be improved.

The recent adoption of the WHO 2010 adult and paediatric treatment guidelines and subsequent revision of national guidelines should lead to a reduction in morbidity and mortality levels. Improving access to treatment for a number of new-born should help to reduce the number of new infections. It is also crucial that the Government continues the delivery of ART and PMTCT services as it rolls out this new initiative. If the rollout is not properly undertaken it can potentially affect the sustainability and scalability of on-going services and jeopardize the quality of health services provided to those affected.





## Target 6.C: have halted, by 2015, and begun to reverse the incidence of malaria and other major diseases

In 2009, malaria was one of the leading causes of outpatient visits to health facilities, accounting for 14% of the visits and 9% of the admissions (MOH, 2010). There has been clear progress in malaria prevention and control in Ethiopia. On average, two bed nets have been provided to all households in malaria affected areas. The 2010/11 review process of the Government's Growth and Transformation Plan indicates that 65.6% of the households in malaria prone areas have been supplied with two bed nets; 42.5% of the pregnant women and 42.1% of under-five children sleep under the nets. During 2010/11, 4.2 million long-lasting insecticide-treated nets were distributed to replace the old ones and 67% of the households living in malaria prone areas were sprayed with anti-malaria spray. The recent report also indicates that 49.3% of the population living in malaria prone areas use treated bed-nets in 2011/12, (GTP-APR, 2011/12). More than 13 million rapid diagnostic test kits and malaria drugs were procured and distributed to facilitate early detection and treatment of malaria. Consequently, malaria prevalence significantly dropped from 25.2 % in 2004 to 15.1% in 2011 (WMS, 2011).

Ethiopia's integrated health care intervention seeks to reduce the incidence and prevalence of tuberculosis (TB) and leprosy as well as the occurrence of disability and psychological suffering related to both diseases. It also seeks to reduce mortality resulting from tuberculosis to an extent that neither of diseases is a greater public health concern. The target on prevention and control of tuberculosis was set at 85% treatment success rate and at 70% TB detection for new sputum positive tuberculosis cases (MOH, 2010). Regionally disaggregated data shows that the highest case detection rates are in urban areas with 95% in Harar, 81% in Dire Dawa and 63% in Addis Ababa and the lowest in the rural areas with 19% in Somali, 23% in Amhara and 25% in Tigray regions. With reference to treatment success rates, all but Tigray (79%), Addis Ababa (72%), and Harar (64%) were above the national average. The highest performance was recorded in Afar (92%) and Gambella (89%) regions (MOH, 2010). The TB prevention and control measured by percentage of cases successfully treated with DOTS has improved from 60% in 2000/01 to 88% in 2011/12, (GTP-APR 2011/12).

## Summary

Ethiopia remains highly affected by HIV/AIDS with an estimated adult prevalence of 1.5%, a large number of people living with HIV (approximately 800,000) and one million AIDS orphans. The Ethiopian government and development partners have prioritized support to interventions aimed at reducing the prevalence of HIV/AIDS and ensuring universal access to ART treatment. The HIV/AIDS Prevention and Control Office (HAPCO) is mandated to coordinate and lead the multi-sectorial HIV/AIDS response in Ethiopia. This includes coordinating monitoring and evaluation (M&E) progress of the programme implementation. However, improvements in the M&E system are needed to enhance the availability and performance of health personnel. The latter can be boosted by increasing investments in upgrading of technical and managerial competencies in health institutions.

The Government needs to scale up its efforts to accelerate the reduction of HIV/AIDS, to further sharpen the implementation of existing participatory approaches for prevention and care, and to equip people living with HIV/AIDS with skills and knowledge so that they can better handle their own situation. Awareness campaigns on HIV/AIDS have worked well in Ethiopia and the majority of the population is well informed about HIV/AIDS, ways of transmission, and the means for seeking treatment and assistance. Continued and intensified sensitization programmes can help ensure that more people are encouraged to get tested, seek counselling and acquire treatment.

Malaria-related deaths in Ethiopia have declined by more than 50%. The Government can achieve more by providing the necessary infrastructure and needed human resources for conducting malaria diagnosis and treatment, providing universal access to mosquito nets (especially in communities where malaria is most prevalent), delivering an adequate supply of preventive malaria drugs and increasing indoor residual spraying programmes to reduce malaria induced mortality and morbidity.

# Ensure Environmental Sustainability 7

# Goal 7: Ensure Environmental Sustainability

Ethiopia's vast natural resources and ecological systems are sensitive to changes in climatic conditions and exploitation. Addressing current and future climate vulnerabilities and mainstreaming the climate change agenda to the country's overall development planning is critical in ensuring sustainable human development. The Environmental Protection Authority (EPA) is mandated to regulate and coordinate development and implementation of environmental management strategies in Ethiopia.

## Target 7.A: integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Ethiopia has made strong progress in integrating the principles of sustainable development into the country's development policies and programmes. The Climate Resilient and Green Economy (CRGE) strategy and the various policies, regulations and standards aimed at promoting sustainable development demonstrate the country's vision and desire to create a strong, climate resilient green economy. If Ethiopia would pursue a conventional economic development path to achieve its ambition of reaching middle-income status by 2025, the results of business-as-usual approach would increase the country's greenhouse gas (GHG) emissions by more than 150%, roughly the amount of GHG emissions that South Africa currently produces. To ensure effective implementation of the CRGE strategy, the country needs to strengthen the enforcement of environmental laws in all administrative units and sectors. Guidelines have been prepared to help federal sectorial agencies, all regional governments and the two city administrations to prepare action plans for implementing CRGE strategies at strategic and operational levels.

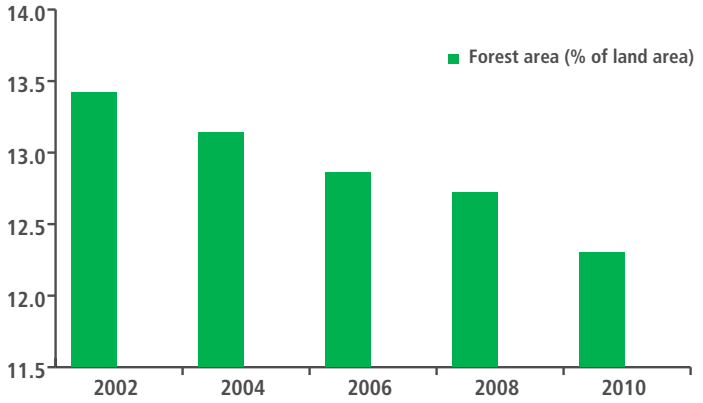
Technologies and practices to ensure that dams being constructed are climate change resilient have also been identified for use in new dam construction projects. Good practices and technologies for improving the environmental conditions of lakes, wetlands and rivers are being implemented on a pilot basis in three regional states and one city administration. A total of 43 technologies and good practices have been identified for solid waste management, crop production (with a focus on reducing the impact of the rainfall variability on yields), rehabilitation of degraded agricultural land, improved availability of energy and construction materials in an environmentally sound manner and purification of waste water released from factories. These technologies are in experimentation within the nine regional states and two city administrations for scaling up the best practices throughout the country.





Poverty, rapid population growth and lack of alternative sources of energy are primary causes of biodiversity losses and degradation of ecosystems. Ethiopia is making progress in implementing environmentally sound policies and strategies to address environmental sustainability alongside the set economic and social development policies. As the majority of the population ekes a living from the agricultural sector, it is imperative that local communities participate actively in environmental and natural resource management programs. Farmers are encouraged to use forest resources in a way that ensures a sustainable flow of forest products and services. They are encouraged to plant multipurpose tree species in dry land areas to maximize economic and environmental benefits. The Government has also invested resources to improve forest coverage and launched a "plant two trees per citizen program" during the Ethiopian millennium celebration in 2007/08. This program has been extended and scaled up throughout the country. The pace of deforestation and forest degradation has declined from 12.5% in 2000 to 11.9% in 2005 and to 11.2% in 2010 (World Bank, 2011). A recent report indicates that national forest coverage stands at 12.2% in 2011/12 (GTP-APR MoFED, 20211/12).

**Figure 3.13: Proportion of Land Area Covered by Forest (%)**




*Source: World Bank, 2011*

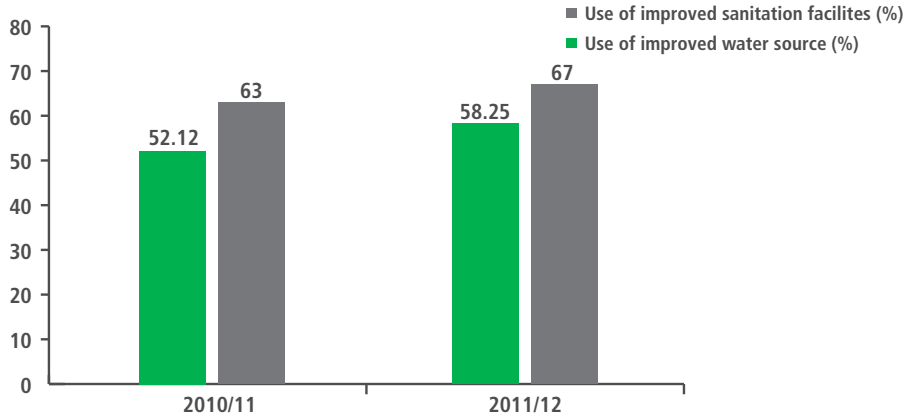
Ethiopia's total GHG emission amounts to 150 Mt CO2e, representing less than 0.3% of global emissions. In 2010, more than 85% of these GHG emissions originated from the agricultural and forestry sectors; followed by power, transport, industry and building sectors, and each contributing 3% of the national GHG emissions (EPA, 2011).

### Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Public investments in urban and rural water supplies have yielded significant results in recent years. The Government has implemented comprehensive policies, strategies, and programmes, including the National Water Resources Management Policy developed in 1998 and its strategy published in 2000 to provide strategic guidance for investing in rural, town and urban water supply and sanitation. The National Water Strategy (2001) promotes decentralized decision-making in the water sector. The National Hygiene and Sanitation Strategy (2005), Health Extension Programme, and the National Hygiene and Sanitation Strategic Action Plan (2011) advocate for stakeholder involvement and increased cost recovery models to fast-track progress and ensuring sustainability.

The percentage of households with access to improved drinking water has increased from 25.3% in 2000/01 to 58.25% in 2011/12 (GTP-APR MoFED, 2011/12). The same report indicates that sanitation coverage per household has increased from 6.8% in 2004/05 to 67% in 2011/12. Ethiopia is therefore on-track to achieve MDG targets on access to safe drinking water by 2015. More efforts are required to sustain the current progress towards achieving the target on improved sanitation coverage

**Figure 3.14: Proportion of Population Using Improved Drinking Water and Sanitation (%)**




*Source: GTP APR MoFED, 2011/12*

The high population and urban growth rates combined with a high prevalence of urban poverty have placed enormous strain on Ethiopian cites and the ability for the Government to provide housing and other essential amenities. A majority of the Ethiopians live in sub-standard slum houses that need significant upgrading or complete replacement. In 2005 the government formulated and approved a consolidated Urban Development Policy and introduced the Integrated Housing Development Programme (IHDP) to address shortfalls in housing. The programme has addressed issues of providing the low-income households with affordable housing and improving the living conditions of the low-income urban dwellers to ensure Ethiopia meets the MDG target on reducing the proportion of urban population living in slums. 171,000 condominiums were constructed during the period between 2006 and 2010, building an average of 2,850 housing units monthly. If this progress is adequately supported and sustained, it will improve the living conditions of all people currently living in slums across the country.

## Summary

The country is on track to achieve targets set on environmental sustainability, although performance needs to be enhanced to improve access to safe drinking water and sanitation facilities especially among rural households where this is a big challenge. Improving reliability of data on environmental, water and sanitation indicators will be critical in understanding current needs, including identification of critical interventions that would provide the most optimal positive impact. However, CRGE and the GTP provide the most comprehensive medium term policy response for addressing environmental sustainability target. If these are effectively implemented, the country is poised to attain or even over-perform the targets set under the environmental sustainability goal. Improvements have been made in the last five years to boost residential development especially for low and medium households in Addis Ababa and other peri-urban towns. For example, over 90,000 condominium-housing units were constructed by the Government and handled over to residents between 2009/10 and 2011/12. These efforts should be sustained and intensified in Addis Ababa and other urban towns where the demand for decent but affordable housing is still high and largely unmet.

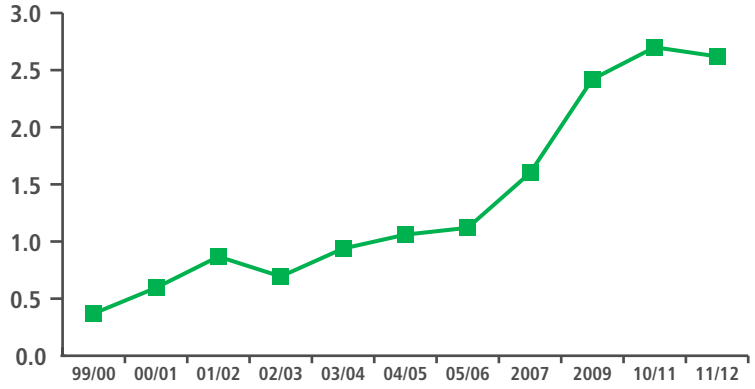
# Develop a Global Partnership for Development 8

# Goal 8: Develop a Global Partnership for Development

Ethiopia has taken major steps towards integrating the MDGs into a unified national development program. All development assistance has been brought together through a single high level forum attended by government representatives and donors. Its separate sub-groups manage the development assistance for each of the major sectors (such as health, education, and food security). A harmonized system for budget support has also been adopted and a series of countrywide sectorial development programs have been developed. General budget support has been allocated to the Protection of Basic Services (PBS) program, which channels the funds directly to local-level governments to finance pro-poor services and investments. Major effort has also been made to channel all development assistance resources to support the country's Growth and Transformation Plan (GTP) and the nationwide poverty reduction program. The results are impressive as Ethiopia has been successful in allocating external assistance to the country's highest priorities. Ethiopia has also managed to ensure accountability and effective use of development assistance with relatively low levels of corruption.

The net Official Development Assistance (ODA) to Ethiopia increased from US$ 1.6 billion in 2006/07, to US$ 2.42 in 2008/09 and further to US$ 2.62 billion in 2011/12. A significant proportion of ODA is allocated to finance social infrastructure services and followed by funds allocated respectively for economic development, general program and humanitarian aid. Funds have also been used to finance development programs and projects in agricultural and rural development, road construction, education, health, industrial development, tourism, capacity building and other integrated development projects.

**Figure 3.15: Total ODA Receipts from development partners (US$, in Billions)**




*Source: PASDEP-2007/08 APR, GTP 2010/11 and 2011/12 APR, MoFED*





Though there are improvements towards enhancing aid effectiveness as stated under the Paris Declaration, the performance is below targets set in the Paris Aid Effectiveness Agenda. For instance, the performance of scheduled aid disbursements and predictability for the 2010/11 was 49% and 39%, respectively. There is scope for improvement both in terms of aid predictability and use of country systems for aid delivery and management.

In 2011/12, the Government paid off US$ 100 million to service its foreign debt (principal and interest payments were 53.4% and 46.4%, respectively). In addition to the public sector debt service, the Government guaranteed and non-guaranteed loans service amounted to USD 42.2 million and 253.95 million in 2011/12, respectively (GTP-APR MoFED, 2011/12).

The initiative for Heavily Indebted Poor Countries (HIPC) continued to reduce the debt burden of countries qualifying for debt relief in 2011. 26 of the 33 African countries eligible for the HIPC/Multilateral Debt Relief Initiative's (MDRI) assistance qualified for irrevocable HIPC debt relief and MDRI debt cancellation. Ethiopia was among these countries and received US$ 9.11 million in 2010/11 and US$ 8.5 million in 2011/12 from the HIPC initiatives.

Ethiopia benefits from the quota, tax and duty free markets access to various countries. The European Union's (EU) "Everything But Arms" (EBA) initiative and Africa's Growth and Opportunity Act (AGOA) are examples. Under the Generalised Scheme of Preference (GSP), broad ranges of manufactured goods in Ethiopia have been granted a preferential access to Europe, Canada, Japan, and other countries. India and China have also granted duty and quota free market access to most Ethiopian products. Ethiopia is likewise an active member of the Common Market for Eastern and Southern Africa (COMESA) that provides access to 19 countries and markets. Ethiopia also seeks to join the World Trade Organization (WTO).

**Table 3.3: Access to Information and Communications**

| Indicators | 1999/00 | 2005/06 | 2010/11 | 2011/12 |
|---|---|---|---|---|
| No. of Mobile telephone Subscribers (in million) | 0.018 | 0.889 | 10.7 | 17.26 |
| No. of Internet Subscribers (in million) | 0.0025 | 0.026 | 0.129 | 2.661 |
| No. of fixed line Subscriber (in million) | NA | 0.912 | 0.854 | 0.805 |

*Source: Ministry of ICT and Ethio Telecom, 2010/11 and GTP-APR 2011/12, MoFED*

The other indicators linked to MDG 8 relate to access and affordability of information and communications technology enabling economic development and improving production capacity and efficiency. Ethiopia is experiencing a rapid expansion of the availability of new technologies. This includes a substantial increase in the percentage of people having fixed and mobile telephones, and also using the internet. The figure for cellular subscribers does not necessarily mean that the number of people owning a mobile telephone has increased, as some people may have more than one cellular telephone and telephone number.

## Summary

There are a number of indicators relevant to Ethiopia under MDG 8. The first and perhaps most critical indicator relates to the flow of ODA to Ethiopia and the whole aid effectiveness agenda. The data shows that global ODA to Ethiopia has been rising since 1990, reaching its pick in 2010 before declining in 2011/12 largely due to the financial crises that affected most donor countries. Most of ODA disbursements are allocated to social sectors, with the top five sectors being: energy, education, agriculture, health, and transport accounting for 58.6% of the total ODA disbursed in 2011. About 27.8% of ODA disbursed in 2011 financed a multi-sectorial program with much of the funds financing the Protection of Basic Services (PBS) and the Productive Safety Nets Programs (PSNP) in 2011(MOFED, ODA Statistical Bulletin 2013). This means that most of the ODA the country receives is allocated to the provision of basic services in accordance with the targets set for ODA under MDG 8. There is scope to improve development effectiveness of aid given to Ethiopia. There is also the need to enhance the capacity and credibility of government public financial management systems and specifically the aid management systems so as to further encourage the use of country systems by development partners. Towards this end, the aid effectiveness taskforce has been set-up as a forum for dialogue between the Government and development partners on matters of aid delivery and effectiveness. The other critical indicator relates to debt sustainability. Ethiopia has benefited from debt cancellation; and its debt stock and debt service have both declined significantly since 1990. For example, debt service as percentage of export fell from 33% in 1990 to 3.2% in 2011/12. The country's debt is therefore within sustainable levels. The country is also making progress on the other two indicators on access to information and communication technologies, and access to affordable essential drugs.

# V. Conclusion

The assessment made in this report shows that Ethiopia has registered remarkable progress in achieving broad-based economic growth and human development over the past decade. This progress also indicates that MDGs can be achieved when the government and development partners have a common vision and demonstrate political commitment to support initiatives aimed at accelerate broad-based socio-economic development. Government of Ethiopia has demonstrated policy commitment towards ensuring macroeconomic stability, which is a perquisite for initiating and sustaining rapid human development and poverty eradication. Poverty has declined significantly and the country is on track to achieve MDG on poverty reduction. Prudent macroeconomic management has played a central role in boosting boost domestic resource mobilization and creating the fiscal space that has enabled government to scale up pro-poor public expenditures on social service delivery (including social protection) and building the requisite economic and social infrastructures.

Ethiopia has taken concrete steps in framing the global development agenda within the national context. The mainstreaming of MDGs in the Growth and Transformation Plan as well as its predecessor—the Plan for Accelerated and Sustained Development to End Poverty—has significantly contributed to the fast progress on MDGs as this enable government to improve coordination of interventions across Government ministries and departments as well as sharpen its focus on achieving prioritized development outcomes. Evidently, government realised the need to allocate extra resources amounting to 35 billion Birr over the last two years to finance specific interventions aimed at accelerating progress on those MDGs where progress has been slow.

It is important to recognize that domestic resources alone are often insufficient to finance programs on MDGs and seeking external resources through development cooperation to supplement the domestic envelop is critical in this regards. Notwithstanding the economic recession in western countries, Ethiopia has managed to attract and maintain steady inflows of official development assistance over the last decade. The country has managed to rally and align development assistance to firmly support the national development agenda and has benefited from debt relief and cancellation. Access to information and communication technologies has continued to increase, albeit more remains to be done to ensure access by households living in remote parts of the country. Government's consistent focus on implementing poverty reduction programmes and its political commitment to achieve all the MDGs has enabled the country to consistently keep six of the eight MDGs (MDGs 1, 2, 4, 6, 7, 8) on track over the last decade. MDGs three and five require implementing innovative interventions to speed up progress and bring them back on track in the remaining few years before the MDGs completion due date in 2015.

While the country has on the overall recorded remarkable progress on MDGs, a number of challenges still remain especially on reducing maternal mortality (MDG 5) and promoting gender equality and women empowerment (Goal 3). The country needs to step up efforts to address the bottlenecks that have impeded progress on maternal health and on selected targets on gender and women empowerment. Ethiopia's policy and programmatic measures in the areas of gender-mainstreaming and women's empowerment have started to yield positive results. The gender disparities at all levels of education have narrowed down significantly and more so in primary education over the last decade. In addition, the proportions of women in formal employment and the number of seats held by women in parliament have increased. Progress on maternal is slow and government and development partners are adopting the MDGs Acceleration Frameworks (MAF) to identify constraints and bottlenecks and implement targeted actions to accelerate progress and meet the goals and targets on maternal health by 2015.

The post 2015 national consultations have indicated that the MDGs are still relevant to Ethiopia's development process but called for improvements in the design of the post-2015 development agenda so that outcomes and targets are more realistic. In addition, the consultations have called for greater focus on promoting good governance, infrastructure and human development, inclusive growth and economic transformation in framing the next global development agenda.

# VI. References


- Africa MDG Report (2012), AUC, AfDB, UNECA and UNDP, Assessing Progress in Africa toward the Millennium Development Goals: MDG Report 2012.
- Central Statistical Agency (2001), Ethiopia Demographic and Health Survey 2000. Addis Ababa, Ethiopia, 2001.
- Central Statistical Agency (2006), Ethiopian Demographic and Health Survey 2005. Addis Ababa, Ethiopia.
- Central Statistical Agency (2007), Summary and Statistical Report of the 2007 Population and Housing Census, Population Size by Age and Sex. Addis Ababa, Ethiopia.
- Central Statistical Agency (2011). Welfare Monitory Survey, Statistical Report. Vol.1.
- Central Statistical Agency (2011), Ethiopian Demographic and Health Survey 2011. Addis Ababa, Ethiopia
- EHNRI (2012), Report on the 2009 Round Antenatal Care Sentinel HIV Surveillance in Ethiopia, Federal Ministry of Health-Ethiopian Health and Nutrition Research Institute, Addis Ababa, Ethiopia.
- Ethiopian Environmental Protection Authority (2011), Country Progress Report on Environmental Sustainability. Addis Ababa, Ethiopia.
- FDRE (2011), Ethiopia's Climate-Resilient Green Economy: Green Economy Strategy. Addis Ababa, Ethiopia
- Fosu, A.K. (2009),"Inequality and the Impact of Economic Growth on Poverty: Comparative Evidence for Sub- Saharan Africa." BWPI Working Paper 98.
- Fosu, A.K. (2011), "Growth, Inequality and Poverty Reduction in Developing Countries: Recent Global Evidence". UNU-WIDER Working Paper No.2011/01.
- Addis Ababa, Ethiopia
- GoE (2011), Ethiopia Progress towards achieving the Millennium Development Goal: Success, challenge and prospect, Annual report. Addis Ababa, Ethiopia
- GoE (2012a), Growth and Transformation Plan (2010/11 – 2014/15).
- GoE (2012c), Ethiopia's Progress towards Eradicating Poverty: an Interim Report on Poverty Analysis Study (2010/11). Addis Ababa. Ethiopia. Banteyargal etal 2011
- GTP APR 2012
- HDR 2013
- IMF Country Report 2012
- ESDP 2010/11 – 2014/15
- HICES 2011
- UNICEF 2012
- MoFED 2012
- UNFPA 2009
- HAPCO GARPR 2013
- MOH 2010
- WB 2011
- PSNP 2011
- HAPCO (2012), Country Progress Report on HIV/AIDS Response, Addis Ababa, Ethiopia.
- IMF (2012), Country Report No. 12/287, 2012 Article IV Consultation—Staff Report; Public Information Notice on the Executive Board Discussion; Staff Statement; and Statement by the Executive Director for Ethiopia.
- MoFED (2010/11), Growth and Transformation Plan-Annual Progress Report (GTP-APR 2010/11), Addis Ababa, Ethiopia.
- MoFED (2011/12), Growth and Transformation Plan-Annual Progress Report (GTP-APR 2011/12), Addis Ababa, Ethiopia.
- MoFED (2011/12), National Accounts Estimates, Brief Note on the 2011/12 NAE Series, Addis Ababa, Ethiopia.
- MoFED and UNCT (2008), Ethiopia: Progress Towards Achieving the Millennium Development Goals: Successes, Challenges and Prospects. Addis Ababa, Ethiopia.
- MoFED and UNCT (2010), Ethiopia: 2010 MDGs Report, Trends and Prospects for Meeting MDGs by 2015.
- MoFED and UNICEF (2012), Investing in Boys and Girls in Ethiopia: Past, Present and Future. Addis Ababa. Ethiopia.
- MoE (2010), Education Sector Development Program IV (ESDP IV) 2010/11 -2014/15. Addis Ababa. Ethiopia

- MoH (2005), Guideline for the Implementation of Antiretroviral Therapy in Ethiopia. Addis Ababa. Ethiopia
- MoH (2010), Health Sector Development Program IV (HSDP IV) 2010/11 -2014/15. Addis Ababa. Ethiopia
- MoLSA (2012), National Social Protection of Ethiopia. Addis Ababa, Ethiopia
- Juma, Calestous (2011), "The New Harvest: Agricultural Innovation in Africa". Oxford University Press, Inc.
- UN (2012), The Millennium Development Goals Report 2012. New York.
- U N (2011), The Millennium Development Goals Report 2011.New York.
- UN (2010), The Millennium Development Goals Report 2011.New York.
- UNFPA (2009), Fact Sheet: Motherhood and Human Rights. New York: UNFPA, Media and Communications Branch.
- WHO (2008), Global Tuberculosis Control, Geneva.






## Annex 1: Summary of Progress toward MDGs

| MDG Indicators | Base Line [1990] | 2000/01 | 2004/05 | 2010/11 | 2011/12 | National Target (2014/15) | MDG Target 2015 |
|---|---|---|---|---|---|---|---|
| **Goal 1: Eradicate Extreme Poverty and Hunger** | | | | | | | |
| **Population Living below Absolute Poverty Line[%]** | 48 | 44.2 | 38.7 | 29.6 | 27.8 | 22.2 | 24 |
| **Population Living below Food Poverty Line [%]** | 49.5 (1995/96) | 41.9 | 38 | 33.6 | 32.7 | 21.2 | NA |
| **Poverty Gap** | 0.129 (1995/96) | 0.119 | 0.083 | 0.078 | | | |
| **Severity of Poverty** | 0.051 | 0.045 | 0.027 | 0.031 | | | |
| **Urban Unemployment Rate** | | 8.2 | 5.2 | 18 | 17.5 | | 0% |
| **Urban Unemployment among the Youth [15 - 29 age]** | | | | 23.7 | 23.3 | | 0% |
| **Income Inequality** | 0.29 (1995/96) | 0.28 | 0.3 | 0.298 | | | NA |
| **Underweight Children [%]** | 45.4 (1995/96) | 472.1 | 37 | 29 | | | 22.7 |
| **Stunting [%]** | NA | 58 (1999/00) | 47 | 44 | 44 | | NA |
| **Wasting [%]** | NA | 12 | 12 | 10 | 10 | | NA |
| **Goal 2: Achieve Universal Primary Education** | | | | | | | |

| MDG Indicators | Base Line [1990] | 2000/01 | 2004/05 | 2010/11 | 2011/12 | National Target (2014/15) | MDG Target 2015 |
|---|---|---|---|---|---|---|---|
| GER Primary Education (Grade 1 – 8) [%] | 32 | 79.8 (2004/05) | 91.7 (2006/07) | 96.4 | 95.4 | 100 | NA |
| NER Primary Education (Grade 1 – 8) [%] | NA | NA | 77.5 (2005/06) | 85.3 | 85.4 | 100 | 100 |
| First Cycle Primary Education Completion Rate [Grade 1- 4] | | | 57.4 | 69.1 | 73.8 | | 100 |
| Second Cycle Primary Education completion Rate [Grade 5-8] | | | 34.3 | 49.4 | 52.8 | | 100 |
| Literacy Rate (%) | 26 (1995/96) | | 38 (2005) | 36 | | 95 | |
| Female | | 18.5 | 29.2 | 38.4 | | | |
| Male | | 39.6 | 58.9 | 65 | | | |
| Goal 3: Promote Gender Equality and Empower Women | | | | | | | |
| Ratio of Girls to Boys: | | | | | | | |
| Primary Education (Grade 1 – 8) | 0.61 (1995/96) | | 0.85 (2006/07) | 0.90 | 0.93 | | 1 |
| Secondary Education<br>First cycle (Grade 9 – 10)<br>Second Cycle (Grade 11-12) | | | 0.59 (2006/07) | 0.79<br>0.93<br>0.63 | 0.83<br>0.88<br>0.76 | | 1 |
| Higher Education | | | 0.24 (2004/05) | 0.36 | 0.39 | | 1 |

| MDG Indicators | Base Line [1990] | 2000/01 | 2004/05 | 2010/11 | 2011/12 | National Target (2014/15) | MDG Target 2015 |
|---|---|---|---|---|---|---|---|
| Percentage of women in the Parliament-HoPR | 12 (1995/96) | | 117 (22%) | 28 % | 28 % | | NA |
| Goal 4: Reduce Child Mortality | | | | | | | |
| Health service coverage (%) | | | | 96 | 93 | 100 | |
| Under 5 Mortality | 190 | 167 (2001/02) | 123 | 88(2011 EDHS) | | 66 | 63 |
| Infant Mortality | 123 (1992/93) | 97 | 77 | 59(2011 EDHS) | | 31 | 31 |
| Neonatal Death | 54 | 49 | 39 | 37(2011 EDHS) | | | NA |
| Immunization Coverage (Measles) (%) | | 27 | 35 | 81.5 | 79.5 | 90 | |
| Immunization Coverage (DPT3) (%) | 14 | 21 | 32 | 84.7 | 84.9 | 96 | |
| Goal 5: Improve Maternal Health | | | | | | | |
| Maternal Morality Ratio [MMR] | 871 | 871 (1993 -2000) | 673 (1998-2005) | 676 (2011 EDHS) | | 267 | 267 |
| % of currently married women who use any modern contraceptive method (%) | 2.9 | 6.3 | 13.9 | 18.7 | | | |
| Ante Natal Coverage [number and timing of (4+) ANC visits (%)* | 20.2 (1992/93) | 10.4 | 12.2 | 16.6 | 20.4 | 86 | |

| MDG Indicators | Base Line [1990] | 2000/01 | 2004/05 | 2010/11 | 2011/12 | National Target (2014/15) | MDG Target 2015 |
|---|---|---|---|---|---|---|---|
| Women Age 15 -49 attended at Least Once by a Skilled Health Provider during Pregnancy | NA | 26.7 | 27.6 | 33.9 | | | 60 |
| Goal 6: Combat HIV/AIDS, Malaria and Other Diseases | | | | | | | |
| HIV/AIDS Prevalence among People Aged 15 -49 (%) | 0.9 | 4.5 | 1.4 | 1.5 | | | <4.5 |
| % of HIV/AIDS receiving Anti-retroviral Treatment | | | 10 (2005/06) | 62.3 | 71.5 | 90 | 100 |
| % of Population with treated Bed Nets | NA | | 43 (2005/06) | | 49.3 | 100 | 100 |
| TB Prevention and Control (% of Cases Successfully treated with DOTS) | NA | 60 (2000/01) | 76 (2005/06) | 82.5 | 88 | 90 | |
| Goal 7 : Ensure Environmental Sustainability | | | | | | | |
| Forest coverage (%) | 13 | 12.5 | 11.8 (2005/06) | 12.3 | | | |
| Use of improved/safe drinking water source (%) | 19 | 25.3 | 64 | 52.12 | 58.25 | | 40.5 |
| Improved Sanitation Facilities (%) | NA | NA | 6.8 | 63 | 67 | | |

## Annex 2: Major Macroeconomic Indicators of Ethiopia.

| Description | 1999/00 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|---|---|---|
| 1. GDP and Sector Growth Rate[%] | | | | | | | | | |
| Agriculture | 3.1 | 16.9 | 13.5 | 10.9 | 9.4 | 7.5 | 6.4 | 6 | 4.9 |
| Industry | 5.3 | 11.6 | 9.4 | 10.2 | 9.5 | 10 | 9.9 | 10.2 | 13.6 |
| Service | 10.4 | 6.3 | 12.8 | 13.3 | 15.3 | 16.0 | 14.0 | 14.5 | 11.1 |
| GDP | 5.9 | 11.8 | 10.8 | 11.5 | 10.8 | 8.8 | 12.6 | 11.2 | 8.5 |
| 2. Contributions of Major Sectors to GDP[ %] | | | | | | | | | |
| Agriculture | 49.9 | 47 | 47.4 | 47.1 | 46.1 | 44.6 | 43.2 | 45.6 | 44.0 |
| Industry | 12.4 | 14 | 13.6 | 13.4 | 13.2 | 13 | 13 | 10.6 | 11.1 |
| Service | 38.7 | 39.7 | 39.7 | 40.4 | 41.7 | 43.5 | 45.1 | 44.5 | 45.6 |
| 3. Share of External Trades | | | | | | | | | |
| Export | 12 | 14.9 | 15.1 | 13.8 | 12.7 | 11.4 | 10.5 | 17 | 14 |
| Import | 23.9 | 31.6 | 35.5 | 36.5 | 32 | 30.8 | 28.7 | 32.1 | 32.1 |
| Trade Balance | (11.9) | (16.7) | (20.4) | (22.7) | (19.3) | (19.4) | (18.2) | (15.1) | (18.1) |
| 4. Investments, Saving , Tax and Inflation | | | | | | | | | |
| Gross Domestic Savings | 9 | 11.9 | 5.9 | 4.6 | 8.7 | 5.3 | 5.2 | 12.8 | 16.5 |
| Gross Capital Formation | 20.3 | 26.2 | 23.8 | 25.2 | 25.8 | 22.5 | 24.7 | 27.9 | 34.6 |
| Inflation | 6.2 | 6.8 | 12.3 | 17.1 | 25.3 | 36.4 | 2.8 | 18.1 | 34.3 |
| Tax Revenue | 12.2 | 11.6 | 10.8 | 10.1 | 9.6 | 8.6 | 11.3 | 11.7 | 11.6 |

*Source: GTP, GTP-APR MoFED, 2010/11, GTP-APR MoFED, 2011/12.*

## Annex 3: Pro-poor capital and recurrent expenditure (in million Birr) by Sector

| Sectors | Base Year 2009/10 | 2010/11 | 2011/12 | Share in total expenditure (%) | Growth over the base year (%) |
|---|---|---|---|---|---|
| **Total government expenditure** | 72,598 | 93,831 | 124,417 | 100 | 71.3 |
| | | | | | |
| **Total pro-poor expenditure** | 47,790 | 62,378 | 87,568 | 70.4 | 83.2 |
| **Education** | 17,249 | 23,345 | 29,710 | 23.9 | 72.2 |
| **Health** | 4,693 | 6,307 | 7626 | 6.1 | 62.5 |
| **Agriculture** | 6,993 | 8,246 | 11,042 | 8.9 | 57.9 |
| **Water** | 4,883 | 5,563 | 10,147 | 8.2 | 107.8 |
| **Road** | 13,973 | 18,918 | 28,836 | 23.2 | 106.4 |

*Source: GTP-APR MoFED, 2010/11 and 2011/12*

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