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MDG REPORT 2014 ETHIOPIA

Millennium Development Goals Report 2014
Ethiopia

Assessment of Ethiopia's Progress towards the MDGs

October 2015
Addis Ababa, Ethiopia

Foreword

In 2000 the United Nations adopted the Millennium Declaration, which provided a comprehensive framework of core values and principles in the areas of sustainable development, human rights, peace and security. The roadmap for the implementation of the Declaration brought forth a set of eight Millennium Development Goals (MDGs) to be achieved by 2015. During the past 15 years, the MDGs have become a platform for fostering global partnership for development and, as the 2015 global MDG report shows the MDGs a rallying point around which has grown a successful worldwide anti-poverty movement. The MDGs have helped to lift more than one billion people out of extreme poverty, and have enabled more girls to attend school than ever before. Experience from the implementation of the MDGs here in Ethiopia, as well as in the wider world, has demonstrated that significant progress can be made with targeted interventions, sound strategies, adequate resources and political will.

Ethiopia must be commended for making significant progress in the achievement of the MDGs. This 2014 MDG report highlights the progress made, identifies some of the key drivers of success and discusses vital lessons that could be replicated in other countries in the region. Today, Ethiopia is globally recognized for having taken ownership of the MDGs agenda and integrating them into successive national development plans from the Sustainable Development Poverty Reduction Programme (2002/03-2004/05) to the Growth and Transformation Plan (GTP) (2010/11-2014/15). It may be recalled that during the SDPRP period, the Government with the support of the UN Country Team (UNCT), the Millennium Project and the World Bank conducted a detailed MDGs needs assessment to estimate what it would cost to achieve the MDGs by 2015. Based on this assessment, a 10-year MDG strategy was formulated, which was incorporated into the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) (2005/06-2009/10) and the Growth and Transformation Plan (2010/11-2014/15).

Reports on the MDGs have been the primary instruments used by the Government and UN to track, monitor and report on the progress made. Ethiopia has so far produced four MDG reports making this the fifth in the series. The 2014 report has gone beyond looking at trends to analyse critically some of the drivers of change and to identify some of the opportunities and entry points for the unfinished business of the MDGs as well as the post-2015 development agenda. As shown in the report, Ethiopia has successfully achieved six of the eight MDGs. Even for the other two lagging MDGs—MDG 3 on ensuring gender equality and empowering women, and MDG 5 on improving maternal health—significant progress has been observed. Today Ethiopia celebrates the fact that the proportion of people below the poverty line has been halved; the prevalence of hunger and undernourishment has been reduced; access to education has expanded; the gap in enrolment between boys and girls has narrowed; under-five mortality has been reduced by two-thirds; and similar progress was recorded in reducing HIV/AIDs, malaria, tuberculosis and other diseases. A Climate Resilient Green Economy Strategy has been formulated and the Government has set itself a bold vision of becoming middle-income carbon-neutral economy by 2025.

The UN and the Government of Ethiopia will redouble our efforts in the quest to achieve inclusive growth and sustainable human development. National ownership coupled with strong partnerships across the entire development spectrum has been the behind Ethiopia's successful achievement of the MDGs and will continue. We recognize that while Ethiopia has made significant progress, more needs to be done. There are still about

25 million people living in absolute poverty despite the commendable progress in reducing the number of people living below the poverty line. Unemployment still remains a challenge particularly in urban areas. The success in raising the net enrolment of children will have to be matched by improved quality of education, reduced grade repetition and lower dropout rates. The gains made in promoting gender equality, particularly in the participation of women in leadership positions, should be complemented with improvement in the quality of that participation. Although Ethiopia has achieved the MDG target of reducing child mortality, we still need to expand child immunization. The Government and UN will strengthen their support for reducing maternal mortality, especially in the pastoral areas that are most in need of it.

As Ethiopia embarks on the implementation of GTP II and Agenda 2030, the important lessons learnt through the MDGs must be replicated during the SDGs process. The Government, the United Nations and the development partners in Ethiopia will work together in a collegial fashion to complete the unfinished business of the MDGs and at the same time will begin to roll out the SDGs in Ethiopia. A set of concrete measures will have to be taken, ranging from the contextualization of the SDGs to make them appropriate to national realities, mainstreaming the 17 goals and 169 targets in the national and sub-national development plans, and assessing the costs and financing needs associated with the SDGs, as well as tracking and monitoring progress towards the achievement of the SDGs by 2030. As the MDGs monitoring and reporting exercises have shown, the improved availability of data is crucial for sound analysis and decision-making. The convergence of the UN's global launch of Agenda 2030, the unveiling of GTP II (2015/16-2019/20) and the roll-out of the UN Development Assistance Framework (UNDAF) (mid-2016-mid-2020) provides a timely opportunity for both the Government and United Nations to strategize with a view to achieving our common vision of eradicating poverty and promoting sustainable human development.

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Addis Ababa,
Ethiopia

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Abbreviations and Acronyms

AA	Addis Ababa
APR	Annual Progress Report
ART	Antiretroviral Therapy
BEmONC	Basic Emergency Obstetric and Neonatal Care
BG	Benishangul-Gumuz
BoFED	(Regional) Bureau of Finance and Economic Development
Br	Birr (Ethiopian currency)
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
COMESA	Common Market for Eastern and Southern Africa
CPRW	Convention on the Political Rights of Women
CPR	Contraceptive Prevalence Rate
CRGE	Climate Resilient Green Economy strategy
DAG	Development Assistance Group
DBS	Direct Budgetary Support
DD	Dire Dawa
DfID	Department for International Development (UK)
DOTS	Directly Observed Treatment, Short-Course (WHO-recommended tuberculosis control strategy)
DPT3	Diphtheria, Pertussis, Tetanus Immunization
EPA	Environmental Protection Agency
FAO	Food and Agricultural Organization
GDP	Gross Domestic Product
GEQIP	General Education Quality Improvement Programme
GNI	Gross National Income
GPI	Gender Parity Index
GTP	Growth and Transformation Plan
H4+	Partnership between UNAIDS, UNFPA, UNICEF, WHO, UN Women and the World Bank
HEW	Health Extension Worker

HIPC	Highly Indebted Poor Countries initiative
HSDP	Health Sector Development Programme
ICT	Information and Communications Technology
IPRSP	Interim Poverty Reduction Strategy Paper
JICA	Japan International Cooperation Agency
LLIN	Long Lasting Insecticide-treated Nets
MDGs	Millennium Development Goals
MEF	Ministry of Environment and Forest
MoFED	Ministry of Finance and Economic Development
ODA	Overseas Development Assistance
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PBS	Protection of Basic Services
PPP	Purchasing Power Parity
PRSP	Poverty Reduction Strategy Programme
PSNP	Productive Safety Net Programme
SDG	Sustainable Development Goal
SDPRP	Sustainable Development and Poverty Reduction Programme
SNNP	Southern Nations, Nationalities and Peoples regional state
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water Supply, Sanitation and Hygiene programme
WFP	World Food Programme
WMS	Welfare Monitoring Service

Symbols Used in Tables

.. = not available

- = not applicable

– = negligible

Executive Summary

Ethiopia is one of the countries which responded positively to the Millennium Declaration of the 2000. Ethiopia has adopted, contextualized, owned and mainstreamed the MDGs into the annual progress reports on its poverty reduction strategies since 2005. Ethiopia is on track to achieve six of the eight MDGs—the two exceptions being MDGs 3 and 5. This section provides a summary of the country's progress in achieving the MDGs by goal.

Goal 1: Eradicate extreme poverty and hunger

In Ethiopia, the population living below the nationally defined poverty line (which is also called the incidence of poverty) in 1996 was 45.5 per cent, while it was believed to be 48 per cent in 1990. In 1996, the poverty gap and poverty severity were 12.9 per cent and 5.2 per cent respectively. Using a conservative estimate, the incidence of poverty declined to 29.6 per cent in 2011 and is estimated to have declined further to 25.1 per cent in 2014 and 23.4 per cent in 2015. The incidence of poverty thus declined by 35 per cent between 1996 and 2011. It is not only the incidence of poverty that has been declining, but also the poverty gap and poverty severity. Between 1996 and 2011, the poverty gap declined from 12.9 per cent to 7.8 per cent and poverty severity declined from 5.1 per cent to 3.1 per cent indicating poverty gap and severity declined by 39.5 per cent and 39.2 per cent respectively over the period. Overall, Ethiopia is on track to meet the MDG target of reducing poverty and hunger by half between 1990 and 2015. Ethiopia had already met one of the three targets (Target 1.C) well ahead of 2015. The reduction in poverty has occurred in all regional states and both rural and urban areas, although the level of decline is not uniform. Increased agricultural production and productivity, effective implementation of the Productive Safety Net Programme (PSNP) that has been providing assistance to over eight million rural people per year since 2005, urban food aid at times of extreme rises in food prices, effective regulation of markets for consumer products and the labour intensive construction projects (which have served as an additional source of income for the poor) are some of the main drivers of the observed progress in poverty reduction.

Despite the decline in the level of poverty, there are about 22.6 million poor people in 2013/14 who are living under the poverty line (which is very close to PPP US$1.25 a day on food and non-food items) and who are unable to satisfy their basic needs. Besides, the severity of poverty increased between 2005 and 2011. Therefore, reducing poverty among the poorest of the poor, ensuring food security and reducing the number of poor people in the country remain priority areas for intervention in the post-MDGs period.

The target of achieving full and productive employment and decent work for all, including women and young people, is also on track, but with a significant gender disparity. Therefore, reducing youth unemployment and gender inequality in employment, especially in urban areas, must be prioritized during the post-MDGs period.

Goal 2: Achieve universal primary education

Net enrolment rates for both primary and secondary education have increased substantially compared with 15 years ago. The net enrolment rate in primary schools was 21 per cent in 1996 and rose to 93 per cent in 2014, indicating that net enrolment in primary education grew by about 18 per cent per annum. If this trend continues, it will reach 100 per cent in 2015. The net enrolment rate for secondary education was 8.8 per cent in 1996 and grew to 20.2 per cent in 2014. However, net secondary enrolment is still very low, having increased by only 6.8 per cent per annum between 1996 and 2014. The literacy rate has increased from 27 per cent in 2000 to 47 per cent in 2011. Such growth is perhaps the result of the increase in gross enrolment in primary education.

Despite the success in providing children with near universal access to primary education in Ethiopia, the completion rate for both the first cycle (Grades 1-4) and second cycle (Grades 5-8) primary education did not improve noticeably so as to enable the attainment of the desired target of 100 per cent completion. Completion rates were 57 per cent for Grade 5 and 34 per cent for Grade 8 in 2005, and had increased to 70 per cent for Grade 5 and 53 per cent for Grade 8 in 2014. Despite these low completion rates, the gender gap in primary completion rates, which was very high in the early years of the period under review, had completely closed by 2014.

Overall, Ethiopia is on track to meet Goal 2 but the growth in net enrolment has been slow in recent years and primary education has suffered from grade repetition, children dropping out and poor learning achievements, such as low competencies in reading and mathematics. Improving completion of primary education through the provision of quality education must continue to be prioritized in Ethiopia's post-2015 development agenda.

Goal 3: Promote gender equality and empower women

Ethiopia has put substantial effort into eliminating gender disparities in primary and secondary education. At all levels of education, Ethiopia started with high levels of disparity in the enrolment of boys and girls. There had been some narrowing of the gap even before Ethiopia adopted the MDGs. The ratio of girls to boys in primary and secondary schools in 1996 was 36 per cent and 41 per cent respectively. The Gender Parity Index (GPI)[1] in 2000 was 0.7 for both primary and secondary education. By 2014, the GPI for Grades 1-8 of primary education had jumped to 0.93 and had reached 0.94 for first cycle secondary education and 0.85 for second cycle secondary. Since 2012, the GPI has not increased beyond 0.94. Therefore Ethiopia is not on track to reach the target of achieving a 1:1 girls to boys ratio, and is thus unlikely to meet Goal 3 by the 2015 deadline. The slow progress of the GPI could be attributed to a number of reasons, including socioeconomic and cultural challenges, such as early marriage, violence against girls, abduction, parents' lack of awareness of the benefits of education, distance to school, and a lack of gender sensitive facilities in school. Therefore, there should be a renewed commitment to eliminating gender disparities during post-2015 period.

In terms of political empowerment, the proportion of seats held by women in the House of People's Representatives (lower house of the national parliament) reached 38.7 per cent in the 2015 election, thus surpassing the 30 per cent benchmark—a significant achievement. This achievement should be complemented by the strengthened capacity of women to engage as effectively in the social, economic and political spheres as their numbers warrant. The role of women in the executive and judiciary should also be further strengthened.

Goal 4: Reduce child mortality

Ethiopia has made progress in reducing child mortality. It fell by two thirds between 1990 and 2015 and the goal has been declared already achieved. Contributing factors to this include increased access to health service coverage, notably immunization. Immunization coverage–for measles and diphtheria-pertussis-tetanus (DPT3) – contributed significantly to reducing child mortality. From 36.5 per cent for measles and 41.9 per cent for DPT3 in 2001, coverage increased to 86.5 per cent and 91.1 per cent in 2014. This shows that the two are on track to meet the MDG target of 90 per cent and 96

1 The GPI is used to measure the level of equity in education between boys and girls. In a situation of equality between boys and girls, the gender parity index (GPI) is 1 whereas as inequality increases it approaches 0.

per cent respectively by the end of the MDGs period (2015). As a result, child mortality per 1,000 live births has fallen substantially over the past 15 years. Under-five mortality per 1,000 live births was estimated to be 166 in 2000 and this had been reduced to 88 by 2011. Under-five mortality is estimated to have declined further to 60 in 2014, which is below the MDG target of 63, indicating that Ethiopia has achieved it target of reducing child mortality by two thirds ahead of time. There are slight variations across regions with Somali (60.5 per cent), Gambella (50 per cent) and Dire Dawa (68.1 per cent) having the lowest coverage in 2014 for DPT3. With respect to immunization for measles, the lowest coverage was recorded in Somali (57.8 per cent) and Gambella (45 per cent). Therefore, reducing regional disparities and ensuring regional equity should be emphasized during the post-2015 era.

Goal 5: Improve maternal health

Ethiopia is unlikely to meet Goal 5 by the 2015 deadline. The Government, the UN and other development partners are endeavouring to meet the target of reducing maternal mortality by two thirds between 1990 and 2015. The Contraceptive Prevalence Rate (CPR) increased from 8.1 per cent in 2000 to 41.8 per cent in 2014. Wide variation was observed across regions, with Afar and Somali lagging behind the rest. In fact, CPR declined over the period in Somali region. Antenatal care (ANC) service coverage increased from 29 per cent to 98.1 per cent between 2000 and 2014. However regional variations have been observed in coverage of ANC services with Afar, Somali and Benishangul-Gumuz (categorized as developing regional states) lagging behind. The proportion of women aged 15-49 who are attended at least once by a skilled health provider during pregnancy improved from 26.7 per cent in 2000 to (a still very low) 39.9 per cent in 2014. There are also rural-urban variations with the percentage of pregnant women attended once by skilled health personnel in rural areas standing at 35 per cent while it was 80 per cent in urban areas. Although the disparity between rural and urban areas was high, the rate of increase between 2000 and 2014 was higher in rural areas (60.6 per cent) than in urban areas (19.4 per cent). As a result of this and other factors, maternal mortality rate improved over time, but very slowly. The maternal mortality rate was estimated to have declined from 1,400 per 100,000 live births in 1990 and 871 in 2000 and 673 in 2005, before marginally increasing to 676 in 2011 and declining again to 420 in 2013. This represents a significant decline, but not a high enough one to enable Ethiopia to reach the target of 267 per 100,000 live births in 2015. Therefore Ethiopia is off track in Goal 5. Cognizant of this fact, the UN community in Ethiopia came together and formulated a flagship joint programme on accelerating maternal health (under the umbrella of the H4+) and also designed an MDG Acceleration Framework for MDG 5, which aims to speed up the expansion of maternal health services in pastoral and semi-pastoral areas. The issue of maternal health is at the centre of human development and should continue to be a priority area for intervention in the post-MDGs period.

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

Combating HIV/AIDS, malaria, TB and other diseases has been prioritized in successive Health Sector Development Programmes (HSDPs) and poverty reduction programmes, including SDPRP, PASDEP and GTP. Ethiopia has succeeded in reducing the prevalence rate of HIV/AIDS from 4.5 per cent in 2000 to 1.1 per cent in 2014, which surpasses the MDG target of less than 4.5 per cent. Though the prevalence rate is low, there are slight disparities between rural and urban areas with a relatively higher prevalence rate observed in the Addis Ababa and Dire Dawa City Administrations. The proportion of people living with HIV/AIDS in the country who were on Antiretroviral Therapy (ART) was 1 per cent in 2004, but that had increased to 54 per cent in 2014, which is far behind

the MDG target of 100 per cent in 2015. With more effort, ensuring universal access to HIV/AIDS person on ART by 2015 seems achievable. The percentage of children under the age of five who sleep under nets treated with insecticide increased from 43 per cent in 2005 to 49.3 per cent in 2012. The national tuberculosis detection and treatment success rates increased from 36 per cent and 85.6 per cent respectively in 2009 to 54 per cent and 92.1 per cent in 2014. By 2013/14, a total of 116,633 TB cases were reported with a TB case notification rate of 133 per 100,000 members of the population. The TB treatment success rate also increased, from 84 per cent in 2009/10 to 92.1 per cent in 2013/14. Therefore, Ethiopia is on track with respect to MDG 6.

Goal 7: Ensure environmental sustainability

Ethiopia has a vision of becoming a middle income and carbon neutral economy by 2025. The implementation of the Climate Resilient Green Economy (CRGE) Strategy developed in 2012 is geared to meeting this ambition. Ethiopia believes that achieving middle income status by 2025 through the conventional development path would result in a dramatic increase of carbon emissions and unsustainable use of natural resources. As part of implementing the CRGE strategy, a management roadmap was prepared for 1,440.8 thousand hectares of forest. About 22,515 quintals of tree seeds have been distributed to communities. About 10.2 million hectares of degraded area were rehabilitated during the first GTP period (2010/11-2014/15). Data from the Ministry of Environment and Forest show that as a result of these and other rehabilitation activities, it was possible to increase the forest cover of from 13 million hectares in 2012 to 15.93 million hectares in 2014. Moreover it was possible to cover 17.7 million hectares of land with multipurpose trees. The forest cover in Ethiopia was around 13 per cent in 2001, declined to 11.8 per cent in 2005, but had increased again to 15 per cent by 2014. After such an impressive performance in ensuring environmental sustainability, Ethiopia is on track to meet its target for increasing forest cover in Ethiopia. Ethiopia has declared the achievement of the MDG target for access to safe drinking water well ahead of 2015. Ethiopia is also on track to meet the MDG target for access to sanitation facilities. However, there is a large gap between the access of rural and urban areas to safe sanitation facilities and safe drinking water. As it is unlikely that the rural-urban gap will close in the near future, much effort is needed by the Government to increase the access of rural people to safe drinking water and sanitation facilities.

Goal 8: Develop a global partnership for development

Net official development assistance was US$1.1 billion in 2000 and increased to US$3.8 billion in 2013, an annual average growth rate of 17.5 per cent. Of total ODA, 58 per cent was allocated for basic social services (social infrastructure and services such as education and health). Ethiopia has prioritized key pro-poor sectors such as education, health, agriculture, water and rural roads, as well as industry, as drivers of sustained economic growth and job creation. Untied aid, or aid that is not limited to procurement from companies in the donor country or in a small group of countries, comprised 87 per cent of ODA to Ethiopia in 2012. ODA was 8.2 per cent of Ethiopia's GNI in 2013, compared with 18.5 per cent in 2004. With regard to aid effectiveness indicators, Ethiopia scores above the global average for all indicators measured at the country-level, but there has been a decrease in partners' use of Ethiopia's public financial management and procurement systems. Ethiopia enjoys preferential market access within COMESA, as well as to the USA and the EU. Since 2003, it has been on the road to accession to the WTO, which has recently been delayed due to protracted negotiations on trade in services. In 2013, 23 per cent of gross ODA consisted of aid

for trade. Ethiopia's total debt service as a percentage of total exports of goods was 8 per cent in 2013, and its risk of external debt distress, although low in previous years, has recently moved towards moderate risk. The proportion of the population with access to affordable essential medicines was 91 per cent, according to a 2009 study. Access to affordable information and communications technology (ICT) has increased considerably, albeit from a low base. In 2013 27 out of 100 people have mobile phone subscriptions, 0.8 out of 100 people have fixed-telephone subscriptions, and 2.3 per cent of the population use the Internet.

Overall, given increases access to modern communication technology, and increasing trends in ODA in both per capita terms and as a percentage of GNI, as well as the possibility of improved debt sustainability, Ethiopia is on track to meet the MDG of developing a global partnership for development.

Introduction

Ethiopia is among the countries that acceded to the Millennium Declaration of 2000, adopting the internationally agreed framework of eight goals and 18 targets to measure progress towards the Millennium Development Goals (MDGs). The country integrated the MDGs into its national development plans and poverty reduction strategies. The three successive poverty reduction medium-term plans, namely the Sustainable Development and Poverty Reduction Programme (SDPRP, 2002/03-2004/05), the Plan for Accelerated and Sustained Development to End Poverty (PASDEP, 2005/06-2009/10) and the Growth and Transformation Plan (GTP, 2010/11-2014/15), mainstreamed the MDGs and are credited with the poverty reduction and impressive human development achievements in Ethiopia. The MDGs framework helped to galvanize national efforts towards poverty reduction and improving educational and health outcomes, as well as towards building a common vision that helped Ethiopia to mobilize resources and the public at large.

The MDG targets which were set to be achieved by the end of 2015, have had to be periodically assessed in order to track their status and monitor progress. Ethiopia has produced evidence-based nationally-owned reports on the MDGs every two years, most recently in 2010 and 2012.

According to the 2012 MDGs report for Ethiopia, six of the eight MDGs were either achieved or on track to be achieved by the end of 2015. To be more explicit, Ethiopia was on track to meet the MDGs targets of reducing poverty by half, achieving universal primary education, eliminating gender disparities in primary education, reducing child mortality, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability and developing a global partnership for development. The 2012 MDG report showed that the targets of reducing maternal mortality and gender disparities at all levels (especially at secondary and tertiary levels) were not going to be achieved, although a lot of progress had already been made towards achieving these two goals. Since 2012, however, the Ethiopian Government, with the support of its development partners, has been putting a lot of effort into accelerating the achievement of these two MDGs, which were believed to be lagging behind.

The objective of the Ethiopia MDGs report for 2014 is, therefore, to assess the progress achieved by 2014, one year before the end date for the MDGs, identify the past and potential future challenges, motivate the final push for the achievement of the MDGs , and generate useful ideas for the framing of the post-2015 development agenda. The report also aims to reflect on and consolidate the experience of work of attaining the MDGs, and to identify the unfinished business that remains as priorities and the emerging or ongoing challenges. The specific objectives of this report are the following:

a. to reflect on the national context and milestones related to the MDGs and analyse how the MDGs have shaped national development agenda;

b. to analyse trends in the achievement of the MDGs and the disparities in their achievement among various socioeconomic groups such as the poor and the rich, male and female, rural and urban, and regionally;

c. to analyse the forces that drive achievement of the MDGs targets and identify the challenges faced in the past and possible future opportunities; and,

d. to identify unfinished business relating to the MDGs and emerging issues, including the post-2015 development agenda.

To meet these objectives, the report looked at Ethiopia's development context and made a detail assessment of some of the enablers and challenges faced in reaching the MDGs. The national planning documents, such as

SDPRP, PASDEP and GTP, as well as sector development programmes, have been key references in analysing the policy context and the mainstreaming of the MDGs in framing the national and regional development agenda. The report specifically looked at the contribution of the MDGs framework in shaping the national development policy landscape.

The report presents a trend analysis of the MDGs targets between 1990 and 2014, including performance indicators, to the extent that the availability of data has allowed. The trend analysis is disaggregated by sex, rural/urban, regional states, and in certain instances by other socioeconomic groups depending on the availability of data. The report strives to identify and categorize the trend for each MDG according to whether it has reached a standstill, is decelerating or is accelerating. A standstill may imply the need to give attention to complementary intervention. A deceleration signals an urgent need to take corrective action to eliminate the element of fragility in previous/recent gains. An accelerated rate of improvement could prompt action to bring about further progress by helping identify measures that could allow these improvements to be scaled up or made sustainable.

Through the review of reports by the Government, NGOs and international organizations, challenges, their prevalence across sectors and ways of addressing them are identified. The report also identifies key driving factors that have contributed to accelerated progress on specific MDG targets to highlight good practice in the Ethiopian context. Ethiopia's current development priorities that go beyond 2015 were identified from the Government's long-term development plans or visions. In this section of the 2014 MDG report, the template provided in the latest guideline has been followed (UNDG, 2013, p.7).

The rest of the report is organized as follows: Section 2 looks at the macroeconomic and social development context; Section 3 focuses on the contextualisation of the MDGs in Ethiopia; Section 4 presents the progress in meeting the MDGs goal by goal; Section 5 identifies the drivers of progress, the challenges encountered and the MDGs' unfinished agenda; and Section 6 provides conclusions and a summary drawing on the analysis in the report.

The Macroeconomic and Social Development Context

Since 2004 the Ethiopian economy has recorded a high growth rate averaging 10.9 per cent annually over the past 11 years. Annual growth in the agriculture, industry and services sectors during this period averaged 9.0 per cent, 13.8 per cent and 12.2 per cent respectively. In 2013/14 the economy grew by 10.3 per cent, with the agriculture, industry and services sectors respectively contributing 2.3 percentage points, 2.7 percentage points and 5.3 percentage points of the growth (MoFED, 2014a).

While there has been rapid economic growth, inflation has emerged as a major macroeconomic challenge since 2008. The average inflation rate was below 20 per cent before 2006/07 but accelerated to 25.3 per cent in 2007/08, peaked at 36.4 per cent in 2009/10 and moderated slightly to 33.7 per cent in 2011/12. This high rate of inflation adversely affected people's well-being and stunted efforts to promote private investment. The government's macroeconomic target is to contain the inflation rate within single digits. The Growth and Transformation Plan Annual Progress Report (APR) for 2012/13 described various stabilization measures that had been taken, including tight fiscal and monetary policies, the financing of budget deficit from non-inflationary sources, the adoption of a new business registration and licensing code aimed at establishing a transparent and competitive domestic trading system, and the implementation of a price stabilization programme involving the supply of basic food items, including wheat, sugar and edible oil, to the urban markets (MoFED, 2014b). These macroeconomic policy measures and stabilization interventions eventually contributed to price stability. Consequently, general inflation declined to 7.4 per cent in 2012/13 and 10.3 per cent in 2013/14 (NBE, 2015).

The fiscal policy pursued over the last 10 years has mainly focused on increasing tax revenue by administering existing tax policies and tax reform programmes effectively, and on increasing budgetary expenditure on capital investment, and pro-poor and growth enhancing sectors. Government expenditure increased from Br22.5 billion in 2003/04 to Br186.6 billion in 2013/14. Pro-poor expenditure was Br62.4 billion in 2010/11 and increased to Br107.8 billion in 2012/13, which was 70 per cent of the total budget and 12.6 per cent of GDP, demonstrating Ethiopia's commitment to meeting the MDG of reducing poverty, not only as manifested in material deprivation, but in all its dimensions. Since 2010/11, the Ethiopian government has allocated an additional Br15 billion to regional governments through an MDGs fund, showing its commitment to meeting the MDGs.

The Ethiopian Government has strived to match rising fiscal expenditure with increased revenues. The MoFED data show that total government revenue, excluding grants, rose from Br13.3 billion in 2004 to Br146 billion in 2013/14. The 2012/13 APR shows that domestic tax revenue as a percentage of GDP was 12.4 per cent in 2010/11and 12.7 per cent in 2013/14. The adoption of a prudent fiscal policy and improvements in the tax administration and tax collection systems have helped to reduce the government budget deficit. As a result of these prudent fiscal policies, the fiscal deficit was about 2 per cent of GDP in 2012/13 and 2.6 per cent of GDP in 2013/14 (NBE, 2015). This clearly demonstrates that Ethiopia has been following a prudent fiscal policy to foster a healthy macroeconomic situation.

Ethiopia's monetary policy focuses on maintaining price and exchange rate stability, thereby creating conducive macroeconomic environment that promotes rapid and sustainable economic growth. In 2012/13, reserve money expanded by 13.4 per cent and broad money supply increased by 24.2 per cent. This was due to the expansion of domestic credit and net foreign assets by 23.4 per cent and 14.7 per cent respectively compared with the previous fiscal year. On the structure of domestic credit, net claims on the government decreased by 1.9 per

cent and credit to the non-government sector expanded by 26.2 per cent to support the ongoing policy direction of encouraging the private sector to continue as an engine of the country's economic growth. The National Bank of Ethiopia continued selling Treasury Bills mainly to mobilize non-inflationary resources to finance the government budget deficit. Accordingly, in 2012/13, the value of Treasury Bills sold was Br 109.2 billion. Out of this total, the shares held by non-banks and commercial banks were 52.8 per cent and 47.2 per cent respectively.

Addressing unemployment remains an important policy challenge even though there has been some improvement recently, bringing the unemployment rate down to 4.5 per cent in 2013 (CSA, 2014a). Urban unemployment declined from 22.9 per cent in 2004 to 17.4 per cent in 2014. The female and male urban unemployment rates both declined even though unemployment remained much higher for females than for males, as it did for youth than for adults. The male unemployment rate was 15.8 per cent in 2004 and declined to 11.3 per cent in 2014, while the female unemployment rate declined from 30.6 per cent in 2004 to 24.1 per cent in 2014. The unemployment rate among urban youth was 22.8 per cent in 2014 with large disparities between males and females whose respective unemployment rates stood at 16.3 per cent and 28.8 per cent (CSA, 2014a).

Overall, the macroeconomic context has remained stable over the past decade, contributing to the high rate of economic growth. The rate of investment and domestic saving reached 40.3 per cent and 22.5 per cent of GDP respectively in 2014 and per capita GDP reached US$632 in 2014 compared with US$129 in 2001 (NBE, 2015).

Ethiopia has also registered remarkable social development over the past two decades in the areas of education and health. Literacy in Ethiopia increased from 26 per cent in 1996 to 48 per cent in 2011, accompanied by a decline in the gap between the levels of male and female literacy. Primary schools have expanded to all *kebeles* (villages) in Ethiopia, thus contributing to a sharp increase in the level of enrolment of girls and boys in primary schools. Net primary enrolment increased from 21 per cent in 1996 to 93 per cent in 2014, while net enrolment in secondary education reached 20 per cent in 2014, from the very low level of 9 per cent in 1996. The primary school gender parity index (GPI) has been increasing and reached 0.93:1 in 2014. Tertiary education has also expanded substantially over the last 15 years. In year 2000, there were only three universities; by 2014, there were about 33 public universities and several private higher education institutions.

Performance reports of the Ministry of Health (MoH) show that there has been substantial improvement in the delivery of health services in Ethiopia (NPC, 2015). Health Sector Development Programs (HSDPs) have also been developed and implemented since 1997. Ethiopia has staffed health facilities with health personnel and equipped them so as to ensure quality primary health care and combat communicable diseases. For example, between 2005 and 2011, about 38,000 health extension workers were trained and deployed and over 10,000 health posts, 2,000 health centres and 73 hospitals were constructed. This has led to significant progress towards achieving universal access to basic health services. More focus has been given to primary healthcare in order to deliver more and better health care to women and children. To this end the HSDPs have been successful in putting in place health extension personnel in all *kebeles* in the country. Due emphasis has also been given to improving the quality of hospital services. As a result of all these activities health service coverage has increased substantially. The Contraceptive Prevalence Rate (CPR) reached about 42 per cent in 2014, when antenatal care coverage reached 40 per cent. The percentage of births attended by skilled personnel is still very low (about 14.5 per cent in 2014. About 66.2 per cent of mothers have received

postnatal care in 2014. The child mortality rate declined from 166 per 1000 live births in 2000 to 88 in 2011, while maternal mortality rate declined from 990 deaths per 100,000 mothers in 2000 to 676 in 2011 but still remains well above the MDG target of 267 deaths by end of 2015. Access to improved sanitation facilities increased from 8 per cent in 1990 to 28 per cent in 2014 (UNICEF and WHO, 2015). Access to safe drinking water increased from 19 per cent in 1990 to 55 per cent in 2014, meaning that the MDG target has been met ahead of the 2015 deadline. The stunting of children has been declining but is still high (at 40 per cent in 2014), while an estimated 25 per cent of children were underweight in 2014. Improvements in nutrition can be attributed to better health and sanitation services, and improved food security.

Following political decentralization in 1994 Ethiopia embarked on fiscal decentralization, which was implemented in two waves. The first wave of decentralization covered the period 1995-2002 (where responsibilities were devolved from federal to regional level), while the second wave covered the period from 2002 to 2008 (during which responsibilities were decentralized from regional level to *woreda* level), coinciding with the implementation of the first generation of the Poverty Reduction Strategy Programme (PRSP). During this period, Ethiopia developed sector development programmes including ones for the education (1997) and health sectors (1997). In 2000, an Interim Poverty Reduction Strategy Paper for the period of 2000/01-2002/03 was developed as part of the Highly Indebted Poor Countries Initiative (HIPC), demonstrating Ethiopia's commitment to reducing poverty. Following the first wave of decentralization from 1995 to 2002, essential steps were taken to solidify fiscal decentralization. During this period, federal government provided block grants to regional states, enabling the regional governments to exercise their powers and decide on the allocation of the block grants and revenues generated by the regions, in accordance with their rights under the constitution. During the first phase, the lower tiers of government (the *woredas*) did not have the power to decide on how much of their budgets to allocate across sectors leaving this power totally to regional governments. Therefore, the degree of decentralization was modest and not translated to the grass roots.

Understanding this shortcoming in the initial phase of fiscal decentralization, the Government pushed fiscal decentralization down to *woreda* government. Beginning in 2001 regional governments revised their constitution, paving the way for the second wave of fiscal decentralization from regions to *woredas*. The revised constitutions of the regional states clarify the allocation of responsibilities and duties between the regional and *woreda* levels and grant limited taxing powers to *woreda* administrations. Following this, regions also allocated block grants to the *woredas*, which the latter could direct to sectors and projects which they saw as relevant to their needs and priorities. As a result of deeper decentralization and implementation of the PRSP, it is evident that public services delivery in education, health, roads and others sectors has improved substantially.

With the much stronger emphasis on local government, the second generation of the PRSP, known as PASDEP, recognized decentralization as central to the country's strategy for ending poverty and ensuring effective service delivery. In addition to consolidating the gains made under the SDPRP, PASDEP envisaged deepening the second generation of decentralization, and strengthening the *woreda* administrations in every aspect to enable them to manage and deliver public services within their jurisdiction.

Recognizing the critical challenges faced by regional states and woreda administrations in discharging their responsibilities, the Government has introduced a multifaceted effort to strengthen the capacities of public institutions at regional and lower levels of government through its District Level

Decentralization Programme. The initiatives include developing a National Capacity Building Strategy (NCBS), Capacity-Building for Decentralized Service Delivery (CBDSD) and a Public Sector Capacity-Building Programme (PSCAP). The PSCAP envisaged addressing the nationwide prevalence of capacity problems in the public sector, and to that end it was designed in an integrated manner through the involvement of the relevant federal and regional institutions, the donor community and consultants. Under the auspices of the regional states, communications infrastructure (telephones and Internet facilities) down to kebele level were built. Training was given in leadership and communication to public servants at regional, woreda and kebele levels to improve public service delivery.

In summary, the prudent fiscal and monetary policies and practices coupled with political and fiscal decentralization, has provided Ethiopia with a development context conducive to designing and implementing interventions that are targeted towards addressing the developmental priorities of the country.

Contextualization of the MDGs

Although Ethiopia used many of the Millennium Development Goals indicators in its Interim Poverty Reduction Strategy Paper (IPRSP) issued in November 2000 (MoFED, 2000), the first time Ethiopia began to integrate the MDGs into its national development strategy was two years after the development of the first poverty reduction strategy programme known as Sustainable Development and Poverty Reduction Programme (SDPRP). The integration of MDGs into the SDPRP involved incorporating MDGs targets in the policy matrix for the SDPRP with annualized actions, targets and indicators. Since then, reporting on the MDGs was first synchronized with the annual progress reports (APRs) of the SDPRP and thereafter separate MDGs reports were produced in 2004, 2008, 2010, and 2012.

The first Ethiopian MDGs report was issued in 2004 (MoFED and UNCT, 2004). The report examined the implications of the MDGs for Ethiopia from the perspective of past trends, prospects and the resource requirements for their realization. In terms of context, the report acknowledged the relevance of MDGs for Ethiopia and in the then prevailing development context. It supported the view that each goal is relevant and of equal importance for Ethiopia. The contextual analysis addressed the issue of harmonizing the MDGs with the existing government policies, strategies and programmes and past performance. The report underlined that the MDGs targets were consistent with the SDPRP, the sector development programmes and other national development policies and strategies. SDPRP targets related to poverty, hunger, education and health were well articulated and are more or less consistent with the MDGs. The first MDGs report also identified targets and indicators that would be monitored at national level.

Ethiopia also looked at the cost implications of implementing the MDGs, particularly the costs associated with reducing poverty by half by 2015, the public expenditure required for the Government and other stakeholders to provide basic services and the direct cost of poverty-focused programmes in health, education, water and sanitation, agriculture and natural resources management. Based on an MDGs Needs Assessment conducted by the Government with support of the UNCT, Ethiopia developed a 10-year MDGs strategy which was implemented through the two consecutive five-year development plans, PASDEP (2005/06-2009/10) and GTP (2010/11-2014/15). The financial gap that would arise if the goals of poverty reduction and providing basic social services were to be achieved was estimated at US$1.1 billion per year and financing requirement for meeting the other goals over the 11 years to 2015 was estimated at Br314.5 billion. The Government believed that the financial gap could be bridged if significant debt relief, increased development assistance and access to external markets could be obtained. Moreover, it was believed that there should be a fundamental shift in aid modalities that would change the composition of ODA to Ethiopia. In 2004, about 31 per cent of ODA went for humanitarian assistance and only 7 per cent supported core sectors of the economy, such as agriculture, education and health (MoFED and UNCT, 2004). In addition, the level of ODA was deemed to be low when compared with other African countries. Ethiopia also identified several areas for further reform needed to ease the path towards achieving the MDGs. These include focused institutional reforms, scaling up of resource mobilization, particularly domestic revenue and savings, and significantly increasing the flow of external resources through debt relief and improvements in the efficiency of ODA disbursement.

The Development Assistance Group (DAG) facilitates donor coordination. Policy issues are discussed during the High Level Forum co-chaired by the Government and the DAG and attended by representatives from both sides (MoFED and UNCT, 2012). Prior to the 2005 election, the amount of ODA provided in the form Direct Budget Support (DBS) was on the rise. However, following the

2005 election—during the PASDEP period (2005/06-2009/10), DBS was frozen and donors shifted the thrust of the ODA delivery mechanism from DBS to PBS (Protection of Basic Services), a shift which among other things was aimed at protecting the progress that the country had made in achieving the MDGs and at preventing reversal of progress on MDGs. , Unlike DBS, which channels ODA through the Ministry of Finance and Economic Development, PBS programmes channel pro-poor services and investments via local level government (the regional Bureaus of Finance and Economic Development–BoFEDs). The PBS programme will continue throughout the GTP period, as a pooled fund. The pooled fund is the largest multi-donor programme. It includes the Promotion (initially Protection) of Basic Services (PBS); the Productive Safety Net Programme (PSNP)—one of the components of Ethiopia's Food Security Programme; the General Education Quality Improvement Programme (GEQIP); and the Water Supply, Sanitation and Hygiene (WASH) programme.

Ethiopia, by endorsing the MDGs and incorporating them into its five year national and sectoral development plans, boosted confidence in the relevance of its policies and strategies for poverty reduction, and drew attention to and focused minds on its social development objectives, such as improvements in health and education outcomes. Its endorsement also provided a strong rationale for mobilizing resources from both domestic and external sources during successive medium-term development plans (the SDPRP, PASDEP and the GTP). The Annual Progress Reports (APR) on the medium term plans have been prepared to take account of the MDGs, and the MDGs reporting was standardized in the APRs for PASDEP and the GTP. The country's ownership of the MDGs and their contextualization to the Ethiopian setting are believed to have contributed to increases in the inflow of ODA. According to the ODA database (OECD and WTO, 2015), Ethiopia obtained an estimated US$3.9 billion of ODA in 2013, which is substantially higher than its level in 2000 (US$1.1 billion) and 2001 (US$1.8 billion). The role of development partners became more prominent and their support came under one umbrella (such as PBS) and through pool funds (such as the Development Assistance Group–DAG–pooled funds managed by UNDP). It has also contributed to the coming together of like-minded donors and the establishment of various elements of the donor coordination architecture, including the DAG.

Progress in the Achievement of the MDGs

4.1. Goal 1: Eradicate Extreme Poverty and Hunger

Economic growth is a necessary condition for poverty reduction, food security and employment. However economic growth is not a sufficient condition for poverty reduction. For one of the benefits of economic growth to be poverty reduction, growth has to be pro-poor. While redistribution is an imperative of reducing poverty, it should be supported by high productivity. This section discusses growth and inequality in Ethiopia, followed by a discussion on the progress achieved in reducing poverty, hunger and malnutrition.

Growth and inequality

The Ethiopian economy started to show steady growth after 2002/03 (Figure 4.1.1 and Table 4.1.1). Annual GDP growth between 2000/01 and 2013/14 averaged 9 per cent. The highest growth was registered between 2002/03 and 2009/10, when the rate was about 11.4 per cent per annum. Per capita income grew from US$129 in 1999/2000 to US$632 in 2013/14. This economic growth has been one of the driving forces behind the reduction of poverty in Ethiopia. During this period, there was not only an increase in per capita income, but also a slight structural change in the economy (Table 4.1.2). In 2002/03, agriculture contributed 54 per cent of the GDP, while the industrial and services sectors accounted for about 10 per cent and 36 per cent respectively. By 2013/14 the share of agriculture in GDP had declined to 40 per cent, while the share of the industrial sector increased to 14 per cent and that of the services sector increased to 46 per cent, surpassing the agricultural sector.

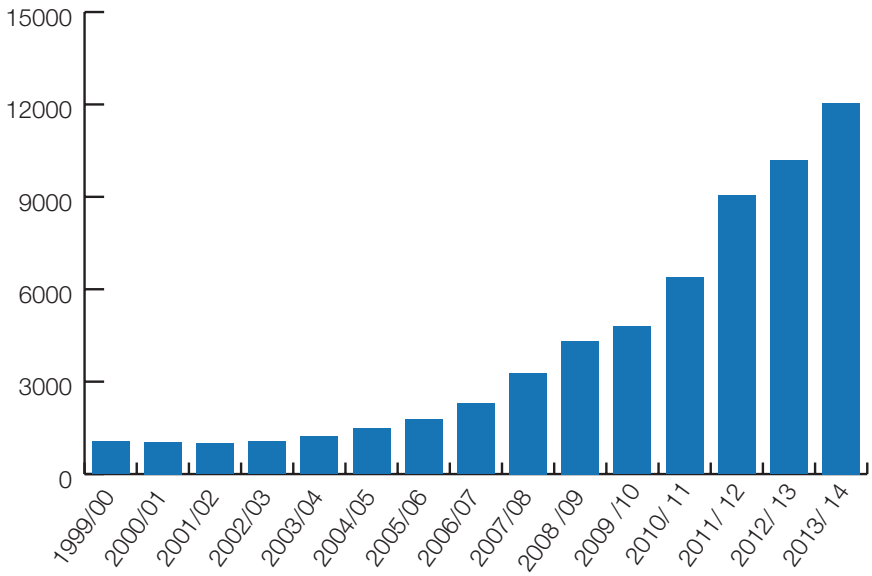
The 2011 poverty report (MoFED, 2013a indicated that compared with 1995/96, all population groups have registered a substantial increase in income measured by the expenditure on consumption per adult. While the expenditure of those at the very top grew by 66.6 per cent, the poorer groups saw their expenditure grow more modestly, by only 16.4 per cent for the bottom 5 per cent and 30.4 per cent for the bottom 25th of the population, compared with 45.7 per cent for top 5 per cent of the population (Table 4.1.3). In rural areas, the income distribution is more even (Table 4.1.4). Compared with 1995/96, all quintiles of the distribution were better off in 2010/11 in real terms, but the differences in the rates of increase between the higher and lower quintiles were not as extreme as in the urban areas (MoFED, 2013a).

Table 4.1.1: Trends in GDP per capita and growth

	Per Capita GDP (Br) (Nominal)	Per Capita GDP (US$) (Nominal)	Implicit GDP Deflator (Basic Prices)	Percentage Change in GDP Deflator	GDP Growth at Constant Prices
1999/2000	1,052	129	0.33		7.4
2000/01	1,043	125	0.31	-5.8	1.6
2001/02	993	116	0.3	-3.6	-2.1
2002/03	1,068	124	0.34	12.8	11.7
2003/04	1,228	142	0.35	3.9	12.6
2004/05	1,475	171	0.39	9.9	11.5
2005/06	1,783	205	0.43	11.6	11.8
2006/07	2,302	262	0.51	17.2	11.2
2007/08	3,282	355	0.66	30.3	10.0
2008/09	4,318	414	0.82	24.1	10.6
2009/10	4,803	373	0.83	1.4	11.4
2010/11	6,384	396	1.0	20.2	8.5
2011/12	9,032	524	1.3	33.5	8.7
2012/13	10,192	558	1.4	4.7	9.8
2013/14	12,045	632	1.5	10.2	10.3

Sources: MoFED, 2013b; and MoFED, 2014a).

Figure 4.1.1: Per capita income at 2011 constant prices (Br)



Source: MoFED, 2013b; and MoFED, 2014a).

Table 4.1.2: Real GDP growth and sectoral shares (% unless otherwise stated)

	2009/10	2010/11	2011/12	2012/13	2013/14	Average 2009/10-2013/14
Growth rate						
Real GDP growth rate	10.5	11.4	8.8	9.9	10.6	10.2
Agriculture	7.6	9.0	4.9	7.1	5.4	7.2
Industry	10.8	15.0	17.1	18.5	21.2	16.5
Large and medium-scale manufacturing	13.6	14.1	15.9	14.5	14.5	14.5
Micro and small-scale manufacturing	7	7.2	4.2	3.0	3.1	4.9
Services	13.2	12.5	9.6	8.9	11.9	11.2
Share						
Agriculture	41.6	44.7	43.1	42	40.2	42.3
Industry	12.9	10.5	11.5	13.0	14.3	12.4
Large and medium-scale manufacturing	2.6	2.6	2.8	2.9	3.2	2.7
Micro and small-scale manufacturing	1.3	1.2	1.4	1.3	1.2	1.3
Services	45.6	45.5	45.9	45.6	46.2	45.8
GDP in Br million at constant market prices	382,939	515,079	747,327	864,673	1,047,393	711,482

Source: MoFED,2013b.

Table 4.1.3: Changes in expenditure per adult across the distribution, all households (Br)

	Percentile								
Year	**1st**	**5th**	**10th**	**25th**	**50th**	**75th**	**90th**	**95th**	**99th**
19995/96	1,150	1,604	1,933	2,597	3,612	4,963	6,775	8,339	13,185
1999/2000	1,254	1,708	2,034	2,697	3,691	5,030	6,781	8,403	13,881
2004/05	1,533	1,990	2,308	2,919	4,100	5,397	7,333	9,170	17,141
2010/11	1,279	1,867	2,402	3,386	4,709	6,553	9,423	12,153	21,962
Changes (%)									
1995/96-2010/11	11.2	16.4	24.3	30.4	30.4	32.0	39.1	45.7	66.6 t

Source: MoFED, 2013a.

Table 4.1.4: Changes in expenditure per adult across the distribution, rural households (Br)

	Percentile								
Year	**1st**	**5th**	**10th**	**25th**	**50th**	**75th**	**90th**	**95th**	**99th**
1995/96	1,153	1,599	1,918	2,557	3,511	4,792	6,294	7,619	10,717
1999/2000	1,253	1,706	2,030	2,686	3,646	4,895	6,409	7,681	11,656
2004/05	1,537	1,989	2,308	2,910	4,017	5,183	6,839	8,023	13,354
2010/11	1,260	1,814	2,306	3,261	4,441	6,018	7,984	9,662	14,333
Changes (%)									
1995/96-2010/11	9.3	13.4	20.2	27.5	26.5	25.6	26.9	26.8	33.7

Source: MoFED, 2013a.

In general, inequality in Ethiopia is largely an urban problem. Because of the more or less egalitarian land distribution, income inequality in rural areas is extremely low. Since 99 per cent of rural households own land (MoFED 2008), though holdings could be as small as 0.5 ha, any land augmenting technological growth benefits all households. As shown in Table 4.1.5 and Figure 4.1.2, in rural areas, the Gini coefficient was 0.27 in 1995/96 and 15 years later, in 2011, it was 0.274 indicating that inequality was unchanged over this decade and half. Due to low rural inequality, the overall Gini coefficient for the country remained more or less unchanged between 1995/96 and 2010/11.

From 19995/96 urban inequality increased at an alarming rate reaching 0.44 in 2004/05, but because of the change in urban development policy after 2005, the rising trend of urban inequality was reversed resulting into a huge decline in poverty (MoFED, 2013a). These positive developments in urban areas can be attributed to urban focused development activities, including urban infrastructure development (roads, private and condominium housing construction), the promotion of labour intensive activities (the use of cobblestones to construct urban roads), the promotion of micro and small-scale enterprises through the provision of training, credit and business development support, and the distribution of subsidized basic food items to the urban poor in times of crisis over the past 10 years as well as the growth of the services sector (MoFED, 2013a; World Bank, 2015, p.6.).

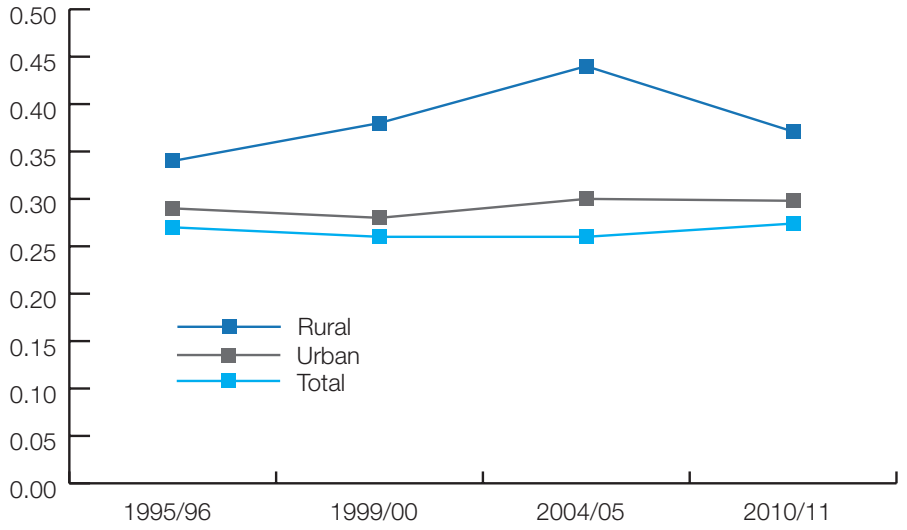
Based on the Gini coefficient estimates by region and rural/urban, regions can be classified into two categories: (1) regions with Gini coefficients below 0.3 (Amhara, Oromia, Somali, Gambella, Harari, and Dire Dawa with Harari region the lowest); and (2) regions with Gini coefficients above 0.3 are Tigray, B.G., SNNP, and Addis Ababa with inequality the highest in Tigray Region. It was found that inequality is higher in urban areas for all regions. Among the regional urban, highest inequality is observed in Amhara (0.41), followed by Benishangul-Gumuz and Tigray (Table 4.1.6).

Table 4.1.5: Trends in national, rural and urban Gini coefficients

Year	Rural	Urban	Total
1995/96	0.27	0.34	0.29
1999/00	0.26	0.38	0.28
2004/05	0.26	0.44	0.30
2010/11	0.274	0.371	0.298

Source: MOFED, 2013a.

Figure 4.1.2: Trends in inequality as measured by Gini coefficient, 1995/96-2010/2011



Source: MoFED, 2013a.

Table 4.1.6: Inequality measured by Gini coefficient by region and rural/urban, 2010/11.

Region	Urban	Rural	Total
Tigray	0.375	0.295	0.344
Afar	0.333	0.262	0.305
Amhara	0.416	0.270	0.296
Oromia	0.368	0.262	0.283
Somali	0.301	0.276	0.286
Benshangul-Gumuz	0.380	0.299	0.319
SNNP	0.360	0.293	0.303
Gambella	0.381	0.211	0.289
Harari	0.309	0.189	0.266
Addis Ababa	0.336	.	0.336
Dire Dawa	0.332	0.187	0.292
National	0.371	0.274	0.298

Source: MoFED, 2013a.

Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Based on the Household Income, Consumption and Expenditure Survey conducted by the Central Statistical Agency (CSA) of Ethiopia in 1996, the poverty line was Br1,075 at 1996 constant prices which would buy 2,200 kcal per day per adult plus essential non-food items, such as housing and clothing. At that time 45.5 per cent of the population was living below this poverty line (hereafter called incidence of poverty or people under extreme poverty), down from 48 per cent in 1990 (Table 4.1.8). In 1995/96, the poverty gap and poverty severity were 12.9 per cent and 5.1 per cent respectively. The incidence of poverty declined to 29.6 per cent in 2010/11 and is estimated to have declined to 25.1 per cent in 2013/14 and 23.4 per cent in 2014/15 (Figure 4.1.3) (see Table A4.1.1 for the assumptions underlying these estimates). Estimates were for poverty incidence at the regional level applying the same rates of change as those used at the national level (see Table A4.1.1 in the Appendix for the underlying assumptions). In

summary, the incidence of poverty declined by 35 per cent between 1995/96 and 2010/11. As well as the incidence of poverty, the poverty gap and poverty severity have also been declining. Between 1995/96 and 2010/11, the poverty gap declined from 12.9 per cent to 7.8 per cent and poverty severity declined from 5.1 per cent to 3.1 per cent, declines of 39.5 per cent and 39.2 per cent respectively over the 15-year period. Though since 1995/96 rural poverty has been higher than urban poverty, the disparity narrowed over the 15-year period as the rate of decline of the rural poverty indices was higher than that of the urban poverty indices. While the incidence of poverty, the poverty gap and poverty severity in rural areas declined by 13.4 per cent, 31 per cent and 41 per cent respectively between 1995/96 and 2010/11, in the urban areas these variables declined by 4.7 per cent, 24 per cent, and 36 per cent respectively over the same period. While gains in agricultural productivity and the support of eight million people every year via the Productive Safety Net Program are the main reasons for the reduction of undernourishment (poverty) in rural areas, labour intensive construction (of roads and buildings) and the availability of subsidized food crops in Addis Ababa during periods of high food prices could also explain the reduction in the poverty gap and poverty severity in the urban areas.

The incidence of poverty declined in all regions between 1995/96 and 2010/11 (Table 4.1.9). Overall, Ethiopia is on track to meet the Target 1.A of halving the proportion of people whose income is below the poverty line between 1990 and 2015 (Figure 4.1.3 and Table 4.1.7). However, although all regional states and rural and urban areas have experienced reductions in poverty incidence, there are still about 22.6 million poor people in Ethiopia as of 2014 . The severity of poverty has also not declined much since 2004/05.

Table 4.1.7: Progress in eradicating extreme poverty and hunger (%)

Indices	Baseline	1989/ 90	1995/ 96	1999/ 2000	2004/ 05	2010/ 11	2013/ 14	2014/ 15	Target 2015
Proportion of people living below absolute poverty line (baseline 1990)	48.0	48.0	45.5	44.2	38.7	29.6	25.1	23.4	24
Proportion of people living below food poverty line (baseline 1996)	49.5		49.5	41.9	38	33.6			..
Poverty gap (baseline 1996)	12.9		12.9	11.9	8.3	7.8			
Severity of poverty (baseline 1996)	5.1		5.1	4.5	2.7	3.1			..

Sources: CSA, Labour Force Surveys (various years); MoFED, 2013a.

Table 4.1.8: Trends of national and rural/urban poverty incidence

Indices by location	1995/96	1999/2000	2004/05	2010/11	Change between 1995/96 and 2010/11 (%)
National					
Head count index	0.455	0.442	0.387	0.296	-34.9
Poverty gap index	0.129	0.119	0.083	0.078	-39.5
Poverty severity index	0.051	0.045	0.027	0.031	-39.2
Rural					
Head count index	0.475	0.454	0.393	0.304	-36.0
Poverty gap index	0.134	0.122	0.085	0.08	-40.3
Poverty severity index	0.053	0.046	0.027	0.032	-39.6
Urban					
Head count index	0.332	0.369	0.351	0.257	-22.6
Poverty gap index	0.099	0.101	0.077	0.069	-30.3
Poverty severity index	0.041	0.039	0.026	0.027	-34.1

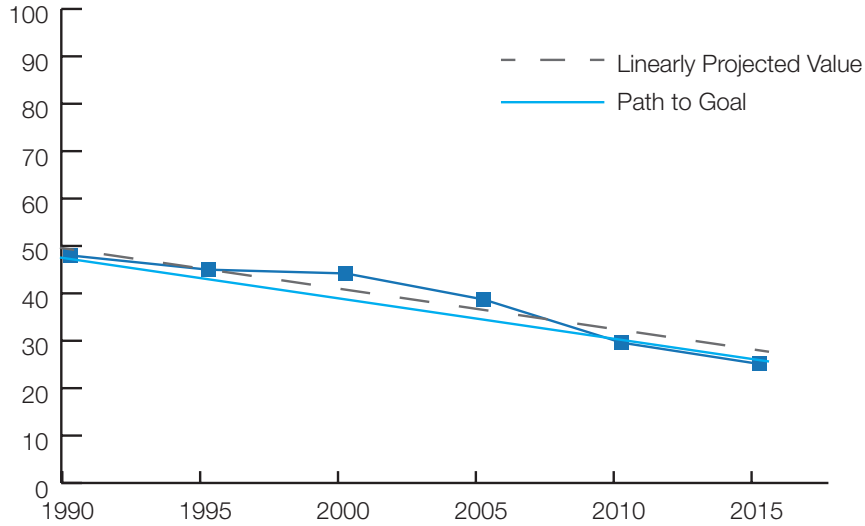
MoFED, 2013a.

Table 4.1.9: Trends of regional poverty incidence

Region	1995/96	1999/2000	2004/05	2010/11	Change between 1995/96 and 2010/11 (%)	Change between 1999/2000 and 2010/11 (%)
Tigray	0.561	0.614	0.485	0.318	-43.3	-48.2
Afar	0.331	0.560	0.366	0.361	9.1	-35.5
Amhara	0.543	0.418	0.401	0.305	-43.8	-27.0
Oromia	0.340	0.399	0.370	0.287	-15.6	-28.1
Somali	0.309	0.379	0.419	0.328	6.1	-13.5
Benishangul-Gumuz	0.468	0.540	0.445	0.289	-38.2	-46.5
SNNP	0.558	0.509	0.382	0.296	-47.0	-41.8
Gambella	0.343	0.505	..	0.32	-6.7	-36.6
Harari	0.220	0.258	0.27	0.111	-49.5	-57.0
Addis Ababa	0.302	0.361	0.325	0.281	-7.0	-22.2
Dire Dawa	0.295	0.331	0.352	0.283	-4.1	-14.5
Total	0.455	0.442	0.387	0.296	-34.9	-33.0

Source: MoFED 2013a.

Figure 4.1.3: Actual and desired trends in population living in extreme poverty, 1990-2015 [a] (%)



[a]*The population living in extreme poverty is defined as the proportion of the population living on less than PPP US1 per day.*
Source: Based on MoFED, 2013a.

Target 1.B: Achieve full and productive employment and decent work for all

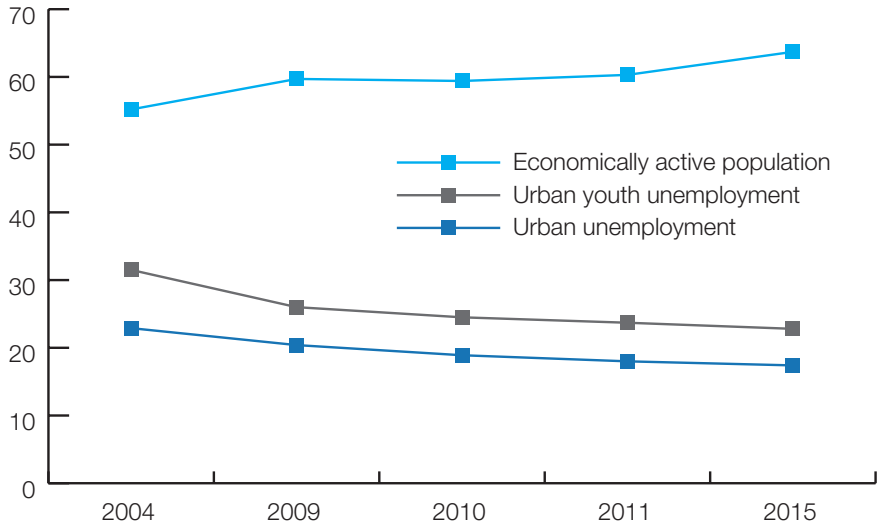
Two indicators, namely the urban unemployment rate and unemployment among youth aged 15-29, were selected for monitoring progress on the target of achieving full and productive employment and decent work for all. Figure 4.1.4 and Table 4.1.10 show that the overall unemployment rate in urban areas declined from 22.9 per cent in 2004 to 17.4 per cent in 2014. When disaggregated by sex, unemployment among males was 15.8 per cent in 2004 and 11.3 per cent in 2014, while it was 30.6 per cent for females in 2004 and declined to 24.1 per cent in 2014 indicating that there is still huge disparity between male and female unemployment. Unemployment among the youth was 22.8 per cent in 2014, again with large disparities between males and females: youth unemployment among males was 16.3 per cent, while it was 28.8 per cent among female youth (Table 4.1.10; Figure 4.1.5).

The percentage of the population who are economically active increased from 55 per cent to 64 per cent during the same period (Table 4.1.11). The economically active male population increased from 61 per cent to 71 per cent, while the corresponding percentage for the female population increased from 50 per cent to 57 per cent during 2004-2014. Despite the increase in the economically active population for both sexes, the active female population has been increasing more slowly than the active male population and action is required to change the situation.

Urban unemployment varies by region. In both 2004 and 2014, the highest rates were recorded in Addis Ababa (29.1 per cent and 23.5 per cent respectively) and Dire Dawa City Administration (33.5 per cent and 22.8 per cent respectively), while the lowest rates were observed in Benishangul-Gumuz (12.1 per cent and 6.3 per cent respectively) and Gambella (8.0 per cent in 2014). In the other regions, the rate was found to be between 12 per cent and 18 per cent in 2014. These figures show that urban unemployment declined in all regions, but that unemployment is still very high in the big cities such as Addis Ababa and Dire Dawa because of the influx of migrants which has a negative effect on employment, particularly on youth employment.

Overall, the progress in meeting Target 1.B has been commendable, but there is very high gender inequality suggesting that females are behind meeting Target 1.B.

Figure 4.1.4: Trend in unemployment in urban areas, 2004-2014



Sources: CSA, 2009; CSA, 2010; CSA, 2011; CSA, 2014.

Table 4.1.10: Trends in urban unemployment among the general population and youth, 2004-2014 (%)

	Overall Unemployment			Youth unemployment (15-29)		
	Male	Female	Total	Male	Female	Total
2004	15.8	30.6	22.9	23.3	38.7	31.5
2009	12.2	29.6	20.4	17.4	33.9	26.0
2010	11	27.4	18.9	16.6	31.6	24.5
2011	11.4	25.3	18	16.5	30.3	23.7
2014	11.3	24.1	17.4	16.3	28.8	22.8

Sources: CSA, 2004; CSA, 2009; CSA, 2010; CSA, 2011.

Table 4.1.11. Trends in economically active population (% of total population)

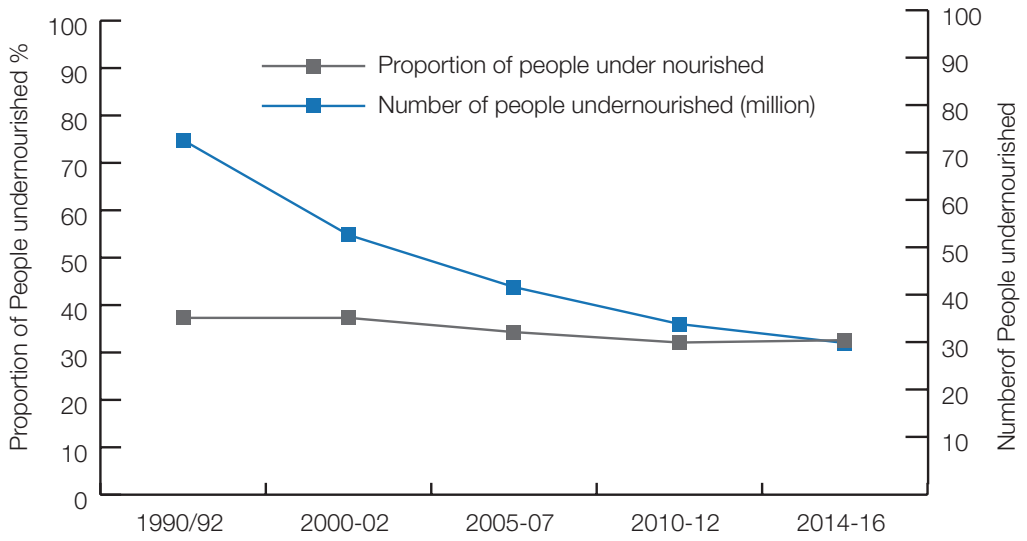
	2004	2006	2009	2010	2011	2014
Total	55.2	58.6	59.7	59.4	60.3	63.7
Male	61.2	66.1	67.2	65.7	67.9	71.1
Female	49.9	52.2	53.1	53.7	53.5	57.2

Sources: CSA, 2004; CSA, 2009; CSA, 2010; CSA, 2011.

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

There is evidence indicating that Ethiopia has made significant progress in achieving the MDG target of reducing hunger by half between 1990 and 2015 (FAO, IFAD and WFP, 2015). On 30 November 2014, the FAO declared that Ethiopia had achieved the MDG target of reducing hunger by half.[2] According to the FAO, the prevalence of undernourishment in Ethiopia decreased from 74.8 per cent in 1990-92, to 35 per cent in 2012-14, and is further projected to decline to 32 per cent in 2014-16. The number of undernourished people declined from 37.3 million to 32.9 million during the same period, and is projected to decline further to 32.6 million in 2014-16, thus indicating the achievement of MDG Target 1.C. According to the FAO, IFAD and WFP (2015), the prevalence of undernourishment (the proportion of undernourished people in total population) in Ethiopia declined by 57.2 per cent and the absolute number of undernourished people declined by 12 per cent—a significant achievement by any standard. (Figure 4.1.5). Gains in agricultural productivity, the Productive Safety Net Programme and increases in labour productivity are thought to be the main drivers for the progress in reducing undernourishment.

Figure 4.1.5: Trend in number and proportion of undernourished people (%)



Sources: FAO, IFAD; WFP, 2015.

The other measure of progress on reducing hunger is the proportion of the population below the minimum level of dietary energy consumption (the food poverty line). Food poverty is highly associated with hunger and is the main component of extreme poverty. The population whose food consumption expenditure was below the food poverty line (receiving sufficient income to be able to buy 2,200 kcal per day per adult) fell from 49.5 per cent in 1995/96 to 41.9 per cent in 1999/2000 and to 33.6 per cent in

2 http://www.fao.org/post-2015-mdg/awards/country-achievements-2014/en//.

2011 (Table 4.1.12). In rural areas, the food poverty index declined steadily from 51.6 per cent to 34.7 per cent between 1995/96 and 2010/11, while in urban areas, it declined from 36.5 per cent to 27.9 per cent in the same period. When regions are compared in terms of declining food poverty, it is observed that food poverty incidence declined between 1995/96 and 2010/11 in all regions by more than 20 per cent except Afar and Gambella but between 1999/2000 and 2010/11, it declined in all regions except Amhara (Table 4.1.13) .

Table 4.1.12: Trends of national and rural/urban food poverty

	Poverty indices over time				% change	
	1995/96	1999/2000	2004/05	2010/11	1995/96-2010/11	1999/2000-2010/11
National						
Head count index	0.495	0.419	0.38	0.336	-32.1	-19.8
Poverty gap index	0.146	0.107	0.12	0.105	-28.1	-1.9
Poverty severity index	0.06	0.039	0.049	0.046	-23.3	17.9
Rural						
Head count index	0.516	0.411	0.385	0.347	-32.8	-15.6
Poverty gap index	0.152	0.103	0.121	0.111	-27.0	7.8
Poverty severity index	0.062	0.038	0.049	0.05	-19.4	31.6
Urban						
Head count index	0.365	0.467	0.353	0.279	-23.6	-40.3
Poverty gap index	0.107	0.127	0.117	0.073	-31.8	-42.5
Poverty severity index	0.044	0.047	0.048	0.029	-34.1	-38.3

Source: MoFED, 2013a.

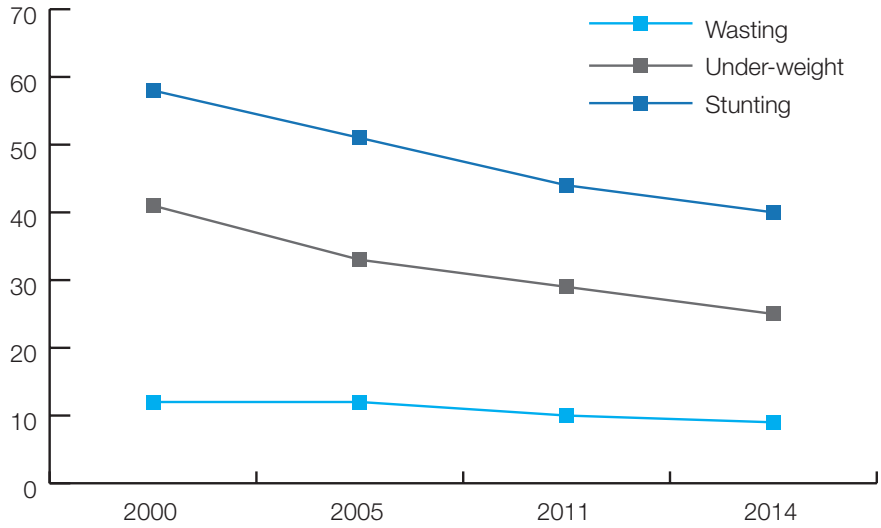
Table 4.1.13: Trends of regional food consumption poverty headcount indices, 1995/96-2010/11

	1995/96	1999/2000	2004/05	2010/11	% change 1995/96-2010/11	% change 1999/2000-2010/11
Tigray	0.649	0.537	0.468	0.371	-42.8	-30.9
Afar	0.333	0.534	0.392	0.322	-3.3	-39.7
Amhara	0.574	0.325	0.388	0.425	-26.0	30.8
Oromia	0.419	0.380	0.369	0.331	-21.0	-12.9
Somali	0.384	0.425	0.409	0.267	-30.5	-37.2
Benishangul-Gumuz	0.592	0.552	0.444	0.351	-40.7	-36.4
SNNP	0.517	0.547	0.37	0.259	-49.9	-52.7
Gambella	0.283	0.572	..	0.26	-8.1	-54.5
Harari	0.227	0.328	0.251	0.046	-79.7	-86.0
Addis Ababa	0.366	0.475	0.324	0.261	-28.7	-45.1
Dire Dawa	0.351	0.276	0.345	0.217	-38.2	-21.4
Total	0.495	0.419	0.38	0.336	-32.1	-19.8

Source: MoFED, 2013a.

Other indicators that are closely related to hunger are wasting, stunting and being underweight. The Ethiopian Demographic and Health Survey (EDHS) has measured these three indicators based on comparisons between Ethiopian children aged under 60 months with the latest WHO multi-country growth references (de Onis, Blössner and Borghi, 2011). Table 4.1.14 shows stunting, wasting and underweight over the past decade. Figure 4.1.6 shows a clear downward trend, indicating success in the nutritional policies pursued by the Government of Ethiopia, which lowered the rate of stunting from 58 per cent in 2000, to 40 per cent in 2014. Underweight is similarly on a downward trend. The prevalence of wasting, or low weight-for-age, has fallen less significantly, though was at a lower starting level in 2000.

Figure 4.1.6: Trends in child malnutrition, 2000-2004



Sources: CSA, 2000; CSA, 2005; CSA, 2011; CSA, 2014.

Tables 4.1.14 and 4.1.15 present breakdowns of child nutrition indicators by rural/urban and by region. In 2014 there was still a large discrepancy in stunting and underweight and a slight difference in wasting between rural and urban areas with rural areas lagging behind urban areas. Though Ethiopia is in line with the MDG targets for reducing hunger, children in rural areas may still be in hunger.

When difference in child malnutrition and hunger is analysed by regions (Table 4.1.15), stunting is the highest in Afar, Tigray and SNNP and the lowest in Gambella and Addis Ababa. Afar has the highest underweight and wasting compared with the rest of the regions, implying that Afar taken in isolation may not meet the MDG target of reducing hunger by half.

Table 4.1.14: Trends in child malnutrition by place of residence, 1996-2014

	Wasting	Stunting	Underweight
National			
1996	9.2	66.6	..
2000	12.0	58.0	41.0
2004	12.0	51.0	33.0
2011	10.0	44.0	29.0
2014	9.0	40.0	25.0
Rural			
1996	7.6	66.6	46.7
1998	9.7	56.2	46.3
2000	9.8	57.9	46.7
2004	8.4	48.5	38.7
2011	30.4	46.2	10.2
2014	9.0	41.8	26.6
Urban			
1996	5.3	58.4	34.4
1998	8.5	40.5	30.7
2000	6.4	44.4	27.0
2004	6.5	29.6	20.8
2011	16.3	31.5	5.7
2014	7.9	24.3	13

Sources: MoFED, 2002; MoFED, 2008; MoFED, 2013; EDHS, 2014.

Table 4.1.15: Trends in stunting by region, 2000-2014

	Stunting of children aged 0-59 months			
Region	**2000**	**2004**	**2011**	**2014**
Tigray	58.9	48.6	51.4	44.4
Afar	41.8	40.7	50.2	49.2
Amhara	64.6	62.5	52.0	42.4
Oromia	53.6	45.1	41.4	37.5
Somali	48.0	42.7	33.0	38.4
Benishangul-Gumuz	51.4	47.0	48.6	39.7
SNNP	56.5	49.5	44.1	44.3
Gambella	40.2		27.3	21.8
Harari	46.9	34.7	29.8	29.2
Addis Ababa	36.9	31.9	22	22.9
Dire Dawa	39.3	30.2	36.3	27.4

Sources: MoFED, 2002; MoFED, 2008; MoFED, 2013a; CSA, 2014b.

Table 4.1.16: Wasting and underweight by region, 2000-2014[a]

	2000		2005		2011		2014	
	Underweight	Wasting	Underweight	Wasting	Underweight	Wasted	Underweight	Wasting
Tigray	41.9	11.6	47.9	11.1	35.1	10.3	30.1	13.6
Affar	34.1	9.9	50.5	12.6	40.2	19.5	45.6	24
Amhara	48.9	14.2	51.8	9.5	33.4	9.9	27.9	9.7
Oromia	34.4	9.6	42.4	10.4	26	9.7	22.2	6.9
Somali	50.9	23.7	44.3	15.8	33.5	22.2	38.8	27
Benishangul-Gumuz	44.6	16	42.3	14.2	31.9	9.9	30.0	18.8
SNNP	34.7	6.5	53.7	11.8	28.3	7.6	26.3	6.8
Gambella	26.7	6.8	39	18.1	20.7	12.5	18.7	19.6
Harari	26.7	9.1	27.1	6.3	21.5	9.1	17.3	5
Addis Ababa	11.0	1.7	14.1	4.2	6.4	4.6	7.2	3.1
Dire Dawa	29.6	11.4	30.8	1.1	27.6	12.3	20.7	11.7

[a]The figures for 2000 and 2005 are computed based on an old WHO reference table while those for 2011 and 2014 are computed based on the new WHO 2006 reference table.

Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014b.

4.2. Goal 2: Achieve Universal Primary Education

The main target for MDG 2 is to "ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling". In Ethiopia, this target is monitored through the following indicators: (1) the net enrolment ratio in primary education; (2) first cycle primary completion rate; (3) second cycle primary education completion rate; (4) literacy rate; and (5) gross primary enrolment rate (though the last of these is not recommended by the original UN declaration). The Ethiopian Education Abstract, published by the Ministry of Education, and the Welfare Monitoring Survey (WMS), conducted by the Central Statistical Agency (CSA), are the main sources of data for monitoring this goal.

Education has been the most important pro-poor sector in that it has commanded the highest public expenditure by regional states. Regional level average spending on education between 2005 and 2010 was the highest, at 35 per cent of the total spending, followed by spending on administrative and general expenses, which averaged 29 per cent of the total (MoE, 2012). Since the development the Ethiopia's Education and Training Policy in 1994, Ethiopia has implemented four successive Education Sector Development Programmes (ESDPs), namely ESRP I, ESDP II, EDP III and ESDP IV. Three of these sector development programmes were implemented after Ethiopia adopted the MDGs. Through the implementation of these sector development programs, access to education at primary, secondary and tertiary levels has expanded substantially. The number of primary schools has increased from 9,900 in 1995, to 16,500 in 2005 and to 32,048 in 2014 while the

number of secondary schools increased from 346 in 1996 to 706 in 2005 and to 2,333 in 2014 (MoE, 2015).

Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

The Welfare Monitoring Service (WMS) and the Ethiopian education statistical abstracts provide information on enrolment, by location and gender. The net enrolment rates for both primary and secondary have increased substantially compared with 15 years ago. As table 4.2.1 shows, the net enrolment rate in primary education increased from 21 per cent in 1996 to 93 per cent in 2014, indicating that net enrolment in primary education grew by about 18 per cent per annum. If this trend continues, it will reach 100 per cent in 2015. The net enrolment rate for secondary education increased from 8.8 per cent in 1996 to 20.2 per cent in 2014 (Table 4.2.2). Though the net secondary enrolment is still very low, it increased by 6.8 per cent per annum between 1996 and 2014.

In both primary and secondary schools, enrolment rates are not significantly different between boys and girls, and the initial gender gap seen in 1996 in primary schools has now been almost closed. Table 4.2.1 and Table 4.2.2 show that female-male net enrolment differentials have narrowed markedly at primary education level and it has disappeared since 2012 at secondary level when the percentage of girls enrolled in secondary school for the first time exceeded the percentage of boys enrolled at this level.

There remain substantial differences between urban and rural areas however, in both primary and secondary education (Table 4.2.3). The WMS indicated that in 2011, almost 85 per cent of urban children were in primary school, compared with only 60 per cent of rural children. Similarly, whereas just over 35 per cent of urban children attended secondary school, the proportion of rural secondary school attendees was extremely low, at under 5 per cent. In the future more attention should be given to reducing this rural-urban difference.

Initially in 1996, there were huge disparities among regions in both primary and secondary school enrolment. In the two pastoral regions, namely Afar and Somali, the net primary enrolment rate was less than 20 per cent in 2000 compared with more than 30 per cent in the rest of the regions. The gross enrolment rate for primary education, which was 31.6 per cent in Afar and 33.4 per cent in Somali in 2000, had increased to 74.4 per cent in Afar and 134.9 per cent in Somali by 2014. The net enrolment rate, which was 17.9 per cent and 19.1 per cent for Afar and Somali respectively in 2000, had reached 100 per cent in Somali and 60 per cent in Afar by 2014 (Table 4.2.5). This indicates that, with the exception of Afar, there is no region that is left behind in providing universal access to primary education.

Table 4.2.1: Trends in net enrolment in primary education

	Boys	Girls	Total
1996	24.0	17.9	21.0
1998	32.5	24.6	28.7
2000	35.8	31.6	33.8
2004	38.9	36.8	37.8
2006	81.7	73.2	77.5
2007	82.6	75.5	79.1
2008	86.1	80.7	83.4
2009	84.6	81.3	83.0
2010	83.7	80.5	82.1
2011	87.0	83.5	85.3
2012	86.8	83.9	85.4
2013	87.5	83.9	85.7
2014	95.1	90.1	92.6

Sources: MoFED, 2008; MoE, Annual Educational Abstracts various years.

Table 4.2.2: Trends in net secondary school enrolment, Grades 9-10

	Male	Female	Total
1996	8.8	8.7	8.8
1998	10.9	9.6	10.2
2000	12.2	10.9	11.6
2004	16.6	12.4	14.5
2010	16.8	16.1	16.4
2011	16.4	16.2	16.3
2012	16.9	17.6	17.3
2013	18.8	20.1	19.4
2014	19.6	20.9	20.2

Source: MoFED, 2008; MoE, Education Statistics Annual Abstracts (various years).

Table 4.2.3: Trends in net primary and secondary education by place of residence and gender

	Primary					Secondary				
	1996	**1998**	**2000**	**2004**	**2011**	**1996**	**1998**	**2000**	**2004**	**2011**
Country										
Male	24	32.5	35.8	38.9	60.7	8.8	10.9	12.2	16.6	11.4
Female	17.9	24.6	31.6	36.8	64.3	8.7	9.6	10.9	12.4	11.1
Total	21.0	28.7	33.8	37.8	62.4	8.8	10.2	11.6	14.5	10.8
Rural										
Male	17.4	27	30.7	34.2	57.3	1.9	3.6	5.0	10.6	5.6
Female	9.9	17.8	25.2	31.2	61.2	0.9	1.5	2.6	5.9	4.2
Total	13.7	22.5	28.0	32.8	59.2	1.4	2.6	3.9	8.3	4.9
Urban										
Male	67.6	76.0	74.1	78.8	85.4	48.6	48.6	52.2	50.1	39.4
Female	70.2	70.2	74.8	75.8	84.1	38.6	44	45.3	40.1	32.9
Total	68.9	72.9	74.5	77.2	84.8	42.9	46.1	48.4	44.5	35.7

Source: MoFED, 2008, from Welfare Monitoring Survey.

Table 4.2.4: Net enrolment rate in primary Grades 1-8 by region and gender, 2014

Region	Boys	Girls	Both
Tigray	98.1	100.9	99.5
Afar	61	59.2	60.1
Amhara	97.1	97.6	97.3
Oromia	88.5	80.9	84.8
Somali	123.6	110.4	117.7
Benishangul-Gumuz	88.3	77.6	83

SNNP	98.5	90.1	94.3
Gambella	123.3	115.9	119.8
Harari	92	83.7	88
Addis Ababa	120.9	151.1	136.2
Dire Dawa	80.4	74.5	77.5
National	95.1	90.1	92.6

Source: MoE, 2015.

Table 4.2.5: Gross and net primary enrolment rate by region, 2000 and 2014

	Gross primary enrolment			Net primary enrolment		
	2000	2014	Percentage change (2000-2014)	2000	2014	Percentage change (2000-2014)
Tigray	59.6	106.2	78.2	33.6	99.5	196.1
Afar	31.6	74.4	135.4	17.9	60.1	235.8
Amhara	51.9	106.7	105.6	34.3	97.3	183.7
Oromia	59.0	91.2	54.6	32.4	84.8	161.7
Somali	33.4	134.9	303.9	19.1	117.7	516.2
Benishangul-Gumuz	84.0	99.9	18.9	44.7	83.0	85.7
SNNP	60.4	102	68.9	30.0	94.3	214.3
Gambella	124.9	150.5	20.5	69.6	119.8	72.1
Harari	101.5	98.1	-3.3	66.6	88.0	32.1
Addis Ababa	109.6	167.2	52.6	77.9	136.2	74.8
Dire Dawa	75.8	91.4	20.6	51.8	77.5	49.6
National	58.9	101.3	72.0	33.8	92.6	174.0

Source: MoE Annual Educational Abstracts, 2000 and 2015.

Many factors have contributed to the success in achieving universal primary education. Following the political decentralization of 1994, the Government adopted a decentralized fiscal system which was further enhanced by *woreda* level decentralisation in 2002. Public expenditure on education subsequently increased and this contributed to significant increases in the number of schools, better teacher development programmes, revisions to the curriculum, efficient planning and resource use by schools, and the implementation of targeted interventions to increase girls' access to primary education.

Despite the success in providing universal access to primary education, the completion rate for both the 1st and 2nd cycle primary education is not encouraging (Table 4.2.6). From 57 per cent for Grade 5 and 34 per cent for Grade 8 in 2005, the completion rates had risen to 70 per cent for Grade 5 and 53 per cent for Grade 8 by 2014. Despite a very low completion rate, the gap between male and female primary completion rates had been nearly eliminated at Grade 5 and completely eliminated at Grade 8 by 2014.

Table 4.2.6: Completion rates for 1st and 2nd cycles of primary education, (% unless otherwise stated)

	Grade 5 (1st cycle primary)			Grade 8 (2nd cycle primary)			Gender gap in completion rate (percentage points)	
Year	Male	Female	Total	Male	Female	Total	Grade 5	Grade 8
2004/05	65.2	49.5	57.4	42.1	26.3	34.3	15.7	15.8
2005/06	69.2	56.0	62.7	50.1	32.9	41.7	13.2	17.2
2006/07	71.6	61.6	66.6	51.3	36.9	44.2	10.0	14.4
2007/08	71.7	67.0	69.4	49.4	39.9	44.7	4.7	9.5
2008/09	79.4	78.4	78.9	48.4	40.5	43.6	1.0	7.9
2009/10	77.5	73.7	75.6	51	44.5	47.8	3.8	6.5
2010/11	72	66.1	69.1	52.5	46.2	49.4	5.9	6.3
2011/12	74.1	73.4	73.8	52.4	51.9	52.1	0.7	0.5
2012/13	77.1	75.1	76.1	53.3	52.2	52.8	2.0	1.1
2013/14	70.7	68.2	69.5	46.7	46.7	46.7	2.5	0.0

Source: MoE Annual Statistical Abstracts, various years.

The main reasons for the low completion rates are children dropping out from school and the repetition of grades. Repetition rate measures the proportion of students who have remained in the same grade for two or more consecutive years after having either left the grade prematurely or returning for a second or third time. Either form repetition reduces the efficiency of education, and is an indication of unqualified teachers and a lack of learning materials, among other things. The evidence (Table 4.2.7) shows that in recent years the repetition rate of boys has been higher than that of girls except in the 2010 and 2011. It can also be observed that the total repetition rate was lower in 2010, at 4.9 per cent than in subsequent years when it has hovered around 8 per cent.

As seen in Table 4.2.8, the dropout rate is very high in Ethiopia (MoE, 2013a; MoE, 2015). It was 14.4 per cent in 2004 and was increasing until 2013 reaching 16 per cent, and then declined by 2 percentage points in 2014 to 14 per cent. The reason for children dropping out were (1) child have to take on a heavy work burden to support their families; (2) the illness of parents and family members; (3) having to travel long distances to school; (4) low levels of parental education; and (5) shortages of money to cover school expenses (Woldehanna, 2011; Woldehanna and Adiam Hagos, 2015; CSA, 2012c; NPA, 2015). Demand for children's labour particularly affects the dropout rate when children reach the 2nd cycle of primary education.

Table 4.2.7: Trends in repetition rates in primary education, Grades 1-8 (%)

Year	Boys	Girls	Total
2010 (2009/10)	4.7	5.2	4.9
2011 (2010/11)	7.2	10.0	8.5
2012 (2011/12)	8.7	8.2	8.5
2013 (2012/13)	8.1	7.7	7.9
2014 (2013/14)	8.6	8.1	8.4

Source: MoE, 2012b, 2013a and 2015.

Table 4.2.8: Trends in dropout rates in primary education, Grades 1-8 (%)

Year	Boys	Girls	Total
2004 (2003/04	14.9	13.6	14.4
2005 (2004/05	12.3	11.3	11.8
2006 (2005/06)	12.6	12.1	12.4
2007 (2006/07)	13.1	11.6	12.4
2008 (2007/08)	15.9	13.2	14.6
2009 (2008/09)	18.2	19.0	18.6
2010 (2009/10)	13.3	13.5	13.1

2011 (2010/11)	17.4	15.1	16.3
2012 (2011/12)	16.3	16.1	16.2
2013 (2012/13)	14.0	13.8	13.9

Source: MoE, 2010b, 2012b, 2013a, 2015.

The net enrolment rate (NER) for secondary schools increased by 129.5 per cent between 1995/96 and 2013/14. However, the NER started at very low level (8.8 per cent in 1996) and is still extremely low (20.2 per cent). Hence achieving universal secondary education is remains a challenge (Table 4.2.9 and Table 4.2.10). There does not seem to be significant difference between NER for boys and girls at secondary school level. In fact, between 1995/96 and 2013/14, the NER for girls increased more than that for boys.

Table 4.2.9: Trends in net secondary school enrolment, Grades 9-10 (%)

	Male	Female	Total
1996	8.8	8.7	8.8
1998	10.9	9.6	10.2
2000	12.2	10.9	11.6
2004	16.6	12.4	14.5
2010	16.8	16.1	16.4
2011	16.4	16.2	16.3
2012	16.9	17.6	17.3
2013	18.8	20.1	19.4
2014	19.6	20.9	20.2
Overall change	**122.7**	**140.2**	**129.5**

Sources: MoFED, 2002; MoFED, 2008; MoE, 2012b, 2013a, 2015.

Table 4.2.10: Net secondary school enrolment rates by region, 2014 (%)

	Grades 9-10			Grades 11-12		
	Boys	**Girls**	**Both**	**Boys**	**Girls**	**Both**
Tigray	46.6	54.0	50.3	10.0	10.9	10.4
Afar	2.6	1.1	1.9	1.4	1.1	1.3
Amhara	17.5	22.2	19.8	5.5	5.6	5.5
Oromia	15.6	16.2	15.9	3.2	3.2	3.2
Somali	4.8	3.6	4.3	3.7	2.5	3.2
Benishangul-Gumuz	16.1	18.7	17.4	6.3	5.4	5.8
SNNP	23.1	20.7	21.9	5.8	4.7	5.3
Gambella	23.6	18.1	21.0	8.3	3.5	6.0
Harari	30.7	27.2	29.0	10.9	10.2	10.6
Addis Ababa	71.7	55.5	63.0	30.4	35.9	33.5
Dire Dawa	19.4	18.6	19.0	8.7	7.5	8.1
National	19.6	20.9	20.2	5.5	5.5	5.5

Source: MoE, 2015.

Literacy

In 1995/96, only 25 per cent of the population were literate; by 2010/11 the literacy rate had increased to 46.7 per cent (Table 4.2.11 and Figure 4.2.1). Literacy increased over time in both rural and urban areas, and for both males and females. The increase in literacy is partly the result of an increase in gross enrolment in primary education. There remain considerable disparities in literacy rates between men and women, though the gap in rural areas had closed slightly by 2010/11. Just under half the population are literate (56 per cent of males and 47 per cent of females). The gap between rural and urban residents is more striking: 88 per cent of urban residents over ten years are literate, compared with only 40 per cent of rural residents. The proportion of rural women who can read is only 30 per cent, which however represents a considerable increase since 2004, and an even greater improvement since 1996, the year of the first WMS, when less than 10 per cent of rural women could read. However, the gap is still considerable: the current rate of literacy for rural women is around the same as it was for rural men 15 years ago, and it is less than half the rate of urban areas.

Table 4.2.12 shows the trend in literacy by region. In 1999/2000, there were large discrepancies in literacy rate between regions. Literacy rates ranged from 18.6 per cent and 24.3 per cent in Afar and Somali respectively, to 79.3 per cent and 55.1 per cent in Addis Ababa and Dire Dawa. Literacy rates increased in all regions between 1999/2000 and 2010/11 in all regions, but by 2010/11, the literacy rate was still the highest in Addis Ababa (86.7 per cent) followed by Dire Dawa (63.8 per cent) and Harari (59.8 per cent). The lowest literacy rate in 2010/11 were observed in Somali Region (30.5 per cent). The rates in other regions ranged from 47.3 per cent in Benishangul-Gumuz to 59.0 per cent in Gambella. Regions which were those with lower literacy rates in 2000 have recorded faster growth than those regions which had higher literacy rates in 2000, resulting in declining differences in literacy among regions.

Table 4.2.11: Literacy rates, by location and gender, 1995/96-2010/11, (%)

	1995/96	1997/98	1999/2000	2003/04	2010/11
National					
Male	34.8	36.4	39.7	49.9	56.2
Female	16.9	17.2	19.4	26.6	37.6
Total	25.8	26.6	29.2	37.9	46.7
Rural					
Male	27.9	28.8	32.8	43.4	49.7
Female	8.4	8.8	11.0	18.7	30.0
Total	18.3	18.8	21.7	30.9	39.7
Urban					
Male	77.5	81	81.8	86.2	87.6
Female	56.7	59	60.6	64.4	69.6
Total	65.7	69	69.9	74.2	77.9

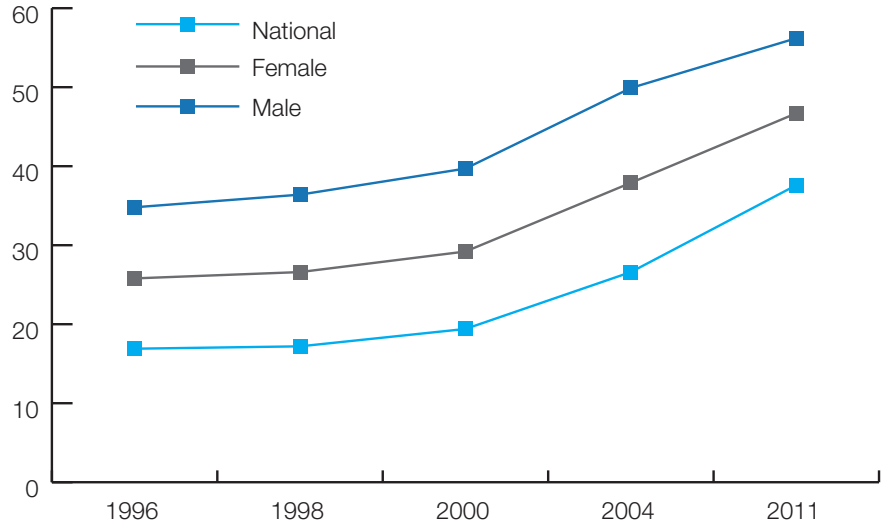
Source: MoFED, 2008; MoFED, 2013a.

Table 4.2.12: Literacy rates, by region and rural/urban, all persons 10 and older, 1999/2000-2010/11 (%)

Region	1999/2000	2003/04	2010/11	Percentage change 1999/2000-2010/11
Tigray	29.6	42.5	53.5	80.7
Afar	18.6	37.0	34.2	83.9
Amhara	23.3	30.1	41.4	77.7
Oromia	27.1	36.7	45.4	67.5
Somali	24.3	25.5	30.5	25.5
Benishangul-Gumuz	31.8	37.0	47.3	48.7
SNNP	29.8	36.7	46.8	57.0
Gambella	46.3	..	59.0	27.4
Harari	55.0	60.6	59.8	8.7
Addis Ababa	79.3	82.3	86.7	9.3
Dire Dawa	55.1	60.4	63.8	15.8
Total	29.4	37.6	46.8	59.2

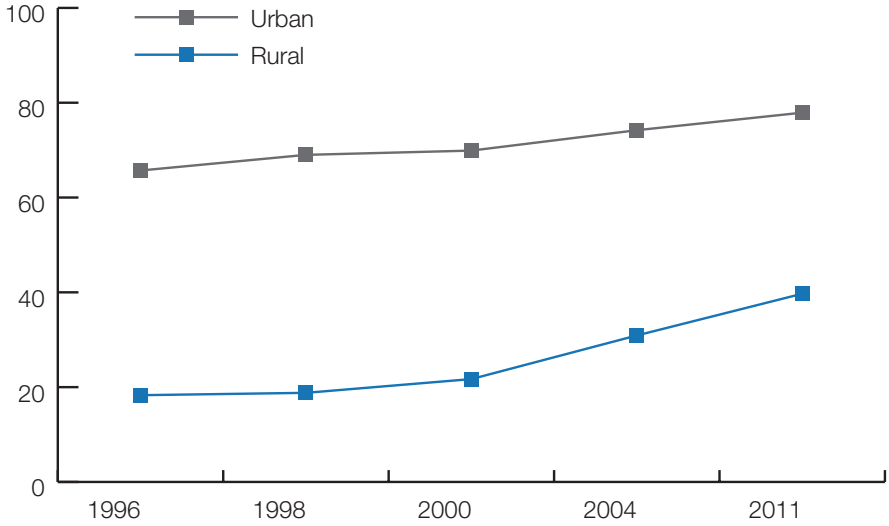
Source: CSA, 2012b.

Figure 4.2.1: Trends in literacy in Ethiopia by gender, 1996-2011 (%)



Source: CSA, 2012b.

Figure 4.2.2: Trends in literacy by rura/urban, 1996-2011 (%)



Source: CSA, 2012b

4.3. Goal 3: Promote Gender Equality and Empower Women

The target for MDG 3 is to "eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015". The main indicators for monitoring the progress are:

- the ratio of girls to boys in primary, secondary and tertiary education;
- the ratio of literate women to men, aged 15-24 years old;
- the hare of women in wage employment in the non-agricultural sector; and,
- the proportion of seats held by women in the national parliament.

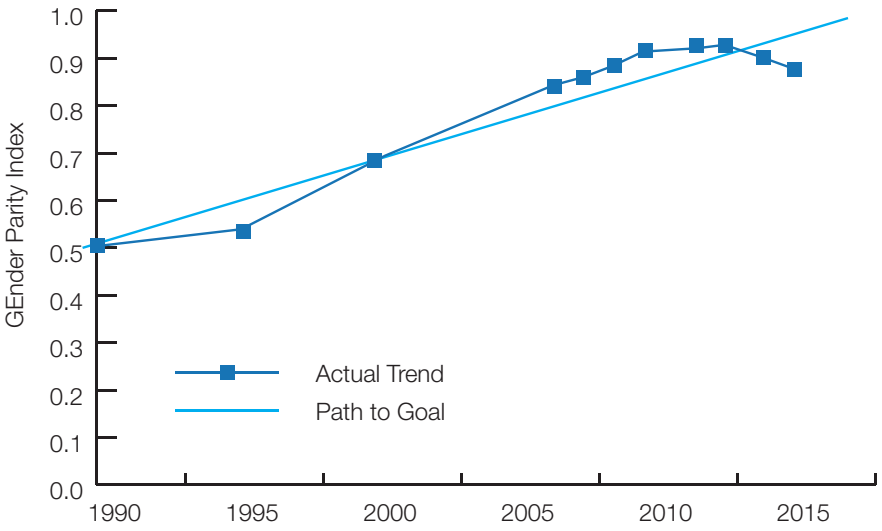
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

The indicators used for monitoring progress towards Goal 3 are the ratio of girls to boys at all levels of education (the Gender Parity Index (GPI) in education) and the proportion of seats in parliament held by women. The GPI is used to measure the level of equity in education between boys and girls. In a situation of equality between boys and girls, the gender parity index (GPI) is 1 whereas as inequality increases it approaches 0.

At all levels of education, Ethiopia started with high levels of inequality between the enrolment of boys and girls. Many of these inequalities had been narrowing even before Ethiopia adopted the MDGs. Table 4.3.2 shows that the ratio of girls to boys in primary and secondary schools in 1995/96 was 36 per cent and 41 per cent respectively. The Gender Parity Index (GPI) in 1999/2000 was 0.7 for both primary and secondary education (MoE, 2000). By 2013/14, the GPI for primary education (Grades 1-8) had reached 0.93, while the GPIs for first and second cycle

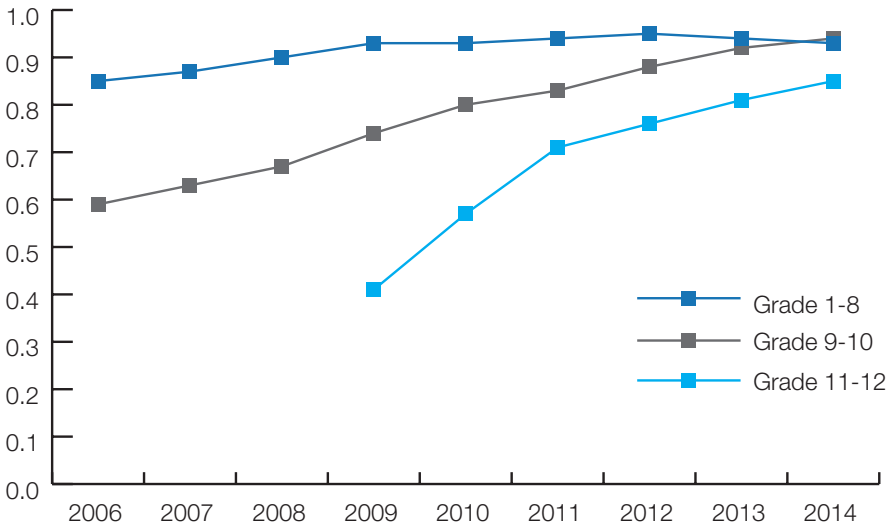
secondary education had reached 0.94 and 0.85 respectively (Figures 4.3.1 and 4.3.2). These data indicate that Ethiopia, despite starting from a low GPI, has progressed well in its quest to achieve gender equality in primary and secondary education. However, it seems that the GPI may have stagnated at around 0.93 and 0.94. In fact, as Figure 4.3.2 shows, GPI declined marginally between 2012/13 and 2013/14, implying that the country had to work harder to eliminate gender inequality completely by the end of 2015.

Figure 4.3.1: Actual and desired trends in ratio of girls to boys in primary education, Grades 1-8, 1990-2015



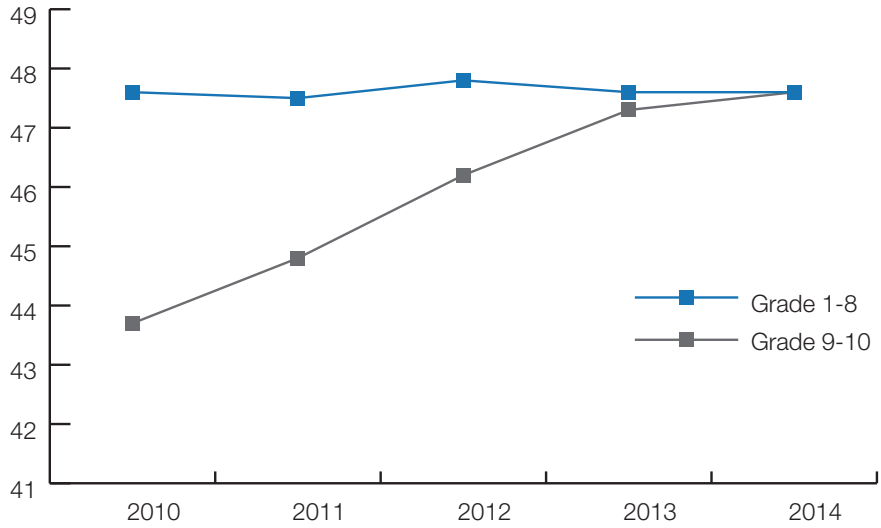
Source: MoE Annual Statistical Abstracts, various years.

Figure 4.3.2: Trends in gender parity index in primary and secondary education



Source: MoE Annual Statistical Abstracts, various years.

Figure 4.3.3: Trends in ratio of girls to boys in primary and secondary schools (%)



Source: MoE Annual Statistical Abstracts, various years.

When the disparity among regions in terms of GPI is analyzed, in 2005/06, Tigray, Somali, SNNP, Benishangul-Gumuz, Oromia and Gambella had less than the national average GPI in primary education, which was 0.7 (Table 4.3.1). In 2013/14, whereas Tigray and Gambella had GPIs above the national average, the GPIs of two other regions, which were above average in 1995/96, Harari and Dire Dawa, were below average by 2013/14, though all regions showed a marked improvement in their GPIs over this period. (Tables 4.3.1 and 4.3.2).

Table 4.3.1: Gender Parity Index by region, 1995/96 and 2013/14

	1995/96		2013/14		
	Primary (1-8)	Secondary (9-12)	Primary (1-8)	Secondary (9-10)	Secondary (11-12)
Tigray	0.9	0.5	0.99	1.08	1.06
Afar	0.8	0.8	0.95	0.69	0.88
Amhara	0.9	0.9	0.99	1.09	0.87
Oromia	0.5	0.6	0.90	0.85	0.73
Somali	0.5	0.6	0.89	0.71	0.57
Benishangul-Gumuz	0.5	0.5	0.84	0.86	0.73
SNNP	0.5	0.5	0.90	0.76	0.77
Gambella	0.6	0.2	0.94	0.75	0.29
Harari	0.7	0.7	0.90	0.83	0.86
Addis Ababa	1	0.8	1.28	0.85	1.04
DireDawa	0.8	0.7	0.91	0.75	0.79
National	0.7	0.7	0.93	0.92	0.85

Source: MoE Annual Statistical Abstracts, various years.

Table 4.3.2: Gender Parity Index, 2013/14

Region	Grades 1-4	Grades 5-8	Grades 1-8	Grades 9-10	Grades 11-12
Tigray	0.95	1.06	0.99	1.08	1.06
Afar	0.92	1.00	0.95	0.69	0.88
Amhara	0.93	1.12	0.99	1.09	0.87
Oromia	0.90	0.90	0.90	0.85	0.73
Somali	0.89	0.82	0.89	0.71	0.57
Benishangul-Gumuz	0.87	0.78	0.84	0.86	0.73
SNNP	0.91	0.90	0.90	0.76	0.77
Gambella	0.96	0.92	0.94	0.75	0.29
Harari	0.92	0.86	0.90	0.83	0.86
Addis Ababa	1.34	1.22	1.28	0.85	1.04
Dire Dawa	0.95	0.85	0.91	0.75	0.79
National	0.91	0.98	0.93	0.92	0.85

Source: MoE Annual Statistical Abstracts, various years.

The main challenge to advancing women's empowerment and addressing the stagnation of the GPI emanates from the gap in the enrolment of girls and boys, especially in secondary education. This phenomenon has a number of explanations, including socioeconomic challenges such as early marriage, violence against girls, such as abduction, girls' domestic responsibilities, such as fetching water and fuelwood, parents' lack of awareness about the benefits of education, and the lack of gender sensitive facilities in schools.

One of the major achievements recorded in the economic sphere is the improvement in the economic empowerment of women. This has been made possible through improvements in access to and control over productive resources, such as land through the certification of land and property ownership. In this regard, the Government has adopted a mix of policies and legal reforms to ensure women's equal access to these productive resources. The FDRE Rural Land Administration and Use Proclamation (2005) provided women with the same rights as men in the use of rural land through the issuance of landholding certificates. Regional states have also issued land use and administration laws in conformity with the federal law. While in urban areas the incidence of poverty in female-headed households is higher than that for male-headed households, the poverty head count index for female headed households is the same as that for male headed households in rural areas because of women's access to land in these areas (MoFED, 2008).

Women's participation in the political sphere has also shown improvement during the period under analysis. Ethiopia's Constitution grants women equal rights with men. The country issued the National Policy on Women in 1993, which guaranteed women's equality and human rights in various spheres of life. The Family Law (revised, 2000) and the Penal Code (revised, 2005) have been made more congruent with international and regional instruments, in order to give effect to the rights enshrined in the Constitution. Ethiopia has ratified the Convention on the Political Rights of Women (CPRW) and the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW). Ethiopia also adopted the principles of the 1995 Beijing Platform for Action (BPA) long before it adopted the Millennium Development Goals of 2000.

Since issuing the National Policy on Women, Ethiopia has also put in place institutions aimed specifically at ensuring that the rights of women are respected, protected and fulfilled. Examples are Proclamations 471/2005 and 691/2010 that established Ministry of Women's Affairs (MoWA) and Ministry of Women, Children and Youth (MoWCYA), respectively. These institutions are, among other things, responsible for ensuring gender is mainstreamed in the national and sectoral development plans. Similar structures (gender machineries) were established at federal, regional, zonal and *woreda* levels.

Another indicator of progress in the achievement of MDG 3 is the proportion of seats in parliament held by women. Out of the 547 seats in the House of People's Representatives (the lower house of the national parliament), the share of seats held by women increased from 2.8 per cent in 1996 to 7.7 per cent in 2000, 21.4 per cent in 2005 and 27.9 per cent in 2010, and reached 38.7 per cent in the 2015 election. The proportion of seats held by women in national and sub-national parliaments has shown significant improvements over the years. However, it is yet to reach the MDG target of 50:50 adopted by Ethiopia.

Apart from the growing participation of women in the legislative branch, there has also been an increase in women's representation in the executive branch. By 2013, the proportion of women in the executive and the judiciary had reached 34.6 per cent and 20.6 per cent respectively (MoCS, 2014). Despite the upward trend of women's representation in the legislature the judiciary and the executive, the number of positions that women occupy is still very low. The participation of women in the civil service is believed to be 35 per cent.

Overall and youth unemployment remained higher among females than among males in 2010-2014 . The reasons for the very low participation in lower level decision making are lack of sufficiently educated women, the burden of child marriages, the acute time poverty compared with men's duties and roles, a lack of effective political connections, and both physical and social constraints on political party engagement. Women also face constraints in gaining access to their wages and their household's income (FDRE, 2014).

While the participation of women in the political and economic sphere has substantially improved, the remaining challenge is to translate this critical mass of women representatives into meaningful participation. To empower Ethiopian women, it is important that concrete steps be taken to provide relevant awareness raising interventions and undertake confidence building measures so as to better prepare women psychologically and materially. As women play both productive and reproductive roles, they are burdened with heavy responsibilities. Therefore, unless such burdens are minimized participation of women in political and economic sphere will remain limited. It is important to remove the discrimination against women at home, work and other places, avoid stereotypical attitudes towards women's leadership, and build women's self-esteem, avoid gender based discrimination, address poverty, and fight harmful traditional practices like early marriages and female genital mutilation so as to ensure the potential of women is fully realized.

4.4. Goal 4: Reduce Child Mortality

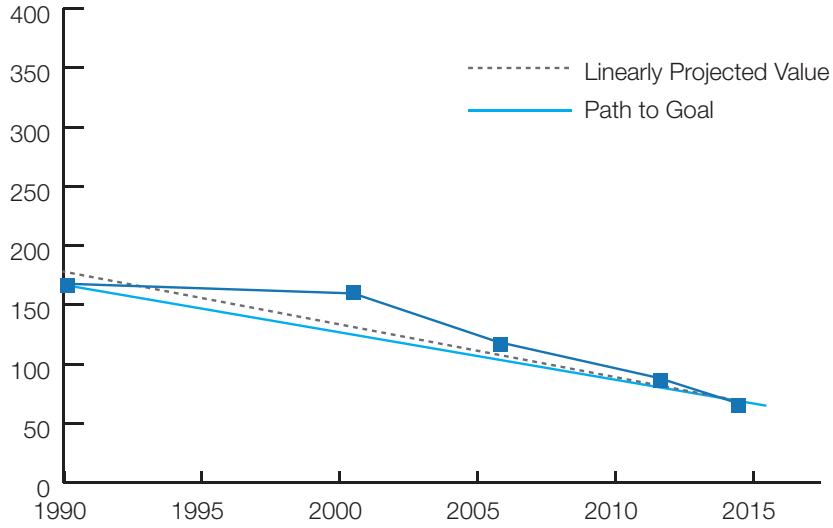
The target for goal 4 is to "reduce by two-thirds, between 1990 and 2015, the under-five mortality rate". This goal is monitored by the following indicators:

- the under-five mortality rate (per 1,000 live births)

- the infant mortality rate (per 1,000 live births)
- neonatal deaths (per 1,000 live births)
- health service coverage (per cent)
- immunization coverage (measles) (per cent)
- immunization coverage (DPT3) (per cent)

Significant progress was made in reducing under-five and infant mortality per 1,000 live births over the 15-year period, 1990-2014. Under-five mortality per 1,000 live births was estimated to be 167 in 1990. This has been reduced to 166 in 2000, 123 in 2005, and 88 in 2011 (CSA and ICF, 2012). According to the UN Inter-agency Group for Child Mortality Estimation, under-five mortality declined to 60 per 1,000 live-births in 2015 (UNICEF and others, 2015), which is below the MDG target of 63 indicating that Ethiopia has achieved its target of reducing child mortality by two-thirds ahead of time (Figure 4.4.1).

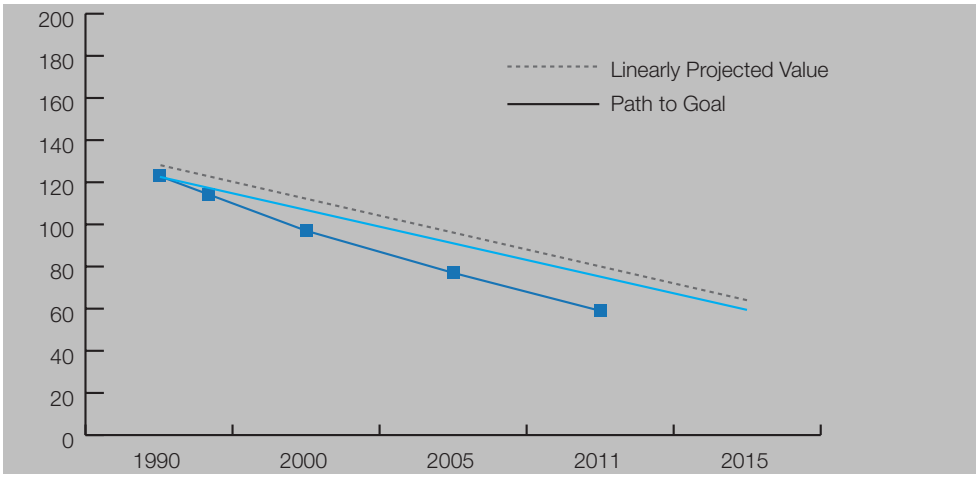
Figure 4.4.1: Actual and desired trends in under-five mortality rate, 1990-2015 (Deaths per 1,000 live births)



Source: Based on CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CME Info, 2015.

Similarly, the infant mortality rate declined from 123 (per 1000 live births) in 1990 to 97 in 2000, 77 in 2005 and 59 in 2011, but it is unlikely that the MDG target of 31 per 1,000 live births in 2015 will be attained (Table 4.4.1 and Figure 4.4.2). Neonatal deaths (per 1,000 live births) showed a decline over time from 54 in 1990 and 49 in 2000, to 37 in 2011.

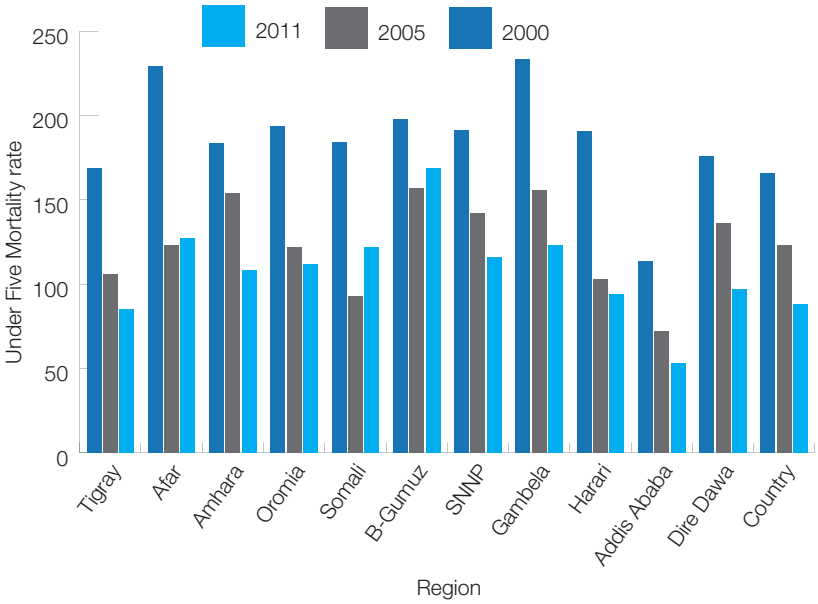
Figure 4.4.2: Actual and desired trends in infant mortality rate, 1990-2015 (Deaths per 1,000 live births)



Source: Based on CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012.

The observed progress in reducing under-five and infant mortality rates is however not uniform across place of residence (urban/rural) and geographical locations (regions). Reductions have occurred in all regions[3] as well as in urban and rural areas. However, under-five and infant mortality rates are higher in rural than in urban areas. While rates have declined in all regions, the progress recorded is not uniform. Some regions were able to reduce rates consistently, while in others there have been reversals of trend, especially between 2005 and 2011. The results are shown in the following figures.

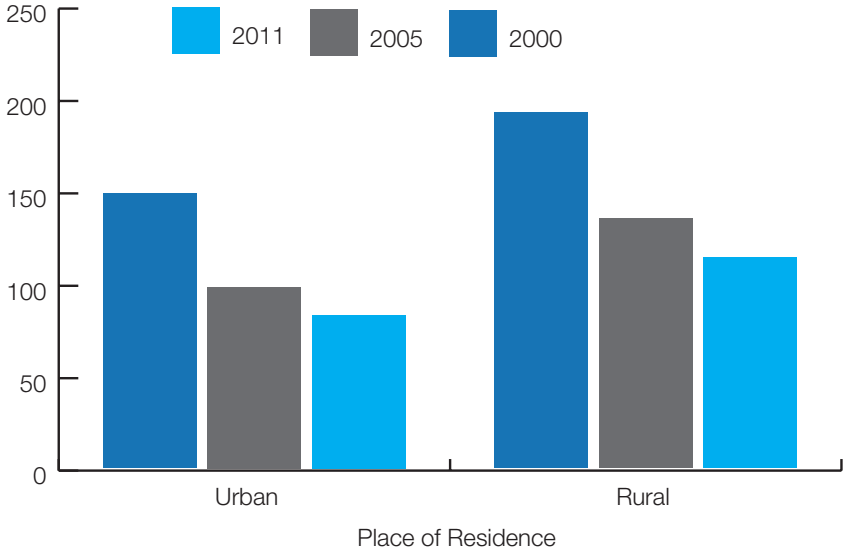
Figure 4.4.3: Under-five mortality rate by region, 2000-2011 (Deaths per 1,000 live births)



Sources: Based on CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012.

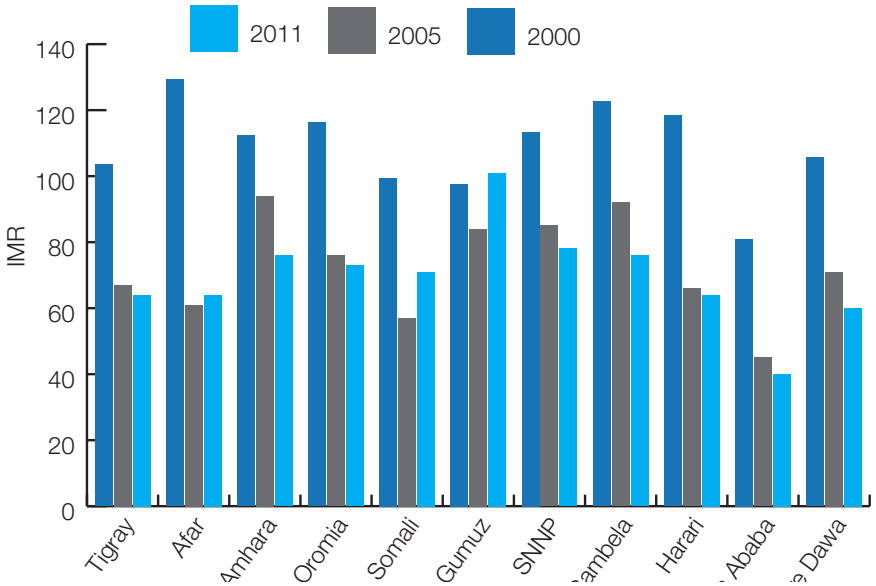
3 Regional rates are for the 10-year period preceding the survey, while national rates are for the five-year period preceding the survey. Therefore comparison between the regional and the national rates is difficult.

Figure 4.4.4: Under-five mortality rate by place of residence (urban/rural), 2000-2011 (Deaths per 1,000 live births)



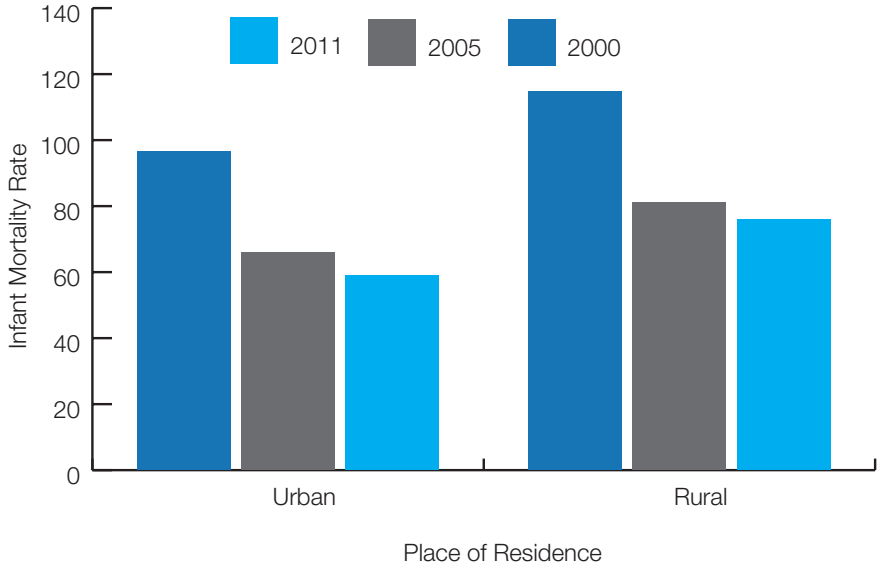
Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012.

Figure 4.4.5: Infant mortality rate (IMR) by region, 2000-2011 (Deaths per 1,000 live births)



Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012

Figure 4.4.6: Infant mortality rate by place of residence, 2000-2011



Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012.

Table 4.4.1: Rate of change in under-five and infant mortality rates, 2000-2011

Region	Percentage change in under-five mortality rate	Percentage change in infant mortality rate
Tigray	-49.7	-38.2
Afar	-44.6	-50.5
Amhara	-41.1	-32.4
Oromia	-42.2	-37.2
Somali	-33.8	-28.6
Benishangul-Gumuz	-14.5	3.5
SNNP	-39.4	-31.2
Gambella	-47.3	-38.0
Harari	-50.8	-45.9
Addis Ababa	-53.3	-50.6
Dire Dawa	-44.8	-43.2
Place of residence		
Urban	-44.1	-38.9
Rural	-40.8	-33.7

Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012.

As indicated in figure 4.4.4 progress in reduction of under-five mortality rate was slightly higher in urban areas than in rural areas, leaving the disparity between urban and rural areas more or less the same over the period of analysis.

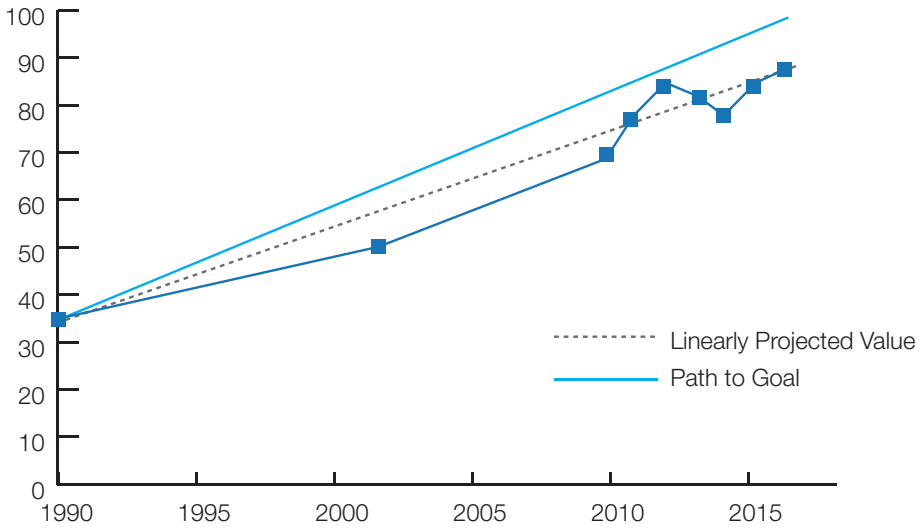
Similarly, analysis of change in under-five and infant mortality rates by region shows that all regions have recorded declines in both rates (except Benishangul-Gumuz where the infant mortality rate in 2011 was more or less the same as in 2000. The greatest progress was recorded in regions that are more or less urban in nature (Addis Ababa, Harari and Dire Dawa), which started from a relatively better position than the other regions. Overall, regional disparities in the level of mortality rates (in terms of range) have not changed much.

Health service coverage has also significantly improved. One of the reasons behind the observed success in reducing under-five mortality has been the expansion of the coverage of health service. According to the 2013/14 Annual Performance Report of the Ministry of Health (MoH, 2014) the health infrastructure and health extension programmes have expanded significantly. The number of health posts increased from 14,192 in 2009/10 to 16,048 in 2012/13. As a result, the ratio of health posts to population reached 1:5,352 in 2012/13, indicating that the standard of 1:5000 was almost achieved. The number of health centres increased from 2,142 in 2009/10 to 3,100 in 2012/13, indicating the ratio of health centres to population declined from 1:37,299 in 2009/10 to 1:27,706 in 2012/13, which is very close to the standard of 1:25,000 set by the Ministry of Health. Similarly, the number of hospitals increased from 116 in 2009/10 to 127 in 2012/13. As a result, primary health service coverage reached 93.4 per cent of the population in 2012/13 and 94.0 per cent in 2013/14, indicating the significant progress made in ensuring universal access to primary health care (MoH, 2014), but it is unlikely to reach 100 per cent in what remains of the MDG time period, i.e. by the end of 2015.

Another important element in the reduction of child mortality is immunization. Immunization for measles and DPT3 are important contributors to reducing child mortality. In 2013/14, pentavalent 3 immunization coverage was 91.1 per cent, pneumococcal conjugate vaccine (PCV) immunization coverage was 85.7 per cent, measles immunization coverage was 86.5 per cent, and the percentage of fully immunized children was 82.9 per cent. Table 4.4.3 shows that the 100 per cent DPT3/Penta3 coverage was recorded in SNNP and Addis Ababa, while the lowest rate of coverage (50 per cent) was recorded in Gambella region. Except for SNNP and Addis Ababa, the performance of all regions was low compared with the national average. Pneumococcal Conjugate Vaccine 3 Immunization (PCV3) coverage was 85.7 per cent at the national level in 2013/14. The highest coverage (99.8 per cent) was found in SNNP and the lowest in Gambella (27.7 per cent). Seven regions recorded improvements in their performance (Amhara, Somali, Benishangul-Gumuz, SNNP, Harari, Addis Ababa, and Dire Dawa) compared with 2012, with only SNNP achieving its annual regional target in 2013/14. Measles immunization coverage was 86.5 per cent in 2013/14, with some variation across regions. SNNP was the best performing region (97.3 per cent) and Gambella had the lowest coverage (45.0 per cent) (Table 4.4.3)

Measles and immunisation DPT3 coverage were 36.5 per cent and 41.9 per cent respectively in 2001, and had reached 86.5 per cent and 91.1 per cent respectively in 2014 which put them on track to meet the MDG targets of 90 per cent and 96 per cent respectively in 2015 (Figure 4.4.7 and Table 4.4.2.

Figure 4.4.7: Actual and desired trend in percentage of 1 year-old children immunized against measles, 1990-2015



Source: MoH, Annual Performance Reports.

The Ministry of Health Annual Performance Report on HSDP IV for 2013/14 (MoH, 2014) noted that the immunisation services faced some challenges including (1) the lack of daily vaccination services at health posts, 2) weak links between health posts and health clinics, (3) a high number of unvaccinated children and a high dropout rate, (4) a lack of automatic generators in areas with frequent power interruptions, and (5) inadequate access to health services.

Table 4.4.2: Trends in indicators of child health

	1990	2000	2005	2011	2013	2014	Target
Health service coverage (%)	..			96.0	93.4	94	100
Under-five mortality rate (per 1,000 live births)	190	167	123	88		60	63
Infant mortality rate (per 1,000 live births)	123	97	77	59			31
Neonatal deaths (per 1,000 live births)	54	49	39	37			..
Immunization coverage (measles) (%)	..	36.5	52.0	81.5		86.5	90
Immunization coverage (DPT3) (%)	14	41.9	61.0	84.7		91.1	96

Source: MoH, Annual Performance Reports; CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012.

Table 4.4.3: Regional distribution of DPT3/Penta3, measles and full immunization coverage, 2013/14

Region	No. of Surviving infants	DPT3/Penta3 coverage (%)	Measles coverage (%)	Full Immunization coverage (%)
Tigray	159,704	84.6	80.5	79.5
Afar	45,103	99.0	90.9	77.9
Amhara	623,368	80.4	78.6	75.9
Oromia	1,055,589	94.5	87.9	82.4
Somali	155,794	60.5	57.8	53.6
Benishangul-Gumuz	29,920	94.8	84.6	77.4
SNNP	568,990	100.2	97.3	96.2
Gambella	10,977	50.0	45.0	40.2
Harari	6,536	90.8	77.3	70.6
Addis Ababa	71,510	100.5	96.7	95.8
Dire Dawa	12,924	68.1	64.4	61.2
National	2,784,353	91.1	86.5	82.9

Source: MoH, 2014.

4.5. Goal 5: Improve Maternal Health

The targets for Goal 5 are (a) "reduce by three quarters, between 1990 and 2015, the maternal mortality ratio" and (b) "achieve universal access to reproductive health by 2015". The agreed indicators to monitor this goal for Ethiopia are the following:

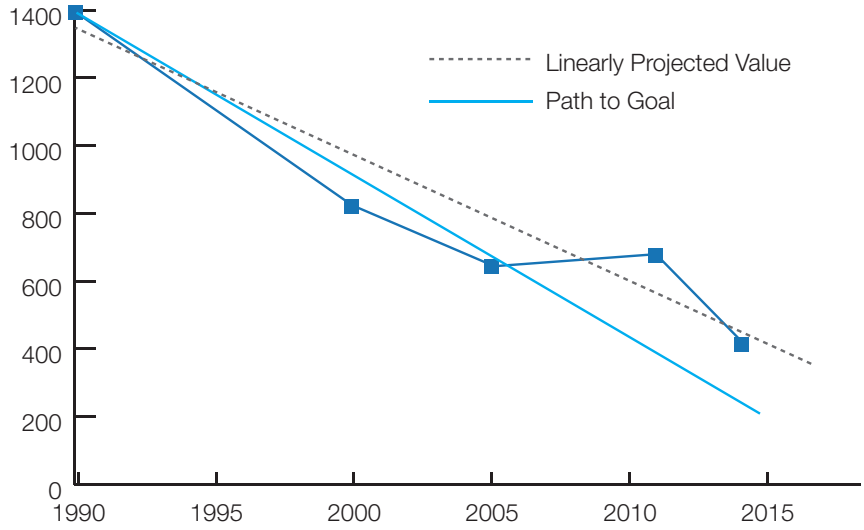
- maternal mortality ratio (per 100,000 live births);
- percentage of currently married women who use any modern contraceptive method (per cent);
- proportion of births attended by skilled personnel (per cent);
- antenatal coverage (number and timing of (4+) ANC visits (per cent); and
- women aged 15-49 who are attended at least once by a skilled health attendant during pregnancy.

Two target indicators, namely adolescent birth rate and unmet need for family planning, were proposed in the UN Declaration to be used as indicators for Goal 5, but have not appeared in the Ethiopian indicator list.

Maternal Mortality

MDG 5 calls for reduction in maternal mortality by 75 per cent from its level in 1990. Of all the MDGs, progress was slowest in reducing maternal mortality. Maternal mortality per 100,000 live births was 1,400 in 1990 and had declined to 990 in 2000. According to the Ethiopian Mini DHS survey report (CSA, 2014b), the figure declined to 420 in 2013, but looking at what had been achieved up to 2011 and the gap that needs to be filled to reach the target, it seems that it is highly unlikely that the target of 267 will have been reached by 2015 unless a huge amount of external funding is provided (Women Deliver, 2010).

Figure 4.5.1: Actual and desired national trend in maternal mortality rate, 1990-2015 (per 100,000 live births)



Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; WHO, 2014b.

Proportion of currently married women who use any modern contraceptive method

Improved access to family planning services has an impact on reducing maternal mortality, and it is one of the four pillars of safe motherhood, as endorsed in the national Safe Motherhood Initiative (WHO, 2014c). The contraceptive prevalence rate (CPR) has shown significant improvement. The proportion of married women who used any contraceptive method increased from 8.1 per cent in 2000 to 41.8 per cent in 2014, an increase of over 400 per cent. There is, however, significant variation in the CPR among regions. The highest coverage in 2014 was registered in Addis Ababa (64.1 per cent), Dire Dawa (50.8 per cent) and Harari (46.3 per cent). Lowest coverage was observed in Somali where the CPR declined from 2.6 per cent in 2000 to 1.7 per cent in 2014 (a decline of 34.6 per cent). The rate of change between the two periods was highest in Oromia, SNNP and Amhara where the CPR increased by 560.6 per cent, 521.9 per cent, and 512 per cent respectively (Table 4.5.1).

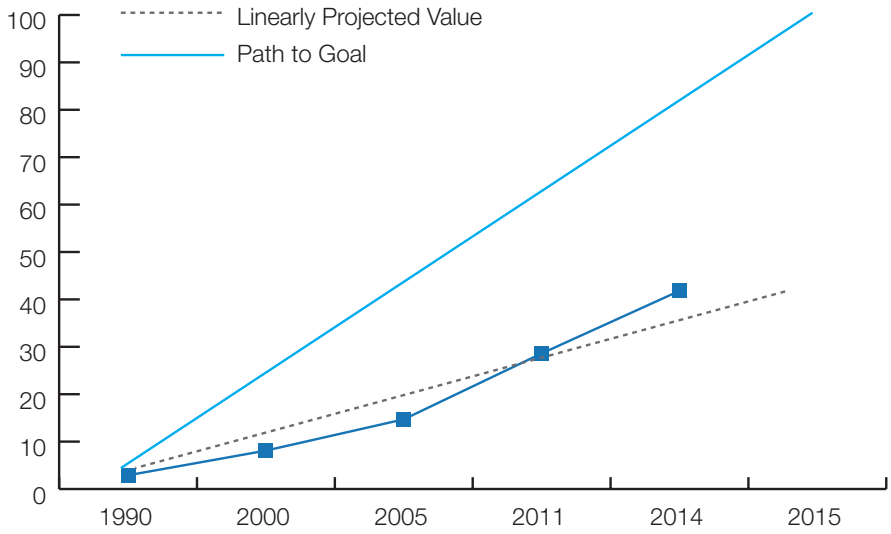
Table 4.5.1: Current use of contraceptives among currently married women age 15-49, by region, 2000-2015 (%)

Region	2000	2005	2011	2014	Percentage change
National level	8.1	14.7	28.6	41.8	416.0
Tigray	10.2	16.5	22.2	32.1	214.7
Afar	7.7	6.6	9.5	15.7	103.9
Amhara	7.5	16.1	33.9	45.9	512.0
Oromia	6.6	13.6	26.2	43.6	560.6
Somali	2.6	3.1	4.3	1.7	-34.6
Benishangul-Gumuz	8.7	11.1	27	35.2	304.6

Region	2000	2005	2011	2014	Percentage change
SNNP	6.4	11.9	25.8	39.8	521.9
Gambella	13.5	15.9	33.8	33.4	147.4
Harari	22	33.5	34.7	46.3	110.5
Addis Ababa	45.2	56.9	62.8	64.1	41.8
Dire Dawa	28.4	34	33.9	50.8	78.9

Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a

Figure 4.5.2: Actual and desired national trends in contraceptive prevalence rate, 1990-2015 (% of currently married women)



Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

Skilled Birth Attendance

Clean and safe delivery and essential obstetric care are the other two pillars of safe motherhood. In this regard, birth attendance by skilled health personnel is one of the most important interventions in reducing maternal mortality. Deliveries attended by skilled birth attendants not only help reduce maternal mortality but also contribute to the reduction of child mortality. Equipping health facilities and deploying skilled health professionals are among key interventions undertaken to increase coverage. The number of health centres delivering Basic Emergency Obstetric and Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services increased from 752 in 2009/10 to 1,813 in 2012/13. A total of 2,366 professionals were trained to provide these services over the same period and 15 hospitals were selected to serve as training centres. Moreover, BEmONC and CEmONC services are being given in 88 hospitals (MOH, 2014).

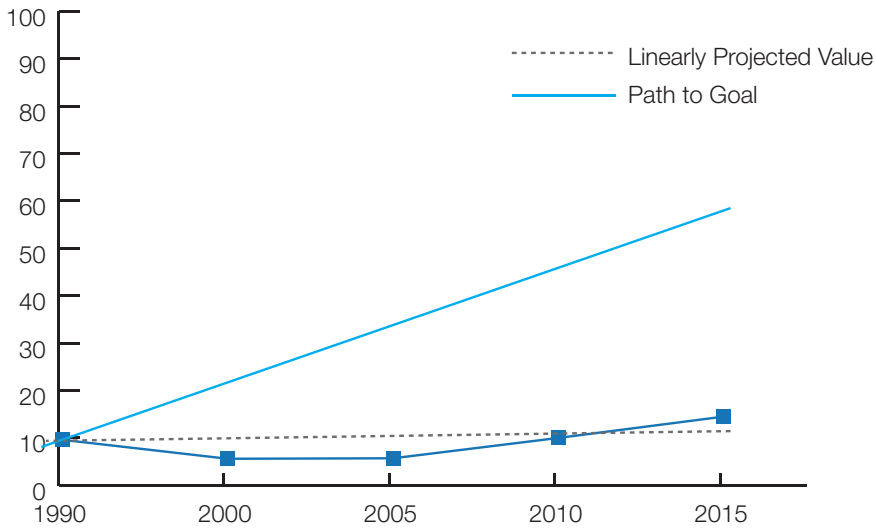
Table 4.5.2: Deliveries attended by a skilled provider (%)

Region	2000	2005	2011	2014	Percentage change
Tigray	4.8	6.0	11.6	24.2	404.2
Afar	5.5	4.5	7.2	6.6	20.0
Amhara	3.1	3.7	10.1	10.0	222.6
Oromia	4.9	4.8	8.1	14.4	193.9
Somali	7.2	5.2	8.4	9.1	26.4
Benishangul-Gumuz	9.1	5.1	8.9	12.1	33.0
SNNP	4.9	4.2	6.1	9.4	91.8
Gambella	23.8	15.3	27.4	24.0	0.8
Harari	26	31.4	32.5	40.0	53.8
Addis Ababa	69.1	78.8	83.9	86.0	24.5
Dire Dawa	33.5	26.7	40.3	58.4	74.3
National	5.6	5.7	10	14.5	158.9
Urban	34.5	44.6	50.8	63.2	83.2
Rural	2.3	2.6	4.0	9.4	308.7

Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

The percentage of deliveries attended by skilled health providers increased from 5.6 per cent in 2000 to 14.5 per cent in 2014, with significant variation between urban and rural areas and also between regions. In 2014 the disparity between regions ranged from 6.6 per cent in Afar to 86 per cent in Addis Ababa. In 2000 the disparity had ranged from 3.1 per cent in Amhara to 69.1 per cent in Addis Ababa, showing that the gap between the worst- and best-served regions in terms of births attended by skilled birth attendants had increased, meaning that the progress recorded by regions was uneven (Table 4.5.2)

Figure 4.5.3: Actual and desired trends in proportion of births attended by skilled health personnel, 1990-2015



Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

Antenatal care

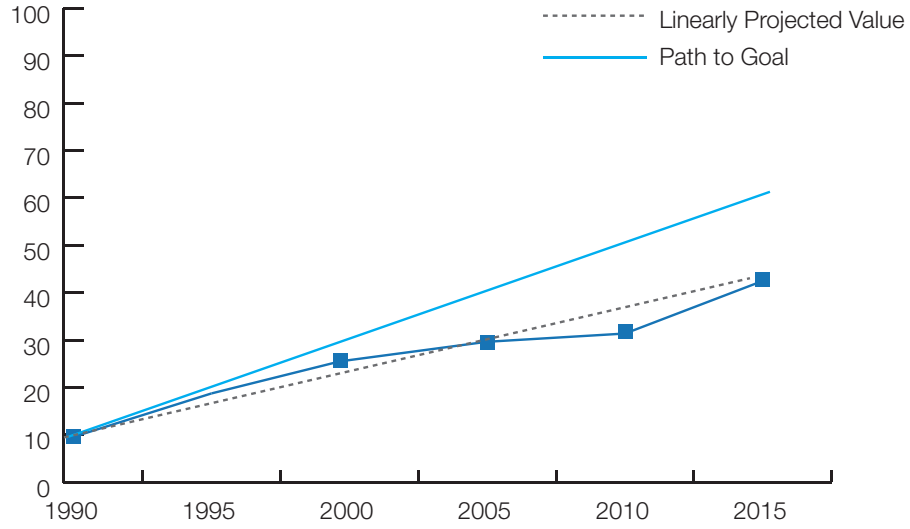
Antenatal care is the other critical element for safe motherhood, and it reflects the degree of utilization of maternal health services. The proportion of women aged 15-49 attended at least once by a skilled health provider during pregnancy improved from 26.7 per cent in 2000 to 27.6 per cent in 2005 and to 39.6 per cent in 2014 (Table 4.5.3). Despite the progress, coverage has lagged behind the target (Figure 4.5.4).

Table 4.5.3: Pregnant women aged 15-49 receiving antenatal care from a skilled provider (%)

Region	2000	2005	2011	2014	Percentage change
Tigray	36.4	35.3	50.1	67.4	85.2
Afar	26.1	15	32.3	28.5	9.2
Amhara	18.9	26.5	33.6	43.1	128.0
Oromia	27.0	24.8	31.3	34.0	25.9
Somali	14.6	7.4	21.5	15.1	3.4
Benishangul-Gumuz	25.7	24.5	35.1	31.0	20.6
SNNP	28.4	30.3	27.3	35.9	26.4
Gambella	49.8	36.6	54.5	45.3	-9.0
Harari	50.2	40.7	55.9	65.9	31.3
Addis Ababa	83.1	88.3	93.6	94.2	13.4
Dire Dawa	57.6	52.9	57.2	78.0	35.4
National	26.7	27.6	33.9	39.6	48.3
Urban	66.6	68.9	76	79.5	19.4
Rural	21.6	23.7	26.4	34.7	60.6

Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

Figure 4.5.4: Actual and desired trends in antenatal care coverage (at least one visit), 1990-2015 (% of pregnant women aged 15-49)



Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

Between 2000 and 2014 there was marked variation between rural and urban areas and also among regions in terms of the current level and progress made over time in the utilization of antenatal care services and the level of skilled birth attendance (Tables 4.5.2 and 4.5.3). The highest level of skilled birth attendance in 2014 was observed in Addis Ababa (94.2 per cent) followed by Dire Dawa (78 per cent) and Tigray (67.4 per cent), and the lowest was observed in Somali (15.1 per cent), Afar (28.5 per cent) and Benishangul-Gumuz (31.0 per cent). In terms of recorded progress between 2000 and 2014, the greatest progress was observed in Amhara (128 per cent improvement), while in Gambella attendance declined by 9.0 per cent. Progress was generally lowest in the so-called developing regional states.

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

The targets for MDG 6 are (1) to have halted by 2015 and begun to reverse the spread of HIV/AIDS, (2) to achieve, by 2010, universal access to treatment for HIV/ AIDS for all those who need it, and (3) to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. There are seven indicators for monitoring progress on MDG 6. The indicators used by Ethiopia are the following for which EDHS and MoH data can be employed to monitor progress:

- HIV/AIDS prevalence among pregnant women aged 15-24 (per cent);
- percentage of HIV/AIDS receiving anti-retroviral treatment;
- percentage of population with treated bed nets; and
- TB prevention and control (percentage of cases successfully treated with DOTS).

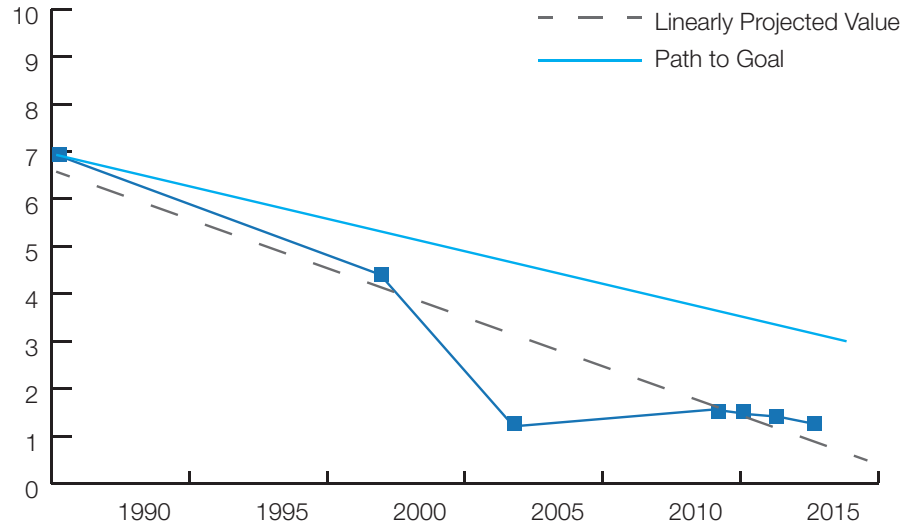
Ethiopia uses only four of the seven indicators proposed globally proposed for monitoring progress on this goal. The progress made by Ethiopia is elaborated below using the above four indicators.

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

Fighting HIV/AIDS has been one of the top priorities of Health Sector Development Programmes (HSDP). According to the 2004 MDG report for Ethiopia, the period when there was the sharpest rise in the HIV/AIDS prevalence rate was between 1984 and 1994. This resulted in increased general mortality, reduced life expectancy at birth and raised the number of orphans and tuberculosis cases. The Ministry of Health estimates that by 2005 HIV/AIDS had probably reduced life expectancy by five years (MoH and HAPCO, 2006).

The adult HIV/AIDS prevalence rate was 4.5 per cent in 2000 and sharply declined thereafter reaching 1.5 per cent in 2011 (CSA and ICF, 2012) and was expected to have declined to 1.1 per cent in 2014, based on HIV estimates and projections produced by EPP/Spectrum modelling, which would be lower than the MDG target of less than 4.5 per cent.

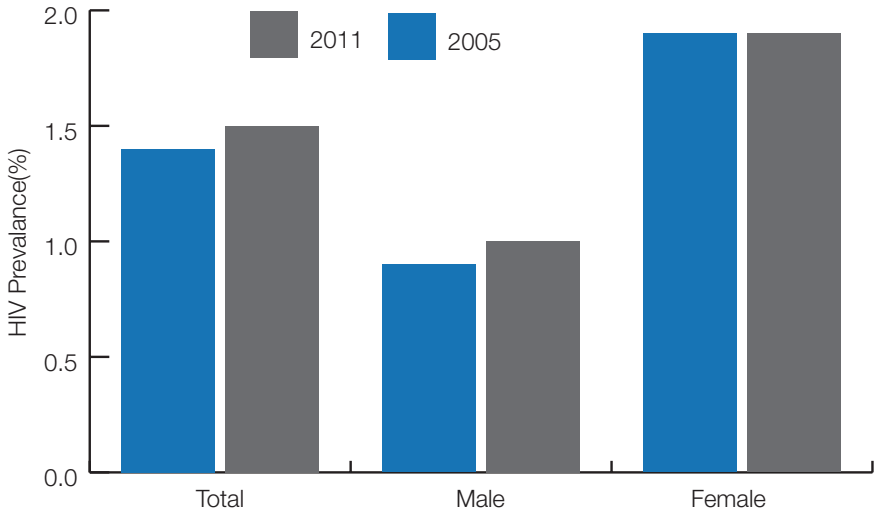
Figure 4.6.1: Actual and desired trends in HIV prevalence among population aged 15-49 years, 1990-2015



Source: CSA and ORC Macro, 2001; CSA and ORC Macro 2006; CSA and ICF, 2012; MOH, 2013

The prevalence of HIV varies according to age, sex and geographical location. In 2011, female adult prevalence (at 1.9 per cent) was almost twice as high as that of male adults (1.0 per cent) (Figure 4.6.2).

Figure 4.6.2: Adult HIV prevalence by gender, 2005 and 2011



Sources: CSA and ORC Macro, 2006; CSA and ICF, 2012.

The distribution of HIV prevalence also varies by age, peaking earlier in females (in the 30-34 years age group) than in males (35-39 years). Looking at the younger age groups it can be seen that young women have a two- to six-fold higher HIV prevalence than young men(CSA and ICF, 2012).

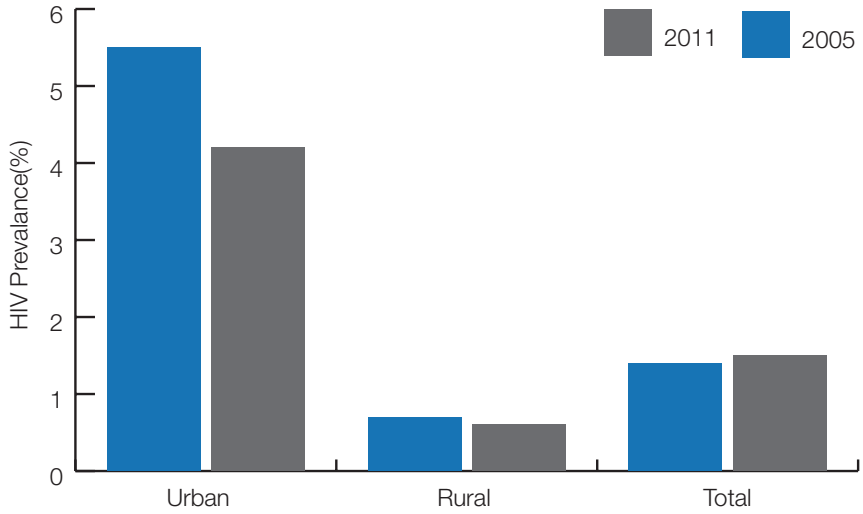
Table 4.6.1: HIV prevalence by age and sex, 2011

	Age group							
	15-19	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**All age groups**
Male	0.0	0.2	0.9	1.0	3.0	2.1	1.4	1.9
Female	0.2	0.9	2.9	3.7	3.0	1.9	1.8	1.0
Total	0.1	0.6	2.0	2.5	3.0	2.0	1.6	1.5

Source: CSA and ICF, 2012

Huge variation in urban-rural prevalence was also recorded in the 2011 Demographic and Health Survey with urban areas having a seven fold higher HIV prevalence compared to that of rural areas (4.2 per cent versus 0.6 per cent). Moreover, the 2011 survey also shows that the HIV epidemic in Ethiopia is most heavily concentrated in urban areas and along major transport corridors (Figure 4.6.3).

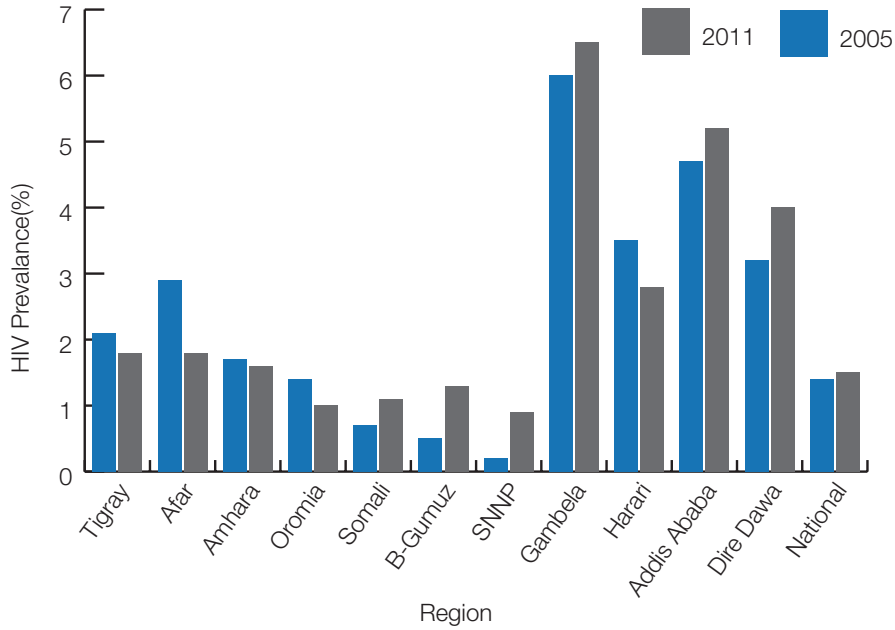
Figure 4.6.3: Adult (15-49) HIV prevalence by urban/rural, 2005 and 2011



Sources: CSA and ORC Macro, 2006; CSA and ICF, 2012.

Variations in HIV prevalence were observed among regions. According to the 2011 Demographic and Health Survey, Gambella region and the urban administrations of Addis Ababa and Dire Dawa have the highest prevalence while SNNP and Oromia have the lowest. Between 2005 and 2005, HIV prevalence increased in some regions (Somali, Benishangul-Gumuz, SNNP, Gambella, Addis Ababa and Dire Dawa), while it declined in others (Tigray, Afar, Amhara, Oromia and Harari).

Figure 4.6.4: Adult (15-49) HIV prevalence by region, 2005 and 2011



Sources: CSA and ORC Macro, 2006; CSA and ICF, 2012.

Data from the Demographic and Health Surveys do not provide sufficient details to analyse the trend of HIV prevalence. However, analysis using data from report on the antenatal care-based Sentinel HIV Surveillance system in Ethiopia shows that the country was able to significantly reduce HIV prevalence among those aged 15-24 from its level in late 1990s and was able to achieve the target indicator (see Table 4.6.2 and Figure 4.6.4).

Table 4.6.2: HIV prevalence in the 15-24 age-group, 2001-2012 (%)

	HIV Prevalence						
Age group (Years)	**2001**	**2002**	**2003**	**2005**	**2007**	**2009**	**2012**
15 – 24	12.4	11.0	8.6	5.6	3.5	2.6	2.1

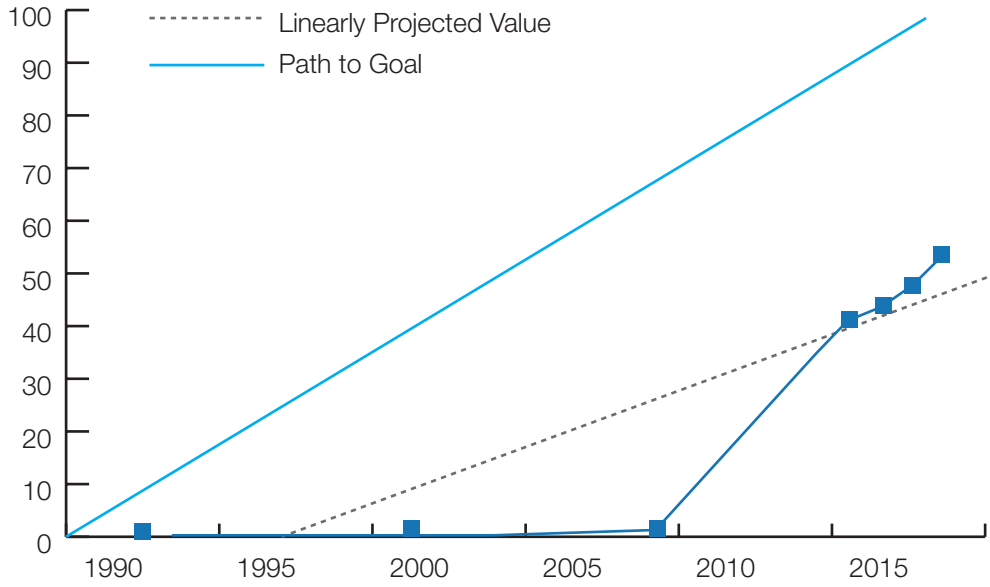
Source: EHNRI/MoH, 2013.

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

The mainstreaming of HIV/AIDS in all sectors in the development plans (the SDPRP, PASDEP and the GTP) helped Ethiopia to reduce the prevalence of HIV. This policy created a conducive environment for donors and government to make a concerted effort to reduce the prevalence of HIV/IADS. Under the umbrella of the development policies and strategies, the HIV/AIDS Prevention and Control Office (HAPCO), together with the Ministry of Health, played a central role in coordinating the HIV/AIDS multi-sectoral response and collaboration with bilateral/ multilateral partners as well as with civil society organizations, community based organizations and people living with HIV/ AIDS.

The scaling up of free ART services is recognized as one of the greatest achievements of the HIV response programme over the last decade and is believed to have contributed to the reduction in AIDS deaths and possibly to the decline in HIV incidence since 2005 (HIV/AIDS Prevention and Control Office, 2014). The estimated number of people living with HIV/AIDS in the country who were on antiretroviral therapy (ART) increased from 1 per cent in 2004 to 54 per cent in 2014 (Figure 4.6.5 and Table 4.6.1), which is far behind the MDG target of 100 per cent in 2015.[4] The trend in the coverage of HIV positive mothers who received the prevention of mother to child transmission (PMTCT) service increased from 32 per cent in 2011 to 73 per cent in 2014. Significant progress could be made during the remaining one year. However, it is less probable that all people with HIV/AIDS will have been put on ART by the end of 2015. Hence the coverage of anti-retroviral drugs is likely to be off track.

Figure 4.6.5: Actual and desired trends in percentage of population with advanced HIV infection with access to antiretroviral drugs, 1990-2015



Sources: WHO, 2015; MoH, 2014; CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

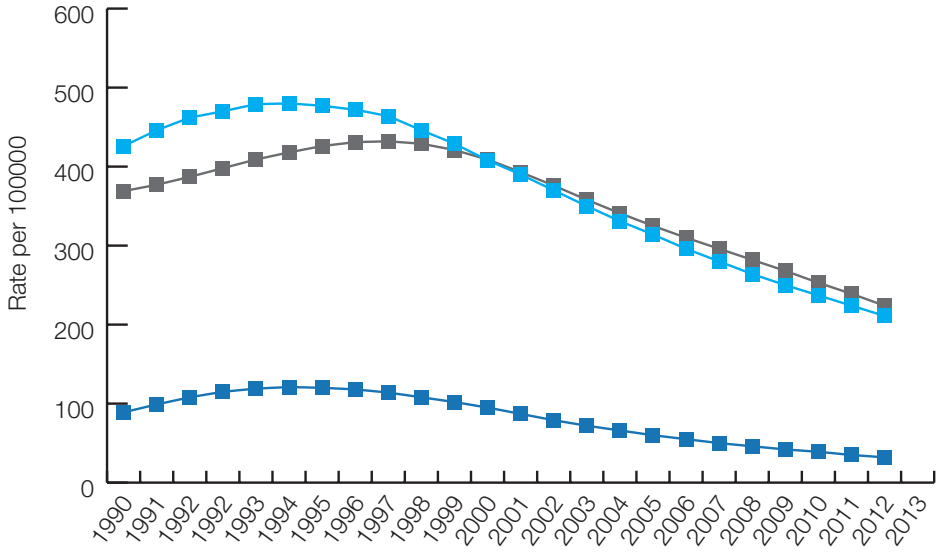
4 When comparing access to ART over the years, it is important to take note of changes in the guidelines for eligibility for treatment, which have meant that those with advanced HIV infection who are considered to require treatment has changed over time. For example, adults with a CD4 count of <200 were considered eligible in 2012, while from 2014 onwards Ethiopia adopted the new WHO integrated guidelines, which made those with a count of less than 500 eligible. This makes it difficult to compare ART coverage over the years.

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

Malaria control and prevention and the prevention of TB are the core interventions of the country's primary health care system. The major activities planned for malaria prevention and control have focused on expanding vector control interventions and strengthening early diagnosis and the prompt treatment of cases. Increasing the availability and use of Long Lasting Insecticide-Treated Nets (LLIN) as well as implementing Indoor Residual Spray (IRS) of houses with insecticidal chemicals are powerful vector control tools for reducing malaria transmission. The MoH Annual Progress Report for 2013/14 states that increasing the availability and use of LLINs and implementing Indoor Residual Spraying (IRS) were the reasons for reduced malaria transmission. In 2013/14, 11.7 million LLINs were distributed and a total of 3.9 million households in malaria endemic areas were sprayed. According to the National Malaria Indicator Survey of 2011, 64.5 per cent of children under five are sleeping under insecticide-treated bed nets (EHNRI, 2012). Moreover, the percentage of population with treated bed nets was 22 per cent in 2010 and reached 45.8 per cent in 2014 which is far from the target of 100 per cent for 2015 (Table 4.6.1). Therefore, substantial effort is needed to reach the 100 per cent target in 2015. According to the WHO World Malaria Report 2013, the proportion of the Ethiopian population protected by any vector control was more than 60 per cent in 2012, which was considered as among the best performing among in Sub-Saharan African countries (WHO, 2013). However, budget constraints at *woreda* level for IRS activities; delays in procurement to replace old LLINs; and inadequate utilization of LLINs were the main challenges to further preventing and controlling malaria.

The other disease that is monitored to assess progress on MDG 6 is tuberculosis (TB). Three indicators are used for this purpose: the TB incidence rate, the TB mortality rate and the TB prevalence rate. WHO (2014a) has reported that Ethiopia has met all the three targets of decreasing the TB incidence rate, halving the TB mortality rate and halving the TB prevalence rate. The country has reduced the TB mortality rate (excluding HIV) by more than half from 89 deaths per 100,000 in 1990 to 32 deaths per 100,000 in 2013. Similarly, the TB incidence rate declined from 421 per 100,000 in 2000 to 224 per 100,000 in 2013, and the TB prevalence rate (number of cases of TB per 100,000 in any given year) declined from 426 in 1990 to 211 in 2013 (a decline of 50 per cent). Figure shows the progress with respect to the fight against TB.

Figure 4.6.6: Trends in the TB mortality rate, the TB prevalence rate and the incidence of TB, 1990-2013



Source: WHO, 2015.

National data also show significant advances in the fight against TB. In 2008/09, the national tuberculosis detection rate (the ratio of the number of notified TB cases to the number of TB cases in a given year) was 36 per cent. In 2013/14, the detection rate increased to 54 per cent. In 2013/14, a total of 116,633 TB cases were reported with a TB case notification rate of 133 per 100,000 population. There were regional variations in TB case notification in 2013/14, ranging from 56 per 100,000 people in Somali to 311 per 100,000 in Dire Dawa. In 2013/14, the TB case detection rate was 53.7 per cent, variations were observed across regions, ranging from 22.7 per cent in Somali Region to over 100 per cent in Afar and Dire Dawa (MoH, 2014).

The TB treatment success rate (TSR) has increased from 61 per cent in 1995 to 91 per cent in 2012 (WHO, 2014a). According to the MOH (2014), the TSR reached 92.1 per cent in 2013/14 which is above the MDG target of 90 per cent (Table 4.6.1). Large variations were observed across regions, with the strongest performances being observed in Tigray, Afar, Oromia, and Benishangul-Gumuz regions and the weakest in Somali region. Six regions, namely, Tigray, Afar, Amhara, Oromia, Benishangul-Gumuz and Harari, improved their performances in 2013/14, while a deterioration in performance was observed in Somali, SNNP, Gambella, Addis Ababa and Dire Dawa. The TB cure rate worsened slightly from 70.3 per cent in 2012/13 to 69.1 per cent in 2013/14. The best cure rate was found in Dire Dawa (81.6 per cent), while the rate in four regions (Somali, SNNP, Gambella and Harari) declined in 2013/14 compared with the previous year.

Underutilization of TB culture diagnostic services due to an inadequate sample transportation mechanism; limited community participation in suspected TB identification through the health extension agent; and inadequate implementation of daily observed treatment at facility level were some of the challenges identified by the Ministry of Health.

Table 4.6.3: Trends in combating HIV/AIDS, malaria and other diseases, 1990-2012

	1990	2000	2004	2010	2011	2012	2013	2014	Target 2015
Percentage of HIV/AIDS prevalence among people aged 15-49	0.9	4.5	1.4	1.5	1.5	1.3	1.2	1.1	<4.5
Percentage of HIV/AIDS patients receiving antiretroviral therapy	..	0	1	35	41	44	48	54	100
Percentage of population with treated bed nets (LLINs)	..	..	..	22.2	35.2	39.5	45.8	58.4	100
TB prevention and control (percentage of cases successfully treated with DOTS)	61 (1995)	80	79	77	89	91	91.4	92.1	90

Sources: WHO, 2015; MoH, 2014; CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

In summary, Ethiopia has achieved the MDG target for reducing HIV/AIDS prevalence among people of aged 15-49 ahead of 2015. The percentage of HIV/AIDS patients who are receiving anti-retroviral therapy is very close to the target. The percentage of TB cases successfully treated with DOTs was 92.1 per cent in 2014 which is above the MDG target of 90 per cent. Hence, Ethiopia is generally on track to achieve Goal 6 on combating HIV/AIDS, Malaria and Tuberculosis.

4.7. Goal 7: Ensure Environmental Sustainability

Goal 7 has four targets, but Ethiopia has adopted only two of them, namely:

- Target 7.A: integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources; and
- Target 7.C: halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

Ethiopia uses the following indicators to monitor progress: (1) forest cover (per cent), (2) use of improved/safe drinking water sources (per cent), and (3) the use of improved sanitation facilities (per cent).

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

Natural resource conservation has been given due priority in Ethiopia's development plans including the SDPRP, PASDEP and the GTP because it plays a key role in ensuring sustainable development. Through mobilizing communities, large-scale soil and water conservation activities and tree planting have been carried out. The Environmental Organs Establishment Proclamation (Proclamation No. 295/2002) was enacted in 2002. According to this proclamation, the Environmental Protection Agency (EPA), since renamed the Ministry of Environment and

Forestry (MEF), coordinates and oversees the activities of the sectoral agencies and environmental units and conducts research with respect to environmental management. The proclamation mandates the establishment of environmental organs at the regional level. Under their mandates, the regional environmental organs are to coordinate regional environmental activities, avoid the duplication of effort and improve the dissemination of environmental information.

Since 2002, with the participation of all concerned stakeholders, various activities have been carried out throughout the country to combat desertification and mitigate the effects of drought. The major activities related to natural resource conservation are physical and biological soil conservation measures and agro-forestry practices, area closure and afforestation, rehabilitation of degraded patches of remnant forest areas through enrichment planting and enclosure by local communities, and the upgrading of two controlled hunting areas to national parks and the establishment of one new national park. Various indigenous practices that conserve natural resources have been adopted. Examples are indigenous terrace building in Konso district (SNNP) and agro-forestry system development in Gedio zone (SNNP), where various conservation measures were taken. Conservation practices undertaken have included terrace building, the practice of multi-storey vegetation and cultivating crops like *Cordia africana, Coffeea arabica*, *Ensete ventricosum* and several root crops, and biological measures. As a result, soil and water resources have been well conserved, home garden agro-forestry and biodiversity have been enhanced, and most areas of the conservation zone are covered by evergreen vegetation. This type of natural resource conservation is believed to have wider environmental benefits, such as increased vegetation cover and carbon storage.

The Ethiopian Government has given greater emphasis to natural resource conservation, including through its forestry policy. Forestry activities have been carried out under the Department of Forest in the Ministry of Agriculture and Rural Development, and more recently through the transfer of the Department of Forest to the new Ministry of Environment and Forestry. Currently the mandate to regulate and coordinate development and implementation of environmental management strategies is the responsibility of the Ministry of Environment and Forest.

In 2011, the Federal Democratic Republic of Ethiopia put forth a strategy for developing a climate-resilient green economy (CRGE) by 2025. This strategy aims at achieving a middle-income country status by 2025 on the basis of a climate-resilient green economy. Ethiopia believes that achieving middle income status by 2025 through the conventional development path would result in dramatically increased carbon emissions and the unsustainable use of natural resources. The strategy identifies four pillars of development in the green economic action plan namely: (1) improved crop and livestock production practices for higher food security and farmer incomes while reducing emissions, (2) protecting and re-establishing forests for their economic and ecosystem benefits, including as carbon stocks, (3) expanding electricity generation from renewable sources of energy for domestic and regional markets; and (4) leapfrogging to modern and energy-efficient technologies in transport, the industrial sector, and construction.

Under the new strategy, the Government understands that deforestation leads to CO_2 emissions, and is mostly caused by the conversion of forested areas to agricultural land. Annual emissions from deforestation are projected to grow from 25 million tons CO_2e in 2010 to almost 45 million tons in 2030, primarily due to fuelwood consumption and logging in excess of the natural yield of the forests.

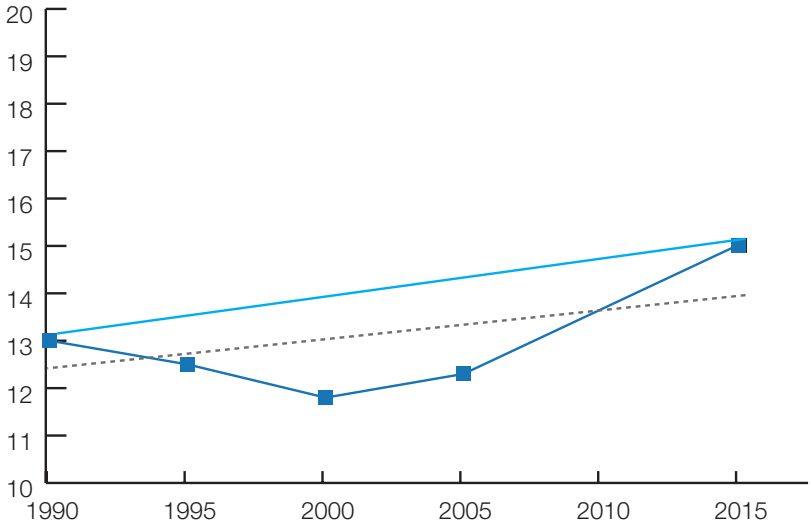
As part of implementing the growth and transformation plan (GTP) and Climate-Resilient Green Economy strategy, appropriate natural resources conservation practices have been carried out as part of a scaling-up strategy in order ensure sustainable agriculture growth. Physical soil and water conservation works were fully implemented through proactive and organized community participation. More effective forestry development, protection and utilization activities were carried out through the participation of communities and stakeholders.

According to the Annual Progress Report of the Ministry of Environment and Forest (2014), key activities related to forestry were accomplished between 2010 and 2014. A management plan map was prepared for 1,440,800 hectares of forest, which is 172 per cent of the GTP plan. About 22,515 quintals of forest seeds have been distributed to communities. About 10.2 million hectares of degraded area have been rehabilitated during the GTP period by constructing soil and water conservation structures and planting trees. As a result of these activities, it was possible to increase the forest cover of the country from 13 million hectares in 2012 to 15.93 million hectares in 2014. It was also possible to cover 17.7 million hectares of land with multipurpose trees.

Forest cover in Ethiopia was around 13 per cent in 2001, but declined to 11.8 per cent in 2005. However, as a result of the activities conducted by the Ministry of Environment and Forestry (MEF) and its predecessor, the Environmental Protection Authority (EPA), in collaboration with regional government, rural and urban communities and other stakeholders, it was possible to reverse the declining trend of forest cover and increase forest cover to 15 per cent by 2014 (Figure 4.7.1).

Though there is no specific MDG target set with respect to forest cover for Ethiopia, as described above and as shown in Figure 4.7.1, the progress achieved so far has been remarkable. The reasons for this success have been the establishment of institutions (such as the EPA and MEF) that can better manage forestry activities, the broad based participation and mobilization of communities in natural resource conservation, the use of biological measures of soil and water conservation, and tree planting and management . However, the sector has still limitations and challenges. The Annual Progress Report of the MEF (2014) identified the following major limitations and challenges: (1) the low capacity of regional bureaus in pursuing legal processes against people who have been illegally cutting trees in protected forests, (2) the lack of sufficient vehicles to monitor conservation and tree planting activities, (3) the lack of logistical and human capacity in the new ministry due to its very recent establishment, and (4) the lack of coordination among sector ministries including the Ministry of Urban Development, Housing and Construction, the Ministry of Transport and the Ministry of Industry. Therefore, it is important that the Ethiopian Government take appropriate action to encourage the forestry sector so as to sustain the current excellent progress in expanding the country's forest cover.

Figure 4.7.1: Actual and desired national trends in the proportion of land area covered by forests, 1990-2015



Source: MEF, 2014.

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

The two indicators used for monitoring progress on this target are (a) the proportion of the population with sustainable access to an improved water source, urban and rural, and (b) the proportion of the population with access to improved sanitation, urban and rural. Access to safe drinking water and improved sanitation facilities are essential elements for human life. The source of water is an indicator of whether it is suitable for drinking. Sources that provide suitable water for drinking are identified as improved sources. According to UNICEF and WHO, safe types of drinking water include a piped source within the dwelling, yard, or plot; a public tap/standpipe; a borehole; a protected well; a protected spring; and rainwater. The same source also indicates that, at the household level, adequate sanitation facilities include an improved toilet and disposal system that separates waste from human contact. A household is classified as having an improved toilet if it is used only by members of one household (that is, it is not shared) and if the facility used by the household separates the waste from human contact (UNICEF and WHO, 2010, as cited in CSA, 2014b).

At the national level, about 55 per cent of Ethiopian households had access to an improved source of drinking water in 2014. According to the Mini Demographic and Health Survey of 2014, the proportion of Ethiopian households with access to an improved source of drinking water had increased to that level from 25.6 per cent in 2000. However, access to piped water, after increasing from 24 per cent in 2005 to 34 per cent in 2011, declined to 33 per cent in 2014.

Urban households have much better access to an improved source of drinking water (95 per cent) than rural households (46 per cent). The most common source of improved drinking water in urban households is piped water, which is used by 88 per cent of urban households, while only 16 per cent of rural households have access to piped water. Sixteen per cent of rural households have access to drinking water from a protected well, and 12 per cent have access to drinking water from a protected spring. The available evidence shows that Ethiopia has achieved Target 7.C of reducing by half people without

sustainable access to safe drinking water. Despite the success in meeting the target, people's access to safe drinking water has been declining since 2005 due to ageing water infrastructure. To reverse the declining trend of access to safe drinking water, much effort is needed from the Government to develop new water sources and repair the existing waters sources in both rural and urban areas.

CSA (2014b) shows that only 4.5 per cent of the population in Ethiopia use improved toilet facilities that are not shared with other households, 17.5 per cent in urban areas and 2.5 per cent in rural areas. This compares with 7.4 per cent in 2005 (22.6 per cent in urban and 5.4 per cent in rural areas), 8.8 per cent in 2011 (18.2 per cent in urban and 6.8 per cent in rural areas), indicating that the use of improved toilet facilities has declined compared with its levels in 2011 and 2005 (Figure 4.7.3). In 2014, 7 per cent of households (33 per cent in urban areas and 1 per cent in rural areas) used shared toilet facilities (Table 4.7.2). The vast majority of households, 89 per cent, use non-improved toilet facilities (96 per cent in rural areas and 53 per cent in urban areas). The most common type of non-improved toilet facility is an open pit latrine or pit latrine without slabs, which are used by 57 per cent of households in rural areas and 43 per cent of households in urban areas.

According to the Joint Monitoring Programme (JMP) of UNCEF and WHO, Ethiopia has shown moderate progress on meeting the MDG target of improving access to improved sanitation facilities and has met the MDG target of access to an improved source of safe drinking water (UNICEF and WHO, 2015).[5] According to the UNICEF and WHO, access to improved sanitation facilities was 3 per cent in 1990 and reached 28 per cent in 2015, while it increased from 20 per cent in 1990 to 27 per cent in 2015 in urban areas and from zero per cent in 1990 to 28 per cent in 2015 in rural areas, making access to sanitation facilities is slightly higher in rural that in urban areas, which is not consistent with the DHS data (Table 4.7.1).

With regard to the access to safe drinking water, the definition used by JMP is similar to that of EDHS and their data are also comparable. As per the JMP record (UNICEF and WHO, 2015) access to safe drinking water 13 per cent in 1990 and has reached 57 per cent in 2015 with access in rural areas increasing from 3 per cent to 49 percent and access in urban areas increasing from 84 per cent to 93 per cent during the same period indicating that rural-urban gap is narrowing.

Table 4.7.1: Access to sanitation facilities and safe drinking water by rural/urban, 1990 and 2015

Year	Urban	Rural	Total
	Access to improved sanitation facilities		
1990	20	0	3
2015	27	28	28
	Access to safe drinking water		
1990	84	3	13
2015	93	49	57

Source: UNICEF and WHO, 2015.

Though Ethiopia has achieved the MDG target of access to safe drinking water and is on track to achieve the MDG target of meeting sanitation facilities, there is a huge gap between rural and urban areas in terms of access to both safe sanitation facilities and safe drinking water (Table 4.7.1, Figure 4.7.2 and Figure 4.7.3). As the gap is unlikely to close in the near future, much effort is needed by the Government to increase the access of rural people to sanitation and drinking water.

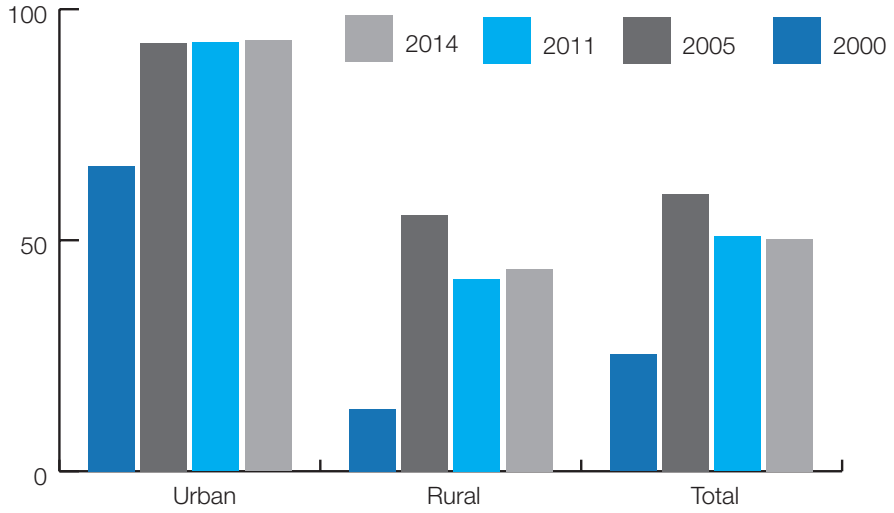
5 JMP uses a stricter definition of access to improved sanitation facilities. Only sanitation facilities that are not shared or not public are considered improved, while the Ethiopian Demographic and Health Survey (EDHS), endorsed by the Ethiopian Government, defines improved sanitation facilities as those with connections to public sewerage or a septic tank system, pour-flush latrines, simple pit latrines, or ventilated improved pit-latrines.

Table 4.7.2: Trends in sanitation facilities and safe drinking water, 1990-2014 (%)

	Baseline 1990	2001	2005	2011	2014	Target 2015
Use of improved/safe drinking water sources	13	25.3	64	52.12	55	57.2
Improved sanitation facilities	3		7.4	8.8	4.5	..

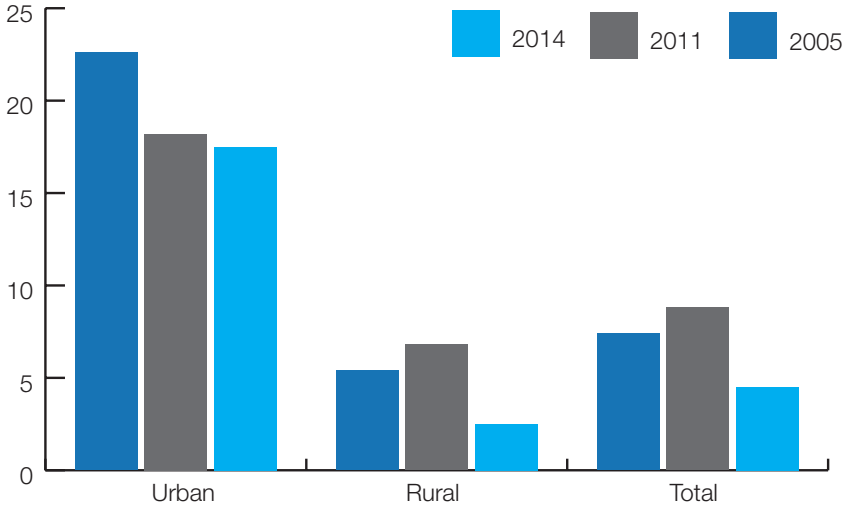
Source: UNICEF and WHO,2015.

Figure 4.7.2: Trends in proportion of population using an improved drinking water source, 2000-2014



Sources: CSA and ORC Macro, 2001; CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

Figure 4.7.3: Trends in proportion of population using improved sanitation facilities, 2005-2014



Sources: CSA and ORC Macro, 2006; CSA and ICF, 2012; CSA, 2014a.

4.8. Goal 8: Develop a Global Partnership for Development

Ethiopia has consistently played a leading role in the global partnership for development, as it most recently demonstrated in July 2015 when it hosted the Third International Conference on Financing for Development in Addis Ababa. The Financing for Development agenda for post-2015 goes beyond the current MDG 8 to include:

- domestic public resources;
- domestic and international private business and finance;
- addressing systemic issues, such as broadening the voice and participation of developing countries in international economic decision making.

This broader post-2015 agenda is one that Ethiopia is well-positioned to embrace given its push to further increase domestic resource mobilisation and attract FDI in the second Growth and Transformation Plan (GTP II, 2015-2020), as well as to attain middle-income status by 2025.

To take stock and assess how Ethiopia has met MDG 8, this chapter will focus on official development assistance and international market access (Targets 8.A, 8.B and 8.C); debt sustainability (Target 8.D); access to affordable medicines (Target 8.E); and access to new technologies (Target 8.F).

Official development assistance (ODA) and market access

Official development assistance (ODA)

The following indicators were used for the analysis of ODA n this report:

- trends in the flow of net ODA and its effectiveness, including through the use of country systems by development partners and mutual accountability;
- the benefits Ethiopia derives from taxes, quotas and duty free market access to various countries and trade blocs, namely the USA, the EU, Canada and Japan, as well as China and India; and
- Ethiopia's interest in joining the World Trade Organization (WTO).

The flow of official development assistance (ODA) and related statistics are provided in Table 4.8.1). Net ODA was US$1.1 billion in 2000 and increased to US$3.8 billion in 2013 with an annual average growth rate of 19.5 per cent. Gross official development assistance was about US$1.1 billion in 2000 (two years before Ethiopia adopted the UN Declaration on the MDGs) and increased to US$3.9 billion in 2013, making the annual average growth rate of gross ODA between 2000 and 2013 18.3 per cent (Table 4.8.1). ODA per capita grew from US$10.4 in 2000 to 40.7 in 2013, while ODA as a percentage of GNI grew from 8.6 per cent in 2000 to 18.4 per cent in 2004, before declining to 8.2 per cent in 2013. ODA per capita between 2000 and 2013 averaged US$29.8, while ODA as a percentage of GNI averaged 13.1 per cent. Of total gross ODA, 77 per cent took the form of grants during the period 2000-2013, and 23 per cent were loans. Over time, the percentage of loans has increased compared with grants, indicating the growing capacity of the country to take on a higher debt burden.

Of its total ODA, 58 per cent was allocated for basic social services (social infrastructure and services such as education and health), 22 per cent for economic infrastructure, including water and sanitation, and 10 per cent for the productive sectors, namely agriculture and industry, and 10 per cent took the form of cross-cutting, multi-sectoral assistance (Table 4.8.3). According to the MoFED's Aid Management Platform (MoFED, 2015), the top 10 providers of development

finance are the IDA (World Bank), DFID (UK), USAID, the WFP, the AfDB, China, JICA, UNICEF, the EU and Canada.

Since 2006, the Protection of Basic Services (PBS) programme has supported the decentralized delivery of health, education, water and sanitation, agriculture and (since 2009) rural roads. Therefore the PBS has played an important role in helping achieve several of the GTP targets and MDGs. In addition to PBS, large multidonor pooled funds that are currently in place include the Productive Safety Net Programme (PSNP), the General Education Quality Improvement Programme (GEQIP), and the Water Supply, Sanitation and Hygiene (WASH) programme. Together contributions from development partners to these four large programmes account for about one-quarter of ODA per year. Ethiopia's medium-term strategies and national budgets, including the most recent one for 2015/16 (EFY 2008), have prioritized key pro-poor sectors such as education, health, agriculture, water and rural roads, as well as industry and agriculture as drivers of sustained economic growth and job creation.

The Busan Partnership document, produced at the 4th High-Level Forum on Aid Effectiveness held in November-December 2011 in Busan, South Korea, embodies four broad principles as the foundation for effective development cooperation: (1) country ownership; (2) focus on results; (3) inclusive development partnerships; and (4) transparency and accountability to one another. In the most recent round of aid effectiveness monitoring, country level indicators identified to measure aid effectiveness are (1) annual and medium-term aid predictability; (2) aid that is included in the Government budgetand subject to parliamentary scrutiny, (3) mutual accountability among development cooperation actors strengthened through inclusive reviews, and (4) effective institutions and systems to be strengthened and used.

MoFED measured these indicators based on data entered in the aid management platform, complemented by data provided by the development partners for the 2013 global monitoring survey (Tables 4.8.4 and 4.8.5). Comparing the results for 2013 with those for 2010, the annual predictability of ODA has slightly improved, a higher share of aid is included in the budget, and more aid is untied (87 per cent in 2013. However, there has been decreasing use of Ethiopia's public finance management (PFM) and procurement systems. When compared with the average for other countries participating in the post-Busan survey, aid to Ethiopia is more effective on all indicators measured at the country-level (MoFED and UNDP, 2014.

Market access

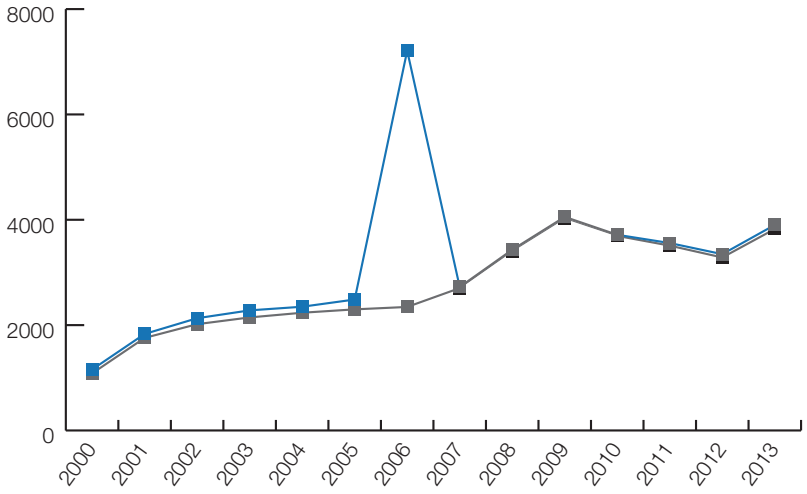
Ethiopia formally applied to join the WTO in 2003, and the Government submitted its Memorandum on the Foreign Trade Regime in December 2006 and subsequently circulated it to members in January 2007. According to the most recent Annual Progress Report on the GTP (2012/13), WTO member countries have already presented their third and fourth rounds of questions for Ethiopia. The Factual Summary of Points Raised, prepared by the WTO Secretariat, was circulated in March 2012. The Working Party met for the third time in March 2012 to continue the examination of Ethiopia's foreign trade regime. Negotiations with WTO member states on import and export tariffs on goods and services are ongoing. These are particularly challenging in the services sector since the Government considers some sectors included in the accession process–such as banking and telecoms–to be strategic. The services sector negotiating documents have yet to be provided by the Government of Ethiopia.

Ethiopia's membership to the Common Market for Eastern and Southern Africa (COMESA) grants it market access to over 400 million people in 19 countries. Ethiopia also continues to benefit from preferential market access to the US and EU through programmes such as the African Growth and Opportunity Act (AGOA) and the Everything But Arms (EBA) initiative. Ethiopia was one

of the top 10 recipients of aid for trade from 2006 to 2013 and currently benefits from one of the largest trade facilitation projects in the world. In 2013, US$891.3 million or 23 per cent of gross ODA consisted of aid for trade (OECD and WTO, 2015). This includes aid to build the supply-side capacity and infrastructure necessary for Ethiopia to compete internationally, but also support to assess and put into effect various trade agreements.

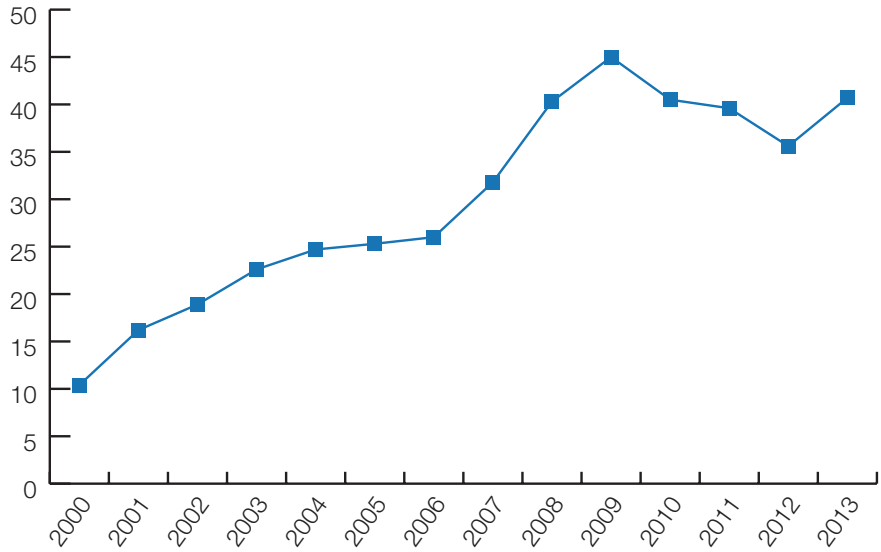
In order to assess the benefits of WTO accession on the Ethiopian economy in advance, various impact assessment studies have been conducted on the areas of goods and services in the past three years. These studies include ones on trade-related aspects of intellectual property rights (TRIPS), the impact of WTO accession on health and education services, a study on the initial offer in agricultural products, non-agricultural products and services, and Ethiopia's WTO accession negotiation strategy. Moreover, the legislative action plan, which contains trade related laws to be employed in the event of accession, was prepared in the standard WTO format, reviewed by the national steering committee and submitted to the WTO Secretariat.

Figure 4.8.1: Trends in gross and net ODA (US$ million)



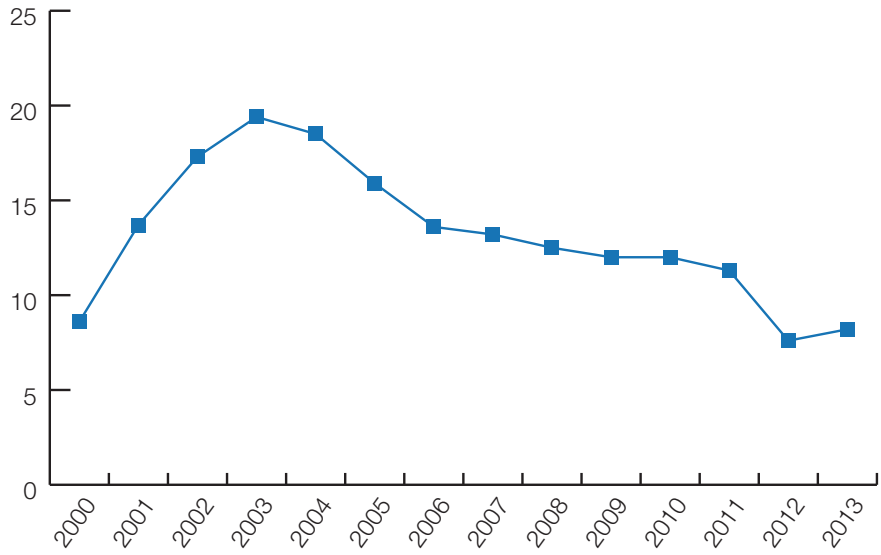
Source: OECD, 2015.

Figure 4.8.2: Trend in ODA per capita (US$)



Source: OECD, 2015.

Figure 4.8.3: Trend in ODA as percentage of GNI



Source: OECD, 2015.

Table 4.8.1: Trends in ODA, 2000-13.

	Gross ODA (US$ million at constant 2013 prices)	Net ODA (US$ million at constant 2013 prices)	% of grant aid in total ODA	% of loans in total ODA	Loan repayment (US$ million at constant 2013 prices)	ODA per Capita (U$ at constant 2013 prices)	ODA as % of GNI
2000	1,157	1,083	75.2	24.8	-74	10.4	8.6
2001	1,832	1,757	50.9	49.1	-73	16.2	13.7
2002	2,131	2,018	52.4	47.6	-61	18.9	17.3
2003	2,280	2,146	84.6	15.4	-53	22.6	19.4
2004	2,349	2,235	86.5	13.5	-57	24.7	18.5
2005	2,486	2,299	80.9	19.1	-32	25.3	15.9
2006	7,210	2,345	94.1	5.9	-12	26.0	13.6
2007	2,724	2,703	83.4	16.6	-12	31.8	13.2
2008	3,431	3,404	90.6	9.4	-16	40.3	12.5
2009	4,055	4,027	75.3	24.7	-21	45.0	12.0
2010	3,715	3,694	81.5	18.5	-14	40.5	12.0
2011	3,558	3,509	81.6	18.4	-43	39.6	11.3
2012	3,347	3,284	77.0	23.0	-56	35.6	7.6
2013	3.902	3,825	67.8	32.2	-70	40.7	8.2
Average			77.3	22.7		29.8	13.1
Growth rate per year (%)	18.3	19.5					

Source: OECD, 2015.

Table 4.8.2: Trends in net debt relief and debt forgiveness grants, 2000-2013, (US$ million)

Year	Debt forgiveness grants	Net debt relief
2000	1.03	1.16
2001	15.14	24.97
2002	74.07	108.25
2003	99.10	51.57
2004	185.02	163.13
2005	183.83	63.95
2006	4,383.75	222.77
2007	21.93	18.17
2008	25.35	14.35
2009	6.30	6.38
2010	5.76	5.99
2011	9.66	5.34

Year	Debt forgiveness grants	Net debt relief
2012	9.35	4.30
2013	7.42	7.00
Total (1998-1999)	175.96	..
Total (2000-2013)	5,027.71	697.33

Source: OECD, (2015.

Table 4.8.3: Allocation of ODA by sector, 2012 and 2013

Type of sector	% share
Social Infrastructure & Services	58.2
Economic Infrastructure & Services	22.3
Production Sectors	9.6
Multi-Sector/Cross-Cutting	9.9

Source: OECD, 2015

Table 4.8.4: Comparison of aid effectiveness in Ethiopia, 2010 and 2013 (%)

Indicator	2010	2013	Status
5a. Annual predictability	88	89	
5b. Medium-term predictability		85	(new in 2013)
6. Aid on budget	49	66	
7. Mutual accountability	Yes	Yes	
9b. Use of country PFM and procurement systems	66	51	-
10. Aid untied	70	87	

Source: MoFED and UNDP, 2014.

Table 4.8.5: Comparison of aid effectiveness in Ethiopia with the global average, 2013 (%)

Indicator	Ethiopia avg.	Global avg.	
5a. Annual predictability	89	84	Above
5b. Medium-term predictability	85	70	Above
6. Aid on budget	66	63	Above
9b. Use of country PFM and procurement systems	51	49	Above

Source: MoFED and UNDP, 2014.

Debt sustainability

Ethiopia was among the 26 African countries eligible for the assistance under the Highly Indebted Poor Countries (HIPC) initiative and Multilateral Debt Relief Initiative (MDRI), which together were worth US$5 billion between 2000 and 2013, with the largest amount of debt forgiveness grants being received in 2006, as depicted in Table 4.8.2. Debt forgiveness grant data cover both debt cancelled by agreement between debtor and creditor and a reduction in the net present value of non-ODA debt achieved by concessional rescheduling or refinancing. As the country moves towards lower-middle income country status and accesses international financial

markets (as demonstrated by Ethiopia's sale of Eurobonds in 2014 and its plans to start an equities and secondary debt market), one would expect the ratio of ODA loans to grants to continue to increase.

Ethiopia's total debt service as a percentage of total exports of goods and services was 3.0 per cent in 2010. In 2012 and 2014, the IMF assessed the sustainability of Ethiopia's debt using the Low-Income Country Debt Sustainability Analysis (LIC-DSA) framework for the period of 2011 to 2030 (IMF, 2012 and IMF, 2014). According to the first of these assessments, Ethiopia's risk of external debt distress was expected to remain low; however, the 2014 debt-sustainability assessment indicated Ethiopia's low risk of external debt distress had moved towards more moderate risk.

The IMF's 2014 public debt sustainability assessment (DSA) suggests that Ethiopia's overall public sector debt dynamics are sustainable under the baseline scenario (excluding remittances and higher commercial loan disbursements) but vulnerable under several alternative scenarios (when commercial loan disbursement is included). Public sector debt ratios (debt to export, debt to GDP and debt service to export ratios) are projected to rise in the medium term, indicating that close monitoring of borrowing by public enterprises remains a necessity. As part of the study, the IMF report suggests that Ethiopia will require an increase in the growth of exports through diversification of the export sector, a medium-term debt strategy for the public sector, and effective imposition of a limit on non-concessional borrowing in order to maintain as low risk of external debt distress as possible.

Access to affordable essential medicines

A 2009 study (Carasso and others) indicated that the availability of essential drugs was 91 per cent (versus 84 per cent based on prescriptions filled), but that one in six patients was forced to purchase the drugs in the private sector, where they are roughly twice as expensive. The Pharmaceuticals Fund and Supply Agency (PFSA) was established in September 2007 and under the reforms finalized in 2009, it is one of the eight core processes of the Ministry of Health. A Revolving Drug Fund is in place to procure essential medicines (special pharmacies sell at a mark-up of 20-30 per cent and supplies are replenished with the profits collected from sales), and evidence shows that it has increased the availability of medicines at facility level. The Revolving Drugs Fund is managed by PFSA branch offices, which aggregate needs to the national level for bulk procurement.

In June 2015, the Government of Ethiopia with the support of the World Health Organisation (WHO) released a 10-year strategic document and action plan to make essential medicines affordable. Among other elements, this strategy takes up the GTP I target of increasing the share of locally manufactured essential medicines to 50 per cent, from around 20 per cent today. Nine local pharmaceutical companies currently operate in the country, together with about 200 importers of pharmaceutical products and drugs. The country currently spends over US$300 million each year in importing pharmaceutical products and drugs, which it hopes to reduce by increasing local production and increasing employment. Tax free loans, customs duty and income tax exemptions, and preferential access to land are some of the current incentives in place to increase local production.

The strategic objectives of the 10-year strategy unveiled by the Government of Ethiopia include: (1) increasing the quality of local production; (2) strengthening the regulatory system for nationally produced medicines; (3) creating incentives designed to move companies along the value chain; (4) developing human resources through relevant education and training; (5) encouraging cluster development and the production of active pharmaceutical ingredients; (6) creating a research and development platform; and, finally, (7) attracting FDI into the pharmaceutical sector (MoH, 2015).

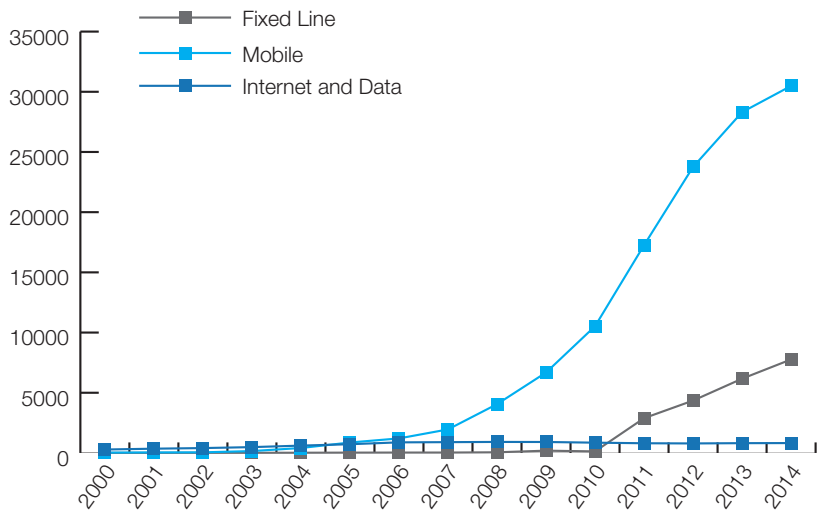
Access to affordable information and communications technology

Access to affordable information and communications technology (ICT) has contributed and will continue to contribute to Ethiopia's economic development. The availability of affordable new technologies in both urban and rural areas has increased dramatically in Ethiopia, albeit from a small base (MoFED, 2014b, NPC, 2015). To illustrate how great Ethiopia's unmet needs are, one has only to compare absolute subscription numbers to the total population size. In 2013, only 27 out of 100 people had mobile phone subscriptions, 0.8 households per 100 inhabitants had fixed telephone subscription and only 2.3 per cent of the population used the Internet. Government efforts to improve both access and quality are commendable, but given the vast geographical expanse of the country, accessibility and affordability of ICT is not a challenge to be underestimated.

The Ethiopian Government is well aware that telecommunications is one of the prime support services needed for rapid growth and the modernization of various sectors of the economy. It has become especially important in recent years because of the enormous growth of information technology and its significant potential for developing partnerships through communication. Pursuant to this government objective, Ethio-telecom has set ambitious targets in customer acquisition, customer satisfaction and the provision of quality services.

With the completion of the Next Generation Network (NGN) project, customers could gain access to services without going to service centres. Most of the automation projects–Enterprise Resource Planning (ERP), the National Network Operations Centre (NNOC), Call Centre and Billing–also became operational. According to an interview with telecommunication experts, the Telecom Expansion Programme (TEP) and the 3G network were expanded to all regional capitals with 4G services available in selected areas of Addis Ababa. The 2012/13 Annual Progress Report on the GTP (MoFED, 2014b) indicated that in 2013 and 2014, poor service and network quality were the major challenges facing the sector; however, recent information shows that the quality of services has improved and network capacity and coverage have expanded.

Figure 4.8.4: Trends in Internet, mobile and fixed line subscribers



Source: Ethio-telecommunication administrative data.

In 2000, there were only 2,500 Internet subscribers. The number had increased to a still relatively modest 129,000 in 2010. After 2010, the number of Internet and data subscribers increased sharply, so that by 2014 there were 7.8 million Internet subscribers. The capacity of the international link in gigabytes per second (GB/s) increased from 3.3 GB/s to 20 GB/s in the same period, showing the improved capacity of the country to increase the Internet service coverage (Table 4.8.7). Mobile service connections have also increased dramatically: whereas in 2000 there were 18,000 mobile subscribers, in 2014 the number of mobile users increased to 30.5 million, which is four times the number of Internet subscribers. The number of fixed line subscribers rose from 284,000 in 2000, to 912,000 in 2005 and 820,000 in 2014, suggesting that fixed line service expansion has stagnated in recent years due to competition from mobile and Internet services.

As a result of the expansion of telecommunication services including Internet, and mobile, fixed line and wireless telephones, mobile, telephone and Internet service coverage has increased substantially (Table 4.8.7). For example, mobile service coverage increased from 8 per cent in 2010 to 40 per cent 2015 while fixed line telephone density increased from 1.36 per cent in 2010 to 3 per cent in 2015. Similarly mobile service coverage increased from 50 per cent in 2010 to 90 per cent in 2015. People in rural areas are the prime beneficiaries of this expansion of telecommunications coverage. In 2010 rural telecom access within a 5 km radius was 62 per cent and it became 100 per cent in 2015 (MoFED, 2014b; NPC, 2015).

Table 4.8.6: Trends in Internet, mobile and fixed line subscribers, 1999/2000-2013/14

	Baseline	Target 2015	1999/2000	2005/06	2010/11	2011/12	2012/13	2013/14
Net flow of ODA (US$ million)	..	..	1,083	2,299	3,509	3,284	3,825	..
Number of mobile subscribers ('000)	18	..	18	889	10,700	23,757	28,308	30,487
Number of Internet subscribers ('000)	2.5	..	2.5	26	129	4,350	6,168	7,767
Number of fixed line subscribers ('000)	912	..	..	912	854	790	813	820

Sources: OECD, 2015; Ethio Telecom (administrative records); MoFED 2014b.

Table 4.8.7: Trends in mobile, fixed line, wireless telephone and Internet coverage, 2010-2015 (% unless otherwise stated)

	2010	2011	2012	2013	2014	2015
Mobile coverage	8.7	12.85	20.4	27.6	32.16	45
Fixed line density	1.36	1.03	0.95	0.9	0.92	3.4
Wireless telephone service coverage	50.0		64	73	73	90
Rural telecom access within 5 km radius	62.14		74	84	96	100
Capacity of international link (GB/s)	3.3	5.4	6.5	8.7	12.3	20.0

Source: MoFED, 2014b; MoFED, 2010.

Table 4.8.8: Regional distribution of rural connectivity, SchoolNet and WoredaNet, 2014

Region	Rural connectivity (No. of kebeles)	SchoolNet (No. of schools)	WoredaNet (No. of woredas)
Tigray	1,112	23	2
Amhara	3,325	71	28
Oromiya	6,369	104	59
Afar	287	7	8
SNNP	3,837	142	23
Harari	18	2	..
Somali	503	23	42
Gambella	81	18	..
Benishangul-Gumuz	461	2	11
Addis Ababa	-	5	-
Dire Dawa	36	7	–
Total	16,029	404	173

Source: Ethio Telecom administrative data/records.

Since 2010, the Ethiopian Government has worked to connect rural *kebeles* so as to facilitate interaction among people and development activities. By 2014 about 16,000 *kebeles* were connected to telephone lines (Table 4.8.8). The largest number of *kebeles* connected to ICT are in Oromia Region (6,369) followed by SNNP (3,837), Amhara (3,325) and Tigray (1,112). Hariri has the lowest number of *kebeles* connected (18), as it is largely urban, small in size and already well connected to mobile and Internet services. The regions with the next lowest number of connected *kebeles* are Gambella (81), Somali (503) and Benishangul-Gumuz (461). WoredaNet is a government network connecting more than 611 *woredas* through terrestrial and satellite-based networks. Similarly, about 404 schools are also connected to SchoolNet, which will eventually help facilitate teaching and learning, and thus improve the quality of education.

Overall there is very high unevenness among regions in terms of rural connectivity, WoredaNet and SchoolNet. To provide people with equal opportunities to communicate and broaden their networks, additional efforts will be needed.

Drivers of Progress on MDGs, Challenges and Unfinished Business

5.1. Drivers of Progress on MDGs

5.1.1. Drivers of Progress on MDG 1

One of the main reasons for the observed decline in poverty, stunting and unemployment is the economic growth that comes from the growth of the agriculture, services and industrial sectors as well as the social protection programme known as the Productive Safety Net Programme. As almost 99 per cent of the people in rural areas are endowed with land, increased agricultural production benefits both the rural poor and non-poor. The aggregate production of all grain, cereal and oil crops is given in Figure 5.1.1. Between 2004 and 2014, crop production increased by 143 per cent. The production of grain (all crops) increased from 103.6 million quintals in 2004 to 251 million quintals in 2014, indicating average growth rate 14.3 per cent per year. When this growth is disaggregated into cereals, legumes and oil crops, the average growth rate per year for each of these crops over the 10-year period was 14 per cent for cereals, 17.6 per cent for legumes and 12.7 per cent for oil crops. Cereals production increased from 62 million quintals in 1995 to 216 million quintals in 2014. The volume of legume and oil crop produced was 7.7 and 1.2 million quintals respectively in 1995, 10.4 million quintals and 3.1 million quintals respectively in 2004, and 28.6 and 7.1 million quintals respectively in 2014.

These increases in crop production come from increasing the land area under cultivation, but substantially from increases in yields (in the productivity of land). While the area of land used for grain production increased by 4.3 per cent per year between 2004 and 2014 (Figure 5.1.2), the increase in grain productivity was 7 per cent per year over the same period. The productivity of grain was 12 quintals per hectare in 2004 and 20.3 quintals per hectare in 2014 (Figure 5.1.4).

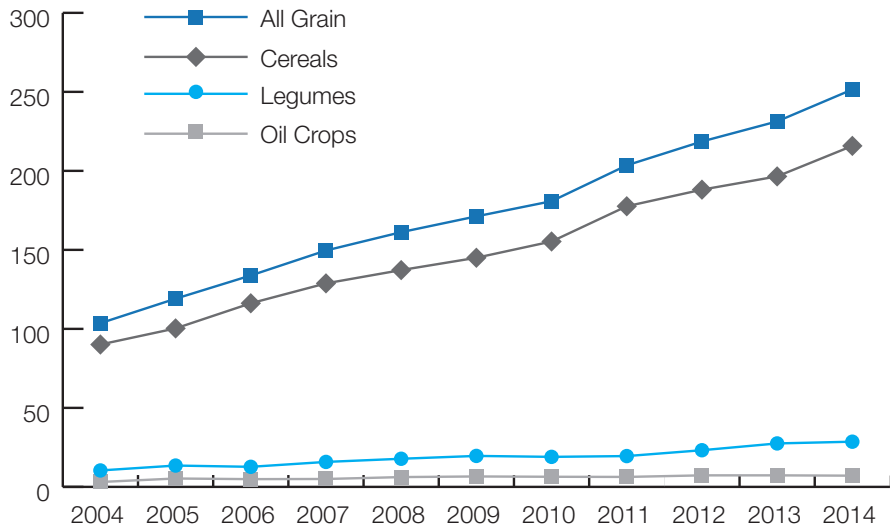
Productivity increases in grain production come from the use of improved agricultural practices, including the intensive use of fertilizers and improved varieties. As shown in Figure 5.1.5, fertilizer consumption and use of improved seeds in Ethiopia grew rapidly between 2004 and 2014. Fertilizer consumption in Ethiopia increased from 246,700 tons in 1995 to 322,900 tons in 2004 and to 858,800 tons in 2014, and showed an annual growth rate of 16.6 per cent between 2004 and 2014. The use of improved seeds increased from 145,400 quintals in 1995 to 216,600 quintals in 2014 and 2.72 million quintals in 2014, and grew at an annual average growth rate of 116 per cent per year between the 2004 and 2014.

Annex 2 shows trends in the production of animal products such as milk, beef, mutton, goat meat, honey and eggs. Cow milk production rose from 2.4 billion litres in 2004 to 3.8 billion litres in 2013, an increase of 19 per cent between those two years, and meat production (beef, mutton, and goat meat) increased from 407,000 tons in 2004 to 629,420 tons in 2014 (an increase of 55 per cent over the 10-year period).

In Ethiopia, the Productive Safety Net Programme (PSNP) was introduced in 2005. It was aimed at ensuring food security and covered about 8 million people in 262 chronically food-insecure *woredas* (districts). It responded not only to chronic food insecurity among Ethiopia's poor, but also to shorter-term shocks, mainly droughts. After 2008, the PSNP was complemented by the Other Food Security Programmes (OFSP) and the Household Asset Building Programme (HABP). An impact assessment made by IFPRI (Berhane and others, 2011) showed that the PSNP has improved household food security by 1.05 months, while beneficiaries of all three programmes (HABP, OFSP and PSNP) had their food security improved by 1.53 months; crop production and holdings of livestock units increased; the number of children's meals increased by 0.15 in the lean season. For recipients of the PSNP, access to the OFSP/HABP increased the likelihood of fertilizer use by nearly 20 per cent, and that of investing in stone terracing by 13 per cent. Overall, the study found that there were

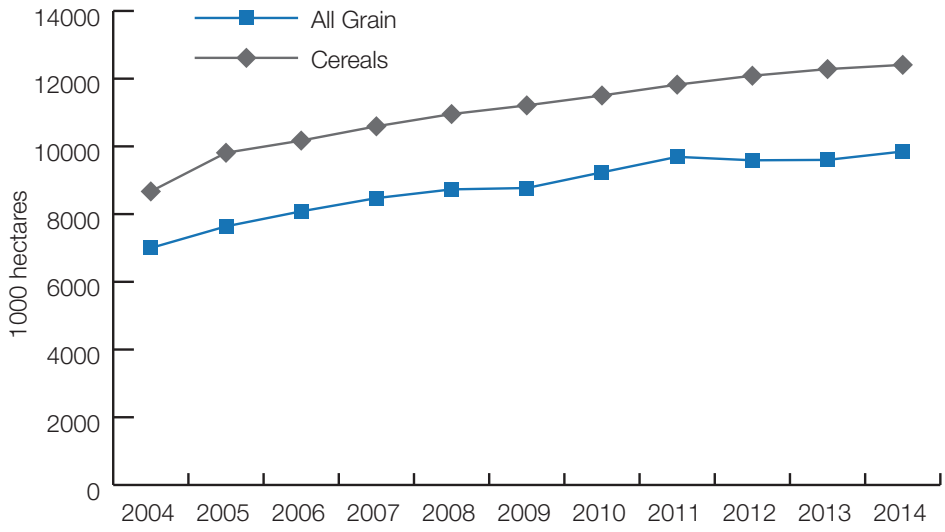
significant improvements in household assets, incomes, food production and nutrition as a result of these food security programmes. A World Bank study (Woldehanna, Tsehaye and Hill, 2014) indicated that PSNP was able to reduce the national incidence of poverty by 2 per cent in 2010/11. Given the popularity of the programme, the reduction of poverty by 2 per cent due to the PSNP is very small, perhaps because the amount of resources devoted to the programme was relatively small compared with many of the Latin American countries where it had been introduced <correct as edited?>.

Figure 5.1.1: Trends in the production of crops in Ethiopia, 2004-2014 (million quintals)



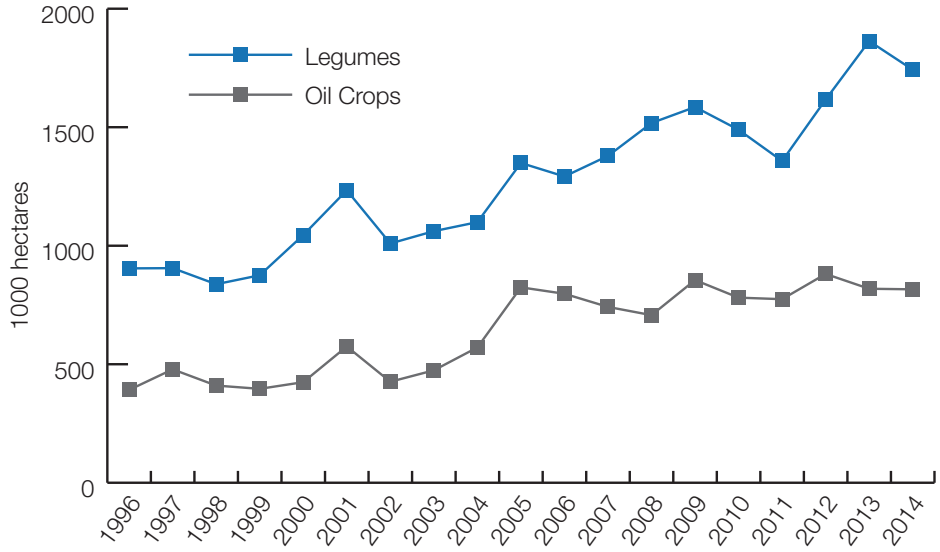
Source: CSA, 2004-2014

Figure 5.1.2: Trends in area used for production of all grains and cereals, 2004-2014 (hectares)



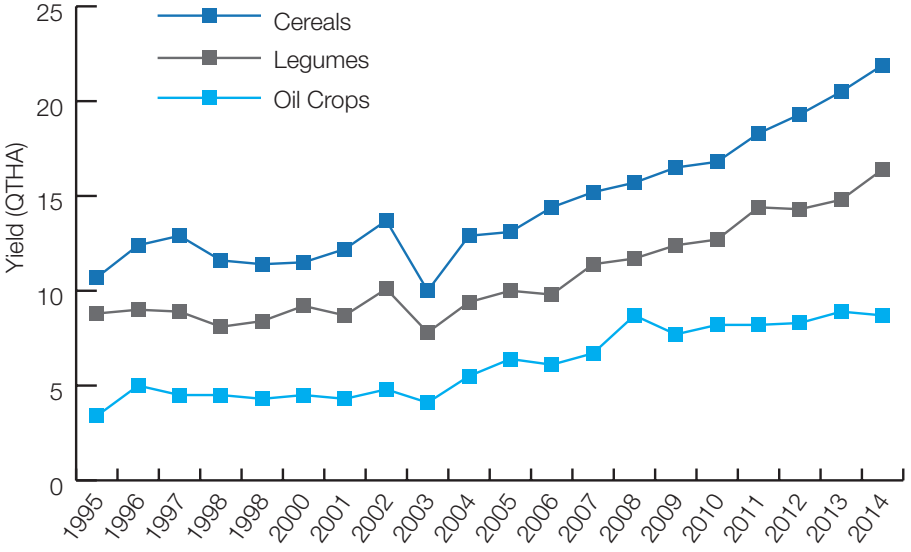
Source: CSA, 2004-2014.

Figure 5.1.3: Trends in area used for production of legumes and oil crops, 1995-2014 (hectares)



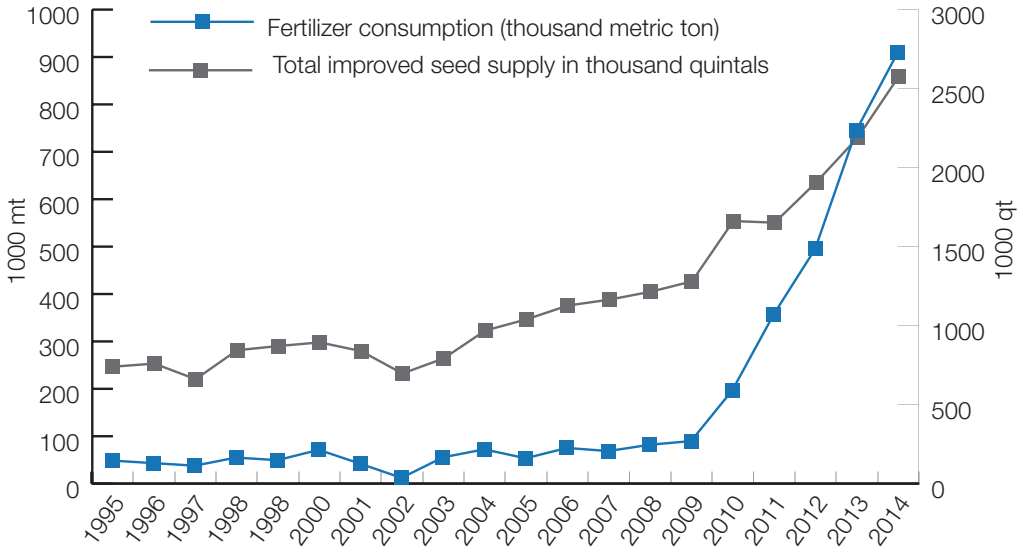
Source: CSA, 2004-2014.

Figure 5.1.4: Trends in crop productivity, 1995-2014 (quintals per hectare)



Source: CSA, 2004-2014.

Figure 5.1.5. Trends in fertilizer consumption and use of improved seeds, 1995-2014



Source: CSA, 2004-2014.

5.1.2. Drivers of Progress on MDGs 2 and 3

The main drivers for the progress achieved in meeting MDG 2 are: (1) the sustained effort made by the Government to reduce poverty and expand the public education system, as evidenced by substantial increases in national expenditure on education and extensive external financial support to the sector; (2) improved planning and implementation capacity of the Government and the education sector at all levels of administration; (3) decentralization of authority, granting autonomy to regional and local government, not only for the provision of educational services but also of other economic and social services; and (4) the participation of communities in expanding access to education across the country.

Ethiopia issued an Education and Training Policy in 1996, which was followed by the formulation Education Sector Development Programme (ESDP). The Government made large allocations for education, but it also devoted resources to other pro-poor (poverty reducing) sectors such as agriculture, health, roads and water sectors, so as to implement ESDP. The Government's effort was supplemented by partnership with donors, which invested heavily in improving access to education.

School fees were abolished and public expenditure was increased in order to finance school construction and maintenance and the hiring and training of new teachers, administrators and officials. This investment has been complemented by adoption of children's mother tongue as the medium of instruction and by the gradual decentralization of the education system to lower administrative levels. This has probably contributed to improved education service delivery in the country.

Improvements in access to education in the rural, pastoral regions of Afar and Somali and the disadvantaged regions of Gambella and Benishangul-Gumuz have helped narrow the gender gap and disparities in access to education, and have benefited the poorest. While traditionally, boys were more likely to attend school and less likely to drop out, over time girls' enrolment has increased more rapidly than that of boys. A number of initiatives have been implemented to close the gender gap in primary education

enrolment including (1) encouraging women's employment in the civil service; (2) promoting gender-sensitive teaching methods; (3) increasing the minimum age at first marriage to 18 years; and (4) promoting alternative basic education for out-of-school children in remote areas and adult literacy programmes. As a result, the gender gap has been narrowing and enrolment among the poorest quintile has increased.

Donors have played a key role in expanding access to education through effective partnership with government and the provision of support to Ethiopia's education reforms by providing substantial amounts of aid and financing, for, among other things, the Teacher's Development Programme (TDP), the Education Management Information System (EMIS) and the General Education Quality Improvement Programme (GEQIP). Cognizant of the fact that access to education has expanded without matching finance and activities targeted at improving the quality of education, donors and the Government jointly developed and implemented two phases of the quality improvement programme in general education known as General Education Quality Improvement program (GEQIP) (MoE 2008; MoE, 2012a; MoE, 2013b. GEQIP's support to the education sector rested on the following five pillars: (1) curriculum, textbooks, assessment, examinations and inspection (CTA), (2) the Teacher Development Programme (TDP), including the English Language Quality Improvement Programme (ELQIP), (3) the School Improvement Programme (SIP), including school grants, (4) the Management and Administration Programme (MAP), including Education Management Information Systems (EMIS), and (5) programme coordination, monitoring, and evaluation, including communication activities.

The first phase of GEQIP ran from 2008 to 2012; Phase 2 started in 2012 and is expected to run until 2015. In Phase 2 of GEQIP, a new pillar was added on Information and Communication Technology (ICT) in order to provide a foundation for equitable, quality learning and teaching in secondary schools with tailored interventions for isolated and poorer communities in emerging regions. Based on the GEQIP assessment study (MoE, 2013b), GEQIP Phase 2 has an additional focus, involving giving attention to interventions for (1) regions, communities and groups that lag behind in access and equity compared with the national average; (2) children with special needs who have limited access to the education system; (3) drop-outs and pupils repeating grades in school improvement programmes, and teacher and leadership training; and (4) gender equity across the whole of the programme that goes beyond gender parity in enrolment to gender equality in access to educational resources, participation in learning and teaching opportunities and in the application of school rules and regulations.

5.1.3. Drivers of progress on the Health MDGs (MDGs 4, 5 and 6)

Many factors have contributed to the improved health of Ethiopians and the achievement of the health MDGs (MDGs 4, 5 and 6). Government leadership has played a key role in improving the performance of health sector in Ethiopia, by mobilizing and effectively using resources from both the domestic and external sources. The Government initiated health sector reforms in 1993, with the preparation of health sector policies, strategies and programmes, which were integrated with initiatives in other sectors, such as education, water and sanitation, and poverty reduction (WHO, 2014c), and starting from 1997, successive Health Sector Development Programmes (HSDPs) were designed, with clear priorities and direction, and implemented. HSDPs prioritized maternal health, child health, HIV/AIDS, malaria, tuberculosis and nutrition—all of which are central to the achievement of MDGs 4, 5 and 6. Government commitment was matched by development partners' commitment. The contribution of health development partners under the leadership of the Government is also credited for the successes achieved on the health front

(WHO, 2014c). A central feature of the strategy for the sector has been the priority given to the Health Extension Programme, which emphasized preventive aspects of health than the curative aspects. This has enabled the delivery of cost-effective basic services that enhance equity and provide care to millions of women, men and children. According to the MoH note, cited in MoFED (2013c), the performance of Ethiopia in ensuring cost effective use of resources provided development partners with the incentive to finance health sector activities.

Heavy public expenditure on health has contributed to the achievements observed in the sector. General Government expenditure on health as a percentage of total government expenditure increased from 5.9 per cent to 11.1 per cent between 1995 and 2012 (WHO, 2014b). Donor support constitutes a significant share of total expenditure on the health sector. WHO (2014b) shows that external resources for health as a percentage of total expenditure increased from 12.7 per cent in 1995 to 50.3 per cent in 2012. As a result, per capita total expenditure on health (at PPP) increased from US$11.11 to US$43.65 during the same period. The public expenditure on the health sector has increased substantially since 2002 when the first generation of the Poverty Reduction Strategy Programme (PRSP)—the Sustainable Development and Poverty Reduction Programme (SDPRP)—was launched. MoFED (2013c) notes that for most of the decade of the 2000s, the largest source of funding to the health sector were international development partners. According to MoFED (2013c), the ODA delivery mechanism, the Protection of Basic Services (PBS) programme, has made very high budget allocations for the health sector at all levels, that is, at federal, regional and *woreda* levels. Funding from the PBS to health sector complements the domestic revenue allocated to the health sector (either through federal allocations to the Ministry of Health or through allocations to regional health bureaus) and have significantly contributed to the expansion of basic health services and the generally positive trends observed in the sector. Though the PBS mechanism has made significant contributions, capacity challenges prevented the full utilization of available resources. For example, due to the low level of capacity in the Ministry of Health in procurement of health commodities, and the institutional capacity constraints of regional health bureaus, only 50 per cent of the health component of the PBS budget was used until 2012 (MoFED, 2013c, p. 23). From 2010 to 2013, of the total budget of US$65 million allocated, only US$54 million was utilized (MoFED, 2013c, p.22). A huge and rapid increase in the number of health facilities and health workers contributed greatly to improvements in health outcomes. In addition, a conscious decision was made to prioritize improved access to basic services in the country. There was a significant infrastructure building programme between 2005 and 2011 which concentrated on rural health facilities. Consequently, over 10,000 health posts, 2,000 health centres and 73 hospitals were constructed during this period. Expansion of other infrastructure also contributed to the improvement in health sector performance by increasing access to health facilities. As a result, between 2005 and 2011, the availability of primary health care units increased from 20 per cent to 100 per cent for health posts and from 18 per cent to 100 per cent for health centres (MoH, 2014.

To provide adequate human personnel for the health facilities, training centres for health workers have expanded greatly since 2004, resulting in significant increases in the number of health workers. The Government has trained and hired health extension workers (HEWs). The number of midwives trained and hired also increased rapidly, the number hired doubling between 2007 and 2010.

Strong social mobilization has also contributed to the achievement of the health MDGs. The health system has focused on primary health care in association with the health extension

programme, which was complemented by the use of the Health Development Army (HDA), also called the Women's Development Army (WDA) . HDAs (groups of volunteer women with 30 members in each group) contributed to the increased utilization of family planning services, improvements in maternal health (by encouraging pregnant women to receive antenatal care (ANC), encouraging expectant mothers to deliver in health facilities, child health, monitoring and regularly reporting the health of the population to health extension workers, and facilitating better access to health information. More than eight million women were expected to participate in the WDA (WHO, 2014c).

5.2. Challenges

Despite good progress in achieving many of the MDG targets, there are challenges, in particular in addressing the fact that certain groups have been left behind and even unable to meet some of the MDGs, such as Goals 3 and 5. Though it was possible to reduce poverty and eradicate hunger as a result of increases in the rate of economic growth and in agricultural production, challenges still remain. There are still about 22.6 million people living in absolute poverty, poverty severity has not declined as expected, and malnutrition is still high. About 40 per cent of the Ethiopian children below the age of five are stunted. Though grain production has increased over the last 15 years, production of livestock products such as milk, meat, and egg is not high. Moreover, the consumption of food is largely dominated by cereals, making the consumption of micronutrient rich food, which are essential for better nutritional outcomes, very low— and thus increasing susceptibility to malnutrition. Consumption of animal protein, vegetables and fruits, which are rich in micronutrient, is very low. The Ethiopian household consumption expenditure survey conducted by CSA and subsequent analysis of it indicate that cereals accounted for the largest share of calories consumed by both urban and rural populations (48 per cent in urban areas and 60 per cent in rural areas) (MoFED, 2013a). Potatoes, tubers and stems also had a significant role in rural diets accounting for 15 per cent of calorie intake compared with 4 per cent in urban areas. Oils and fats (including oil seeds) contributed 4.5 per cent of total calorie intake, and fruit and vegetables contributed just 2.2 per cent. Animal source foods such as meat, fish, milk, cheese and eggs combined contributed only 1.7 per cent of total calorie intake, indicating that micronutrient consumption in Ethiopia is extremely small. The low production of animal products coupled with low consumption of animal sourced food explains the very high level of stunting in the country.

The Ethiopian Nutrition Survey conducted in 2010 by the Ethiopian Health and Nutrition Research Institute (EHNRI, 2009/10) showed that among children of 6-23 months of age and still breastfeeding, 29 per cent had consumed a minimum of four different food groups in the 24 hours previous to survey, compared with 38 per cent for non-breast feeding children. Moreover, the survey showed that 75 per cent of children between 6 and 23 months of age and still breastfeeding received the minimum number of meals (two per day) while 59 per cent of non-breastfed children did so, indicating the consumption of the recommended number of food groups (a well-diversified diet) is very low. This will result in reduced resistance to disease, low absorption of food into body and low cognitive development.

The high level of stunting is directly or indirectly related to morbidity, mortality, school repetition, children dropping out from school and the reduced physical capacity of children to study. The high level of stunting may also contribute to the high cost of health services in Ethiopia. A UNICEF study (UNICEF, 2012 estimated the additional cases of morbidity, mortality, school repetition, school dropouts and reduced physical capacity that can be directly associated to a person's undernutrition status before the age of five. It estimated that about Br55.5 billion was lost in the year 2009 as a result of child

undernutrition, which was equivalent to 16.5 per cent of GDP (UNICEF, 2012).

Unemployment has declined over time, but in 2014 the level of urban unemployment was still very high at 17.4 per cent. Urban unemployment is higher among the youth and women than among the general population. It was 24.1 per cent for females and 22.8 per cent for youth. Despite the urban boom and extensive construction activities in urban areas, the cities cannot provide employment for the people who migrate to them, unless there is significant expansion of job opportunities. To achieve this the development of the private sector can make an important contribution.

As the above analysis shows, there has been good progress towards the target of achieving universal primary education, but challenges remain in narrowing rural-urban and regional differences in enrolment, dropping out from primary and secondary education, repetition and low reading, mathematics and other subject matter competencies at all levels of schooling. The number of children dropping out and repeating grades is high and has been increasing over time resulting into low primary and secondary school completion rates. The following factors may contribute to the high number of dropouts: (1) children being forced to work in order to support their families; (2) the illness of parents and family members, (3) long distances from school (NPC, 2015), which specially discourages girls from going to school (4) low parental education, and (5) shortage of money to cover school expenses. Discussion with the experts from the Ministry of Education confirms that when children reached the 2nd cycle of primary education, they are often needed for work at home to support their families and this results in children dropping out. Grade repetition was 4.9 per cent in 2010 and increased to 8.4 in 2014, showing the severity of the problem and the need to focus on such wastage during the post-MDGs era.

As indicated in the analysis, MDG 3 on promoting gender equality and empowering women is not likely to be achieved. There were tangible results recorded in ensuring gender equality in education. Various policies and strategies were implemented to ensure gender equality in all spheres of life, and the participation of women in political, social and economic spheres has increased meaningfully, the number of women in the national parliament passing the critical mass of 30 per cent . However, challenges remain in moving beyond token participation for women, and ensuring that it becomes meaningful. It is important to work on improving the quality of participation and addressing barriers (social, cultural, economic, legal and political) that impede women from achieving their potential.

Though Ethiopia has achieved the MDG target of reducing child mortality three years ahead of deadline, there are still challenges that limit progress in child health and reducing maternal mortality. The Ministry of Health's 2013/14 Annual Progress Report indicated that the immunization services faced some challenges including (1) the lack of daily vaccination services at health posts, (2) weak linkages between health posts and health clinics, (3) the high number of unvaccinated children and the high dropout rate, (4) the lack of automatic generators in areas with frequent power interruptions, and (5) inadequate access to health services.

Concerning child health services, immunization coverage has improved and child mortality had declined by two-thirds between 2000 and 2014. Good progress has also been recorded in improving nutrition. The National Nutrition Programme is using multisector partnerships to tackle undernutrition through such mechanisms as social protection, food security, community nutrition programmes, micronutrient supplementation, the treatment of severe acute malnutrition and a package of free health services. However, challenges still remain in the areas of maternal and neonatal mortality rates. It is worth noting that the first 28 days of life–he neonatal period–represent

the most vulnerable time for a child's survival, highlighting the crucial need for health interventions that specifically address the major causes of neonatal deaths. There is low coverage of skilled delivery and newborn care.

The Ministry of Health (2014) outlines some of the challenges associated with improving maternal health and reducing maternal mortality. There is a shortage of midwives, doctors and anaesthetists for provision of delivery services. The shortage is particularly chronic in pastoral areas where the turnover of staff is high in the health sector and there is low coverage of maternal health services. There is a 24-hour service seven days a week in most health facilities, especially in health clinics. These facilities, however, do not provide complete services. For example, a separate newborn corner and neonatal unit is not available in some health facilities. The supply of water and electricity at health posts and health clinics is inadequate. Health extension workers and professionals are not equipped with adequate skills. Harmful traditional beliefs and practices continue to militate against improvement in maternal health outcomes. Moreover there is a high dropout rate among HIV-positive pregnant women taking antiretroviral therapy (ART) and access to services for early infant diagnosis of HIV is limited, which makes the fight against HIV a challenging task.

Therefore, targeted interventions which are currently under way, including the development of community-based newborn care, implementation of integrated community case management of common childhood illnesses, and the establishment of newborn corners in health clinics, neonatal units in regional hospitals, and neonatal intensive care units in tertiary hospitals, have to be strengthened.

Ethiopia managed to increase its forest cover from 11.8 per cent in 2005 to 15 per cent in 2014. However, the sector has still limitations and challenges. To start with, the shortage of reliable data is big challenge. Monitoring of progress made on ensuring environmental sustainability (Goal 7) has been hampered by lack of data. Despite this, over the long term there has been a noticeable decline in forest cover. . One of the challenges is that people cut trees illegally and there is low capacity of in the regional bureaus (technical, as well as logistical) in taking legal steps against people who illegally cut trees in protected forests. Ethiopia has a huge population growing at a rate of 2.7 per cent per annum, one outcome of which is the clearing of vegetation for agriculture and commercial logging. Once trees are cut, rejuvenation takes time, especially in drought-prone areas. Therefore, it is important that appropriate action be taken by all stakeholders to ensure progress in expanding forest cover. As the focus of the post-2015 development agenda becomes sustainable development, the negative effects of climate change become observable, and the UN adopts the SDGs, protection of the environment should receive greater attention.

Ethiopia has achieved the MDG target for access to safe drinking water and is on track to achieve the MDG target for improved sanitation facilities. However, there is huge gap between rural and urban areas in access to improved sanitation facilities and safe drinking water, and more than half of the population do not have access to improved sanitation facilities and safe drinking water. Access to safe drinking water declined in certain regions because of ageing infrastructure. Therefore, the target is unlikely to be reached in the near future, and much effort is needed by the Government to increase the access of rural people to these two facilities.

Net ODA has increased over time, but the World Bank has projected that debt to export ratio will rise in the medium term (before declining in the long term), indicating that close monitoring of borrowing by public enterprises will remain a necessity in the medium term. Despite Ethiopia's interest in joining the WTO, it has yet to become a member. The studies that Ethiopia is conducting to assess the possible negative

and positive impacts of joining the WTO are not completed. Therefore, Ethiopia needs to give more attention to finalizing these studies and decide on whether to join the WTO.

Ensuring equity remains big challenge, which needs to be addressed in the global agenda that succeeds the MDGs. As the analysis of Ethiopia's progress on the MDGs has shown, there has been significant and observable inequities (regional, gender, and urban/rural) in the realization of all the goals, including disparities in the provision of services between urban and rural areas (with rural areas consistently lagging behind urban areas), and gender inequality, particularly in education, labour force participation, political participation and vulnerability to HIV/AIDs.

5.3. Unfinished Business

Though poverty has declined in all regions for both male and female headed households and for both rural and urban areas, there are still about 22.6 million poor people who live below the poverty line (set at PPP US$1.25 a day. There are still inequalities in the level of poverty between rural and urban areas and among regions. Reducing these inequalities and reducing the number of poor people require further reduction of poverty and poverty severity in general. Hence the reduction of poverty severity in general and poverty in rural, pastoral (Afar, Somali) and other disadvantaged regions in particular should remain high on the post-2015 development agenda.

Unemployment has declined over the last 15 years, but the level of urban unemployment is still very high, at an estimated 17 per cent in 2014. The gaps in the rates of unemployment between adults and youth and between males and females are very high. Therefore, efforts to achieve the target of meeting full and productive employment and decent work for all must be stepped up during the post-2015 era. Hence the further reduction of urban unemployment, and the elimination of disparities in unemployment between male and female and between youth and adult should be a primary task of the Ethiopian Government post 2015. Given that the private sector is major creator of employment opportunities, producing favourable conditions for private sector investment will not only generate job opportunities but will also contribute to the structural transformation that the country aims to achieve in the post-2015 period.

Notable progress was made in reducing undernourishment in Ethiopia, as evidenced by the country's ability to achieve target 1.C. This, however, does not mean that food insecurity is no longer a problem. As the FAO, IFAD and WFP (2015) have shown, 32 per cent of the population (about 32 million people) are still undernourished. This is, by any measure, a significant number of people, and requires unreserved attention during the post-MDGs era. Eradication of food insecurity thus remains a high priority, although it is not an easy task and will require strengthened partnership among all development partners. Besides, food security is not only about providing access to the recommended number of calories; it also demands that food quality and the economic and social costs incurred to obtain food be addressed (FAO, IFAD and WFP, 2015).

Ethiopia has succeeded in increasing the net enrolment of children in school and now provides universal primary education. However, the education sector is suffering from low quality of education, high levels of grade repetition and drop outs, poor reading, mathematics and subject matter competencies, and low completion of primary education. Therefore raising the quality of education, reducing grade repetition and the number of dropouts, and improving children's achievement in reading, mathematics and other subjects remain pertinent agenda items during the post-MDGs period.

Ethiopia has exerted substantial effort to eliminate gender disparities in primary and secondary education. Many of these inequalities have been narrowing. However, what has been achieved is far from adequate.

The gender parity index (GPI) has remained at 0.94 for the past few years. As indicated previously, several factors are responsible for this. They include: early marriage, violence against girls, abduction, household chores, parents' lack of awareness about the benefits of education, and the absence of gender sensitive facilities in schools. Therefore elimination of gender disparities will remain as valid during the post-2015 era as it was during the MDGs period.

Improvements were observed in the provision of health services for pregnant women, infants, children and mothers. The prevalence of HIV/AIDS has been reduced substantially and has fallen below the MDG target. However infant mortality is still very high and child mortality needs to be further reduced. To realize this, the utilization of skilled care needs to be further enhanced. The quality of emergency obstetric and newborn care needs to be improved. Infrastructure problems need to be solved. As indicated in the section on trend analysis (Section 4.5), the target for maternal mortality has not yet been achieved. Access to information on reproductive health services needs improving. Similarly, there is room for improvement in the control and prevention of tuberculosis and malaria. Non-communicable diseases are increasingly becoming a heavy burden to the society and need to be prioritized. Therefore, further improvements in the provision of antenatal care services, immunization against measles, full immunization coverage, and skilled birth attendance services must be provided so as to further reduce child mortality and significantly cut the unacceptably high level of maternal mortality rate across all regions and locations.

Ethiopia has made excellent progress in integrating the principles of sustainable development into its policies by fostering the development of the climate-resilient green economy. As a result of intensive soil and water conservation and afforestation and rehabilitation programmes, Ethiopia has managed to reverse the loss environmental resources and increase forest cover from 11.8 per cent in 2005 to 15 per cent in 2014. Despite this achievement, the extent of the forest cover needs to be improved so as to address the effects of climate change. Increasing the area covered by forest and further consolidating the integration of sustainable development into the country's current and future development plans such as GTP II will remain crucial during the post-MDGs period. Protecting the environment is not about forests alone. Mainstreaming the climate-resilient green economy strategy across all sectors is essential for the country to achieve its vision of becoming middle income country by 2025 through the adoption of a climate-resilient and green growth strategy. The country's development plan should therefore take note of this fact and mainstream (integrate) the principle of sustainable development into the plan (GTP II).

Though progress towards achieving the MDG targets on access to safe water and sanitation facilities is on track, there are still large rural/urban disparities and there are regions which fall below the national average. Ethiopia has achieved the target for safe drinking water. However, 43 per cent of the population are still not using safe drinking water, which means progress that the country achieved in reducing child mortality could be derailed if access to safe drinking water and sanitation is not expanded to cover all households (people) irrespective of where they live and who they are. Existing infrastructure needs to be in good working order. Otherwise the gains recorded could be reversed. For example, access to safe drinking water has declined over the last few years because of ageing infrastructure. Therefore, improving access to safe water and sanitation facilities and expanding these services in rural areas so as to close the gap between rural and urban areas during the post-2015 era should be a priority.

With regard to the development of a global partnership for development, Ethiopia has showed that it is a global leader in this field as recently as July 2015 when it hosted the

3rd International Conference on Financing for Development. ODA per capita increased from US$10.4 in 2001 to US$40.7 in 2013, while ODA as a percentage of GNI increased from 13.7 per cent in 2001 to 18.5 per cent in 2004, before declining to 8.2 per cent in 2013, demonstrating Ethiopia's increased reliance on other sources of financing. Of the total ODA, 77 per cent was in the form of grants (on average over the 14 years 2000-2013) and 23 per cent were loans. Ethiopia's long road to WTO accession means that it has yet to fully benefit from the multilateral trading system. On the other hand, it benefits from regional preferential trade and preferential access the US and EU markets. Ethiopia's implementation of its new trade logistics strategy will help make its goods more competitive and thus better able to exploit the market access available to it. The IMF's most recent assessment of Ethiopia's public debt sustainability suggests it is moving from low to moderate risk of external debt distress as it takes on more commercial loans. Efforts to expand ICT services throughout the country in the form of mobile access and Internet connectivity have been bearing fruit, albeit from a very low base: Ethiopia is still in the bottom 10 countries in the world in terms of the percentage of the population who are Internet users.

Summary and Conclusions

In conclusion Ethiopia's achievement in meeting the MDGs 1 is very encouraging. Ethiopia has already achieved the MDG targets of reducing hunger by half, achieving universal access to primary education, reducing child mortality by two-thirds and improving access to safe drinking water. Although the country is behind target in reducing maternal deaths and reducing gender disparities at all levels of education, a lot of progress has been made in reducing maternal mortality and eliminating gender disparities and empowering women. The reasons for such success are (1) prevalence of peace and security and the mobilization of people for development; (2) the formulation of appropriate policies, strategies and programmes, particularly the developing agriculture-led industrialization strategy that focuses on rural areas where more poor people are living, and the sector development programmes (education, health, roads, among others); (3) the significant allocation of resources to pro-poor sectors such as agricultural extension, health extension, the Productive Safety Net Programme and market-oriented agricultural production; (4) fiscal decentralization leading to a heavier emphasis on pro-poor budgeting; and (g) aligning policies and programmes to Poverty Reduction Strategy Paper (PRSP) and millennium development goal (MDG) initiatives such as mobilizing the domestic and international community to finance public expenditure.

Despite such remarkable achievements, there are still rural-urban, gender and regional disparities in income, poverty, stunting and underweight, and access to education, health services, improved sanitation facilities, and safe drinking water. There are about 25 million people who are below the poverty line. Eliminating such disparities and ending poverty are crucial tasks for the post-2015 agenda, if Ethiopia is to reach middle income status by 2025 and zero poverty by 2030. Ethiopia therefore needs to be able to sustain the pro-poor double digit economic growth registered over the past 10 years. To sustain economic growth at this level, the productivity of labour and land in both the agricultural and industrial sectors needs to improve and a competitive economy based on the human and technological development needs to be built. Ethiopia should strengthen its commitment to establish a green economy that is resilient to climate change in the long run. While agricultural development is still important to sustaining economic growth, creating additional employment and reducing poverty, special attention has to be given to urban development so as to transform the economy from in which agriculture is the dominant sector to one that is more heavily based on manufacturing and thereby ensure sustained economic growth and the attainment of middle income status by 2025. Private sector participation and human resource development through universal secondary education are key to making urban development viable in a way that contribute to technological development, sustainable economic growth, job creation and poverty elimination.

Macroeconomic policy must target employment creation together with price stability to reduce poverty. It is important to have the broad-based participation of men and women equally in development, through capacity-building and affirmative action. To reduce vulnerable employment, particularly for women, policies and strategies must be designed to improve productivity, income and working conditions in the informal sector, which is dominated by poor people in general and by women in particular. This action must be supplemented by the design and implementation of effective social protection programmes in order to address the needs of the vulnerable and improve the productive

capacities of the labour force. The gender gap in education and income inequalities can be closed by instituting conditional cash transfers that prioritize girls and women, and facilitate the full female participation in schools and the labour market.

In order to Improving health conditions and reduce the child and maternal mortality rate, access to antenatal care and skilled birth attendants, and the availability of contraceptives to stop or reduce the high incidence of adolescent birth rates must be facilitated. Insecticide-treated bed nets should be widely distributed to malarial areas so as to reduce the prevalence and incidence of malaria. The Government needs to ensure that ART coverage for HIV positive and TB patients is expanded and that effective TB preventive treatment for people living with HIV/AIDS be given when needed.

Ethiopia needs to maintain its global partnership for development to maintain the flow of ODA so as to finance its development projects during the post-2015 period, while keeping its export sector highly competitive and thus keep its debt sustainable. To keep ODA flowing smoothly flow into the country and participate in the international market through a viable export sector, Ethiopia should join hands with other developing countries in order to strengthen the voice and participation of developing countries in international economic decision-making. As the Ethiopian economy grows and approaches middle income status, ODA is going to decline. In preparation for this decline, Ethiopia must develop its capacity to enhance its domestic resources to finance its development. To do this, it needs to enhance its domestic revenues, expand its tax base, combat tax evasion and eliminate illicit financial flows. Moreover, to improve domestic resource mobilization, tax enforcement capabilities and the quality of information on existing and potential taxpayers should be strengthened.

Table 5.3.1: Summary of Ethiopia's achievements on the MDGs

	Goals	Status	Direction of trend
Goal 1	Eradicate extreme hunger and poverty	On track	**Upward**
Goal 2	Achieve universal primary education	On track	**Upward but slowing**
Goal 3	Promote gender equality and empower women	Off track	**Reversed**
Goal 4	Reduce child mortality	On track	**Upward trend**
Goal 5	Improve maternal health	Off track	**Slowing**
Goal 6	Combat HIV/AIDS, malaria and other diseases	On track	**Upward**
Goal 7	Ensure environmental sustainability	On tack	**Upward**
Goal 8	Develop a global partnership for development	On track	**Upward**

Legend:

Green	MDG On track
Red	MDG Off track

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Annexes

Annex 1. Prediction of poverty from 2011/12 to 2019/20

Predicting poverty using GDP per capita growth and the growth elasticity of poverty with respect to income estimated using survey data is problematic as the growth rate of consumption per capita is not equivalent to the growth rate of GDP per capita. While GDP per capita includes government expenditure, per capita expenditure measured by per adult consumption expenditure includes only part of private expenditure and does not include savings. Therefore, it might be good to calculate a GDP per capita elasticity of poverty head count index if there is a discrepancy between growth in household consumption per capita and growth in gross domestic product per capita due to savings and methodological differences in estimating macro and micro level growth. Moreover, the latest data available on consumption expenditure are for 2010/11 as consumption expenditure surveys are conducted only every five years. Using the 2004/05 and 2010/11 consumption expenditure, real consumption expenditure per adult grew by 3.4 per cent per annum while real GDP per capita grew by 8.7 per cent. This means the ratio of consumption expenditure per adult to GDP per capita growth is 0.538. Then, the growth rate of consumption expenditure per adult can be predicted from the GDP per capita estimate by multiplying GDP per capita growth estimate by 0.538. If for example, the GDP per capita growth rate is 8.7 per cent per year, per adult consumption expenditure will grow by 0.047 or by 4.7 per cent. Therefore, the rate of reduction in poverty per year with respect to the increase in per adult consumption is provided by multiplying 4.7 per cent by -1.943, which is -0.091 indicating poverty will decline by 9.1 per cent per year.

The assumptions that were used to predict per adult consumption expenditure are summarized in Table A4.1.1. An annual population growth rate of 2.4 was used from 2003 to 2008 Ethiopian calendar (2010/11-2015/16). From 2008 to 2012 (2015/16-2019/20), it was assumed that population will grow by 2.3 per cent per annum. Using the consumption expenditure and poverty estimates (for 1995/96-2010/11), the growth elasticity of poverty is estimated to be -1.94. This means poverty declines by 19.4 per cent when per adult consumption increases by 10 per cent. Using conversion factors of 0.538, the GDP per capita growth rate per annum was converted to growth rate of per capita consumption expenditure per year so as to predict poverty using the growth elasticity of poverty estimated in 2010/11. As a baseline 29.6 per cent of the Ethiopian population was absolutely poor in 2010/11. The predicted poverty figures after 2010/11 is provided below, which indicates that by the end of GTP I (2014/15), the poverty head count index reached 23.4 per cent which is half the level of poverty in 1990 (48 per cent). This indicates that Ethiopia is going to meet MDG Goal 1 (half the population below absolute poverty). By the end of the GTP II (2019/20), the level of poverty will on these assumptions reach 16.7 per cent.

a. Assumptions used to predict poverty

Description of assumptions	Assumed rates
Growth elasticity of poverty with respect to income	-1.943
Annual average consumption growth per adult between 2004/05 and 2010/11	0.0335
Annual average predicted growth rate of GDP between 2004/05 and 2010/11	0.114
Annual average predicted growth rate of GDP per capita between 2014/05 and 2010/11 (assuming population growth rate is 2.7 per cent per annum)	0.087
Ratio of consumption growth per adult to GDP per capita growth (0.0335/0.087)	0.538
Growth rate of consumption growth per adult between 2004/05 and 2010/11 (0.087 x 0.534)	0.047
Predicted reduction in poverty per year (using elasticity estimates) (0.538 x 0.087 x (-1.943)	-0.091
Annual population growth rate between 2011/12 and 2014/15 (%)	2.4
Annual population growth rate between 2015/16 and 2019/20 (%)	2.3
The actual annual average growth rate of GDP between 2003/04 and 2013/14 (%)	10.9
Projected annual average GDP growth rate after 2013/14 (%)	11.0
Inequality will remain unchanged	

Prediction of growth and poverty from 2010/11 to 2019/20

Year (E.C.)	Year (G.C)	GDP growth (%)	Pop growth	GDP per capita growth	Predicted annual average consumption growth per adult (%)[a]	Predicted rate of poverty reduction[b]	Predicted poverty[c]
2003	2010/11	11.4	2.4	9.0	3.47	-0.0673	29.6
2004	2011/12	8.6	2.4	6.2	2.39	-0.0463	28.2
2005	2012/13	9.9	2.4	7.5	2.89	-0.0561	26.6
2006	2013/14	10.4	2.4	8.0	3.08	-0.0598	25.1
2007	2014/15	11.0	2.4	8.6	3.31	-0.0643	23.4
2008	2015/16	11.0	2.3	8.7	3.35	-0.0650	21.9
2009	2016/17	11.0	2.3	8.7	3.35	-0.0650	20.5
2010	2017/18	11.0	2.3	8.7	3.35	-0.0650	19.2
2011	2018/19	11.0	2.3	8.7	3.35	-0.0650	17.9
2012	2019/20	11.0	2.3	8.7	3.35	-0.0650	16.7

[a] Using conversion rate of 0.385. b Using growth elasticity of -1.94. c Using sigmoid model.

Source: own computation from GDP and poverty figures.

b. Predicted poverty incidence at regional level

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Tigray	31.8	29.7	28.3	26.7	25.1	23.5	22.0	20.5	19.2	18.0
Afar	36.1	33.7	32.1	30.3	28.5	26.7	24.9	23.3	21.8	20.4
Amhara	30.5	28.4	27.1	25.6	24.1	22.5	21.1	19.7	18.4	17.2
Oromia	28.7	26.8	25.5	24.1	22.7	21.2	19.8	18.5	17.3	16.2
Somali	32.8	30.6	29.2	27.5	25.9	24.2	22.7	21.2	19.8	18.5
Benishangul-Gumuz	28.9	27.0	25.7	24.3	22.8	21.3	20.0	18.7	17.4	16.3
SNNP	29.6	27.6	26.3	24.9	23.4	21.9	20.4	19.1	17.9	16.7
Gambella	32.0	29.8	28.5	26.9	25.3	23.6	22.1	20.7	19.3	18.1
Harari	11.1	10.4	9.9	9.3	8.8	8.2	7.7	7.2	6.7	6.3
Addis Ababa	28.1	26.2	25.0	23.6	22.2	20.8	19.4	18.1	17.0	15.9
Dire Dawa	28.3	26.4	25.2	23.8	22.3	20.9	19.5	18.3	17.1	16.0

Annex 2: Trends in output of livestock products, 2004-2014

Year	Cow milk (million litres)	Cattle meat ('000 tons)	Sheep mutton ('000 tons)	Goat meat ('000 tons)	Camel meat ('000 tons)	Camel milk (million litres)	Honey (million kg)	Eggs (million)
2004	2431.15	293.39	66.30	47.31	4.45	217.49	25.19	63.52
2005	2138.98	298.37	72.30	50.82	4.33	109.68	30.38	102.78
2006	2321.14	310.93	82.94	55.97	4.14	95.79	41.58	67.46
2007	2634.12	332.06	94.53	63.47	5.82	114.18	51.25	81.66
2008	3221.65	366.29	104.47	74.25	9.54	249.93	42.18	75.28
2009	2764.80	379.59	100.07	74.84	7.18	162.13	39.66	79.09
2010	2940.22	391.81	103.92	75.11	7.63	150.32	41.52	78.07
2011	4058.00	411.04	102.04	77.93	10.42	262.82	53.68	98.30
2012	3329.85	401.39	96.89	77.34	9.25	176.40	39.89	94.68
2013	3804.99	415.72	101.96	82.29	8.65	165.12	45.91	93.13
2014	2903.25	423.71	109.39	96.32	10.38	230.51	43.80	100.84
Growth rate (2004-2014) (%)	19.4	44.4	65.0	103.6	133.1	6.0	73.9	58.7

Source: CSA Livestock Production Surveys, 2004-2014.


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