

Country Case Study: Ethiopia

Country case study prepared for the
***Center for Global Development Working Group on UNFPA's
Leadership Transition***

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* The content of this paper is the responsibility of the author and may not represent the views of the Center for Global Development.

Foreword

In August 2010—three months before a new executive director of the United Nations Population Fund (UNFPA) was announced—CGD formed a Working Group to examine UNFPA’s evolving role in sexual and reproductive health, reproductive rights, and the integration of population dynamics into development. The recommendations from the Working Group on UNFPA’s Leadership Transition were based on consultative meetings, one-on-one interviews, expert-panel deliberation, and literature reviews. In addition, we commissioned four country case studies to represent the diversity of country conditions in two of UNFPA’s most important regions: Asia and Africa. With 76 percent of its staff based outside of headquarters, understanding UNFPA’s role and performance in the field is essential to understanding UNFPA.

In this paper, Oladele O. Arowolo provides a view into UNFPA’s role in population, gender, and reproductive health in Ethiopia. He offers background on Ethiopia and population policy; an assessment of progress made toward reaching large development goals; a review of the role of UNFPA and other population organizations in Ethiopia; and challenges and opportunities for the population and development communities in Ethiopia. Lastly, he discusses what’s to come in the next 30 years, offering recommendations for UNFPA’s continued presence in Ethiopia.

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The Context

Background

Political: With the demise of Ethiopia's last Emperor in 1974, the country came under the 'Derg' (Committee), which ushered in a government that was socialist in name and military in style. The regime collapsed in May 1991 and was quickly replaced by a new Government based on democratic principles and upholding of human rights in accordance with the international treaties and conventions acceded to by the country. The ongoing decentralization in Ethiopia is an outcome of the adoption of a federal system of government, and following the devolution of power to the regional governments, implementation of economic policies and development programs have, to a large extent, been shifted from the center to the regions, and later to the lower levels of governance.

Socio-cultural: Ethiopia as a political entity is said to date back more than 3,000 years, making it one of the oldest civilizations in history; this has prompted historians to conclude that "Ethiopia is old beyond imaginings" (Hancock, et al, 1983). Archaeological evidence shows that Ethiopia is home to one of the most ancient settlements of the human race, dating back to over 3 million years. The variations in its geophysical conditions are equally matched by ethnic diversity, made up of 80 groups, referred to in the Proclamation No 7/1992 by the TGE as nations, nationalities and peoples. Many of the recent regional divisions of the country bear the name of the dominant ethnic group residing there. In regions such as Oromiya, Tigray, Affar, Amhara and Somali, the population of the major ethnic group makes up more than 75% of the population. The remaining regions are multi-ethnic. According to the CSA census classification (1994), the most populous regions are Oromiya and Amhara which make up 34% and 26% of the total population, respectively.

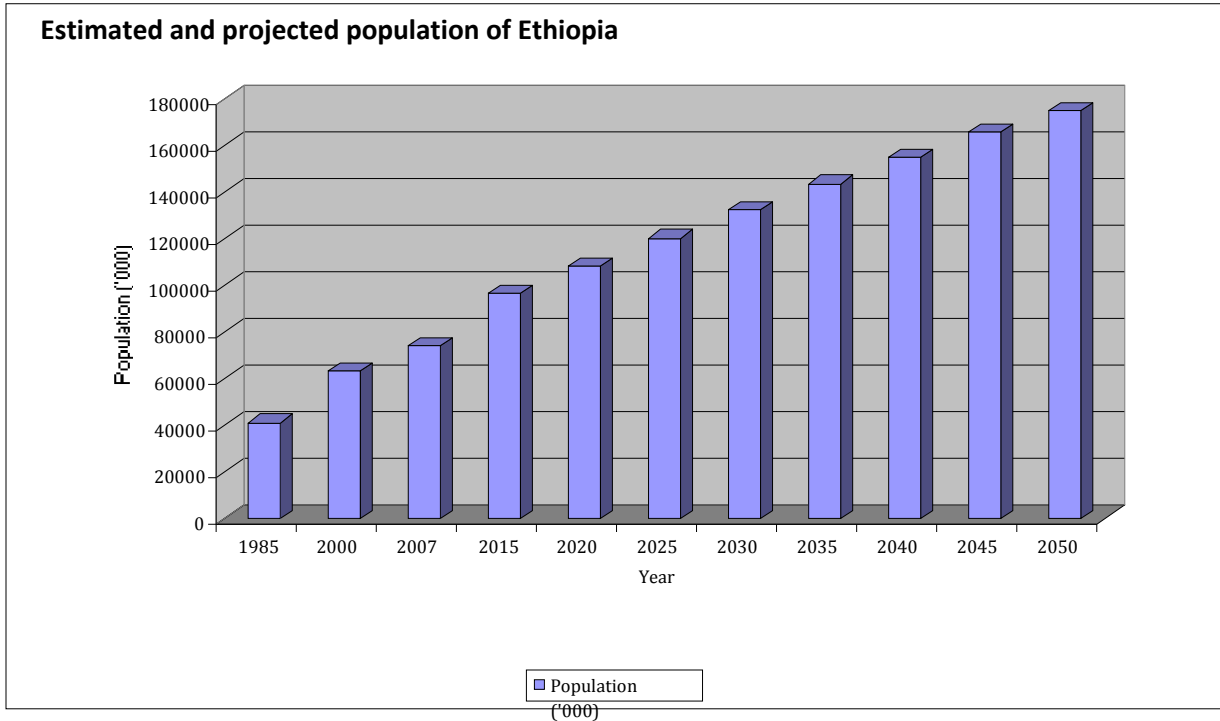
Christianity was introduced to Ethiopia in the 4th century, followed by Islam in the 8th century and ever since, both religions have dominated the religious scene in the country. Followers of Orthodox Christianity constitute 48% of the population while Muslims account for 35%. When Protestants (11%) and Catholics (1%) are added to Orthodox believers, Christians as a whole make up 60% of the population, while 5% of the people affiliate with traditional religions. During the Derg, many churches were confiscated by the state and religious freedom for many small religious groups was abolished. However, recent political changes in the country have brought an unprecedented freedom of religion and an upsurge in attendance at religious institutions in the country.

Women make up close to half (49.85%) of Ethiopia's population; but in spite of their numerical strength, compared with men, their contribution to the overall social and economic development process is not being fully realized due to legal and customary discriminatory practices. In spite of institutional strengthening and program efforts, reports indicate a persistence of low socioeconomic status of women in Ethiopia, lack of control over their sexual and reproductive life and prevalence of superstitions, myths and other harmful traditional practices which increase their vulnerability to sexually transmitted infections (STIs), including HIV/AIDS (National ICPD+15 Report, 2009).

Economy and environment: Ethiopia is a predominantly agricultural country, characterized by high dependence on rain-fed, low-productivity subsistence agriculture. The observed low agricultural productivity in the country is induced by land degradation and low technological input, as well as poor utilization and management of water resources. The Government has recognized that the rapid growth of the Ethiopian population is a major challenge to poverty alleviation. It is also noted that urban unemployment is on the rise due mainly to rural-urban migration and limited capacity to create job opportunities. In order to address these challenges, the Government has determined that the primary development goal is to reduce poverty and that economic growth is the principle, but not the only, means to achieve this. Its development strategy is to promote rapid, broad-based and equitable growth by focusing on rural development and physical and human capital, and deepening the devolution process to empower the people and expand the choices and control they have over their lives (UN, UNDAF, 2007-2011).

Education: Ethiopia has made enormous strides in education provision over the last decade. Primary school enrolment increased from 2.871 million in 1990-91 to 9.537 million in 2003-2004, a more than three-fold increase. At the secondary education level, enrolment increased from 453 985 in 1990-91 to 780 205 in 2003-04, a 70% increase. Higher education has increased from 31 000 students before 2000 to 172 522 in 2003/2004, a five-fold increase. Despite the tremendous increase in primary enrolments over the past decade, Ethiopia nevertheless faces serious and increasing challenges. Due to the high rate of population growth, it may in fact have to more than double its present enrolments to achieve primary education for all. The largest percentage of out-of-school children is in the rural areas. A comparison of rural and urban enrolment in 2003/2004 indicates that 68.9% of primary enrolment was in rural areas and 31.1% in urban areas. However over 80% of Ethiopia's population lives in rural areas. And even for those who manage to get into school, only 72% of rural children make it to Grade 3, and 25% up to Grade 8. The gender gap in Ethiopia is also significant, at about a 18 and 12 percentage points difference for primary and first cycle secondary schooling. At higher education levels there is as much as a 50 percentage points difference in the enrolment of women as compared to men. In order to achieve gender parity, specific steps that favor girls' admission to teacher training institutes, colleges and universities have been taken in the last seven years.

Demographic: The population of Ethiopia has experienced steady growth over the years. Five yearly estimates, based on the results of the 1984 and 1994 census of population and housing and associated parameters, show increases in population size from 41.2 million in 1985 to 63.5 million in 2000. With the 2007 census estimated population of 73.9 million (Ethiopia 2009 National Report on ICPD+15 puts the estimated figure at 79.2 million), Ethiopia now stands as the second most populous country in Sub-Saharan Africa. The high rates of population growth have declined only marginally over the years, from a peak of 3.0 percent per annum in 1990 to 2.7 percent in 2005, and are projected to decline further to 2.6% (2005-2010) and an average of 2.4% during the period 2010-2015.



Sources: National Office of Population, 2000; Projections based on 'Medium Variant', UN, Population Division (2009). World Population Prospects: The 2008 Revision, CD Rom Edition.

The high rate of population growth is attributed to a persistently high level of fertility and declining mortality rates: the Total Fertility Rate (TFR) has declined over the years in Ethiopia from its peak of 7.7 children per woman in 1990 to 5.9 in 2000 and 5.4 in 2005; the under-five mortality rate has declined from 166/1000 live births in 1996-2000 to 123/1000 live births in 2001-2005. Poor nutritional status, infections and a high fertility rate, together with low levels of access to reproductive health and emergency obstetric services, contribute to one of the highest maternal mortality ratios in the world, which is currently estimated at 850/100,000 live births (UN, 2009).

The HIV epidemic has taken off rapidly over the last two decades and the Ministry of Health reports that about 1.4% of Ethiopians ages 15 to 49, or one million people, are HIV-positive, a staggering number to cope with by a resource poor country. Young people constitute one third of the total population in Ethiopia, implying profound reproductive health needs. The major reproductive health problems faced by the young population are gender inequality, early marriage, female genital cutting, unwanted and closely spaced pregnancies, unsafe abortion and STIs, including HIV/AIDS.

Evolution of the National Population Policy of Ethiopia

Prior to the early 1990s, population policy was accorded a low priority in Ethiopia, largely as a result of misgivings about the role of population factors in development. The idea of a national population policy gained credence towards the last quarter of the 1980s and in 1993, the National Population Policy of

Ethiopia was promulgated. It was an outcome of several years of research, policy dialogue and consultations with stakeholders on the burning issue of population and development interrelations in Ethiopia and the direction of policy (ONCCP, 1999).

Policy Goal

The major goal of the population policy is “the harmonization of the rate of population growth and the capacity of the country for the development and rational utilization of natural resources to the end that the level of welfare of the population is maximized over time.” It is argued in the policy document that the rudimentary state of technological development in Ethiopia combined with rapid population growth has made the effort of extricating the country from its severe state of underdevelopment an extremely difficult task. In this regard, the policy states that significant reduction of the rate of population growth by, primarily, addressing the problem of high fertility will, in the long run, be helpful in easing the pressure from contending demands on development resources. The goal of Ethiopia’s population policy is consistent with the goals of the International Conference on Population and Development (ICPD) Programme of Action (PoA) (1994) whose overarching goals emphasize the integral linkages between population and development and focuses on meeting the needs of women and men.

Policy Objectives

The overall objective of the Ethiopia’s population policy is to harmonize the rate of population growth with economic development and thereby improve the welfare of the people. Within the context of current development strategies in Ethiopia, and also the commitment to achieve the ICPD PoA objectives and MDG targets, the general and specific objectives of the population policy, stated below, are still relevant.

The general objectives of the population policy are the following:

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

The specific objectives of the population policy are to:

- Reduce the current total fertility rate of 7.7 children per woman to approximately 4.0 by the year 2015;
- Increase the prevalence of contraceptive use from the current 4.0% to 44.0% by the year 2015;
- Reduce maternal, infant and child morbidity and mortality rates as well as promote the level of general welfare of the population;
- Significantly increase female participation at all levels of the educational system;
- Remove all legal and customary practices militating against the full enjoyment of economic and social rights by women, including the full enjoyment of property rights and access to gainful employment;
- Ensure spatially balanced population distribution patterns with a view to maintaining environmental security and extending the scope of development activities;
- Improve productivity in agriculture and introduce off-farm and non-agricultural activities for the purpose of employment diversification; and
- Mount an effective countrywide population information and education programme addressing issues pertaining to small family size and its relationship with human welfare and environmental security.

After a review of the contents of the population policy in relation to MDG targets, the MDG Needs Assessment for the population sector concluded that in general, the National Population Policy of Ethiopia covers all the major areas that need to be covered in providing directives on the management of population dynamics in the interest of sustainable development (GOE/UNFPA, 2004). Perhaps the major limitation of the policy is the limited reference to sexual rights and reproductive health issues (including HIV/AIDS), understandably because the policy predated the ICPD in 1994. However, since the policy covers the range of major issues in the ICPD PoA, the National Action Plan for policy implementation could be used to address this and any other shortcomings in the policy.

Population Policy Targets

One of the features of the population policy of Ethiopia is that the targets are set within the statements of objectives, and only two of the eight specific policy objectives (TFR and contraceptive prevalence rate) have numerical targets. This poses a challenge for monitoring and evaluating other policy objectives unless official post-policy targets are set. By bringing together related population policy and related policy frameworks, the current national development framework (PASDEP, 2005-2010) has provided information for developing a comprehensive set of population, reproductive health, gender and HIV/AIDS targets for population and development planning in Ethiopia. The specific areas for which target setting is important include, a) fertility and family planning; b) infant mortality; c) child mortality; d) maternal mortality; e) adult prevalence of HIV; f) universal primary education and adult literacy; g) gender parity and empowerment of women; h) employment; and i) population distribution and resettlement.

Role of UNFPA

Regarding the process of population policy formulation in Ethiopia, the role of UNFPA deserves acknowledgement. In spite of the challenging political environment in the latter part of the 1980s, UNFPA with the collaboration of the International Labour Organization (ILO) formulated and implemented a capacity building project (1988-1991) for the development of a national population policy and the establishment of an institution (Population Planning Unit) to support its implementation. In order to implement the project, UNFPA provided the funds and guidance on how the project should be executed, while ILO served as the executing agency. ILO recruited a Chief Technical Advisor (CTA) for the project, placed in the central planning Ministry (ONCCP), which is now Ministry of Finance and Economic Development (MOFED) under a three-year contract. It was under that project that the CTA facilitated research on population and development, disseminated research findings across the country and among the policy makers and planners and advocated for a national population policy even under a socialist regime. Following a series of national and regional consultations, the CTA produced a Draft National Population Policy for Ethiopia. Thereafter, a new Government took over power, and with the support of UNFPA, set up a Committee to finalize the draft. It is ironic that the debates that preceded the formulation of the draft population policy took place during the Derg; though admirably, the process was finalized in 1993 by the current democratic Government.

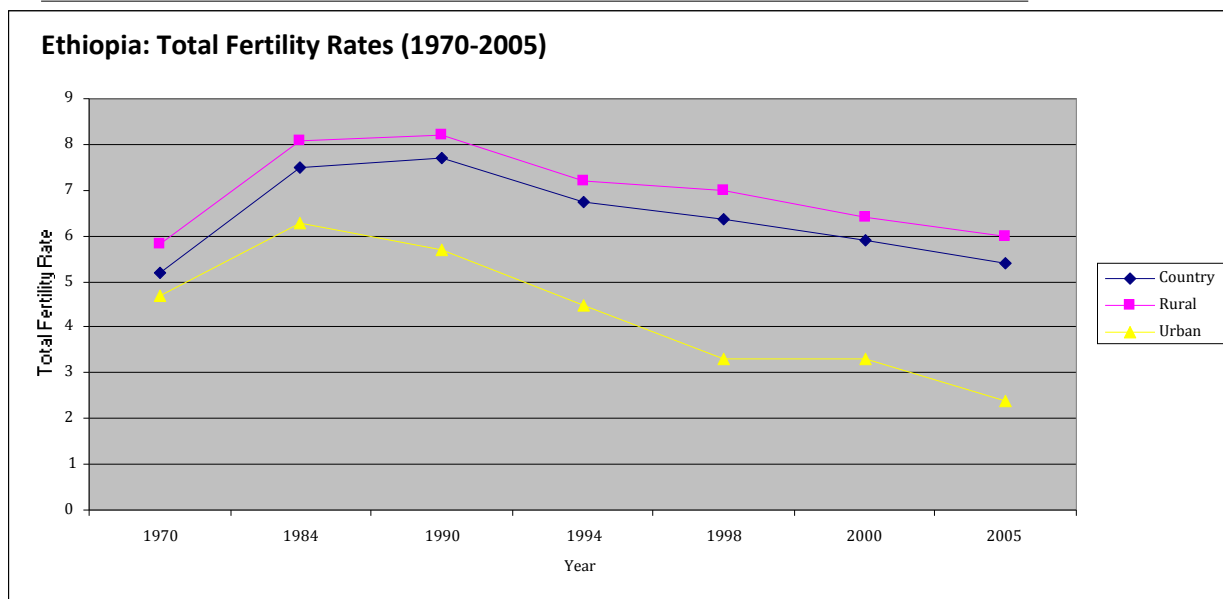
Progress Toward the Achievement of the ICPD PoA and MDGs

Trends in Population Characteristics

Population growth: Regarding the population indicators since 1994, the trends have varied in terms of a move towards achieving the objectives of ICPD and the MDGs, set for 2014 and 2015 respectively. The population of Ethiopia has grown from 47.5 million in 1990 to 63.5 million in 2000, and to the recent census estimate of 73.9 million in 2007 (Ethiopia National Report on ICPD+15 puts the estimated figure at 79.2million). The implied high rates of population growth have shown marginal declines over the years, from a peak of 3.0% per annum in 1990 to 2.7% in 2005, and are projected to decline further to 2.63% (2005-2010) and an average of 2.44% during the period 2010-2015. Ethiopia now stands as the second most populous country in Sub-Saharan Africa, after Nigeria. It is projected that the population will increase to 96.6 million by 2015, and 175.4 million by 2050 (UN, Population Division, 2009). Meeting the challenge of addressing the ICPD PoA and MDG on poverty reduction is compounded by rapid population growth in the country.

Fertility: The persistently high (though declining in recent years) level of fertility is the major factor in the high rate of Ethiopia's population growth. Largely due to programme efforts, TFR has declined over the years in Ethiopia from its peak of 7.7 children per woman in 1990 to 5.9 in 2000 and 5.4 in 2005. As shown in the figure below, there are wide rural/urban differentials in TFR: in 2005 while the overall TFR reached 5.4, the rural rate was 6.0 and the urban rate 2.4. However, the challenge lies in the fact that over 80% of the total population is rural. In addition, Ethiopian women marry at early age, the estimated

median age at first marriage is 16 years. In addition, close to 20% of the births are too close, that is, less than two years of the previous birth (EDHS, 2005).



Sources: National Office of Population, The Ethiopian Population Profile-1999, Addis Ababa (2000); Central Statistical Authority and ORC Macro, Ethiopia Demographic and Health Survey 2000, and 2005, Addis Ababa and Maryland.

About one in three births in Ethiopia are unwanted, and a larger proportion are unplanned. A significant number of abortions are performed each year, many of them under unsafe conditions. Furthermore, antenatal care coverage is only a third of the expected number of pregnancies while attended delivery is about 10%. Relatives who have no skills for identifying or managing emergencies assist most (58%) deliveries. The untrained traditional birth attendants deliver the next highest proportion of births (26%). Only 6% of births take place in health facilities. Government has set a TFR target of 4.0 children by 2015 in the national Population Policy. Such a target requires a large increase in the proportion of sexually active men and women using modern contraceptive methods in the country. The challenge is perhaps in the enormous programme efforts that would be required to push the level of contraceptive use from 14% to 40.0% in 2015.

Within the framework of the MDGs for Ethiopia, the reference to contraceptive prevalence (MDG 6:7) is also to reverse the trend in the spread of HIV/AIDS in the country. Effective and widespread adoption of modern methods of contraception (particularly condoms) will not only contain the spread of HIV/AIDS and STIs, it will reduce the level of fertility and more generally lead to improved health status of mothers and children. While knowledge of contraceptive methods is fairly widespread in Ethiopia, 86.1% (2005) of couples know about contraceptives, use is limited. The contraceptive prevalence rate (CPR) among currently married women has increased from 8.1 percent in 2000 to 14.7 percent in 2005. Unmet need for contraception decreased from 36 percent in 2000 to 34 percent in 2005. Government has attributed the limited access to family planning commodities to frequent shortage of contraceptives; inefficient

logistic management systems and inadequate skilled service providers (National Report on ICPD+15, 2009).

Morbidity and Mortality: The under-five mortality rate has declined from 166/1000 live births in 1996-2000 to 123/1000 live births in 2001-2005. It is projected to decline further to 85/1000 live births in 2009/10. The trends in infant mortality and under-five mortality rates for Ethiopia between 1986 and 2010 are shown in the table below. Although current levels are still high, the trends are quite encouraging. According to estimates from the Ethiopian Demographic and Health Surveys (2000 and 2005), the infant mortality rate declined from 97 per 1000 live births during the period 1996-2000 to 77 in 2001-2005 and it is projected to decline to 45 by the year 2009/10. About 90% of the under-five mortality is attributable to pneumonia, neonatal causes (pre-maturity, asphyxia and sepsis), malaria, diarrhea and measles. On the other hand, malnutrition and currently HIV/AIDS are the major underlying causes.

Ethiopia: Infant and Under-5 Mortality Rates (1986-2010)

5 Year Intervals	Infant Mortality	Under 5 Mortality
1986-1990	133/1000	216.5/1000
1991-1995	129.8/1000	211.4/1000
1996-2000	97/1000	166/1000
2001-2005	77/1000	123/1000
2009/10	45/1000	85/1000

Source: Ethiopia Demographic and Health Survey, 2000 and 2005.

In terms of disease burden, major causes of death are infectious diseases (TB, respiratory illnesses, malaria, gastro-intestinal infections, meningitis, AIDS and leishmaniasis). Nutritional disorders rank among the top problems affecting the population in general and children and mothers in particular. Malaria is the major cause of morbidity and mortality in the country with an estimated 4 to 5 million cases and with proportional mortality rates of 13 to 35% and case fatality rates of 15 to 17% in health facilities every year. The HIV epidemic has taken off rapidly over the last two decades and prevalence was estimated at 4.4% of the adult population in 2003. At present, the epidemic is considered stabilized in urban areas with a slight increase in rural areas. The ICPD+15 country report by Ethiopia indicates that the number of persons who received HIV counseling and testing rose from 448 241 in 2005 to 2.3 million in 2007; the number of HIV patients receiving ART services increased from 900 to 122 243; and the number of those who received services in the prevention of mother to child transmission increased from 2 208 in 2005 to 12 000 in 2007. The major factors that fuel the spread of the HIV/AIDS include: poverty, low level of literacy, stigma and discrimination, gender disparities and the existence of commercial sex, population movement including rural-urban migration, and harmful traditional practices. HIV/AIDS in turn exacerbates the poverty situation, thereby creating the vicious circle of aggravating the

vulnerability of individuals and communities. The estimated burden of tuberculosis amounts to 196/100 000 for 2003, and its proliferation is largely attributed to the chronic high rates of malnutrition (worsened by frequent severe droughts), overcrowding, physical stress, emotional anxiety and the high prevalence of HIV/AIDS.

The most recent national estimate shows that over 1 million people were living with HIV in Ethiopia in 2008, and HIV prevalence is estimated at 2.2% (7.7% urban and 0.9% in rural). Women and children constitute the group most affected by the epidemic. About 59% of people living with HIV in the country are female, 68 136 children under age 15 years are living with the virus, 79 183 pregnant women are HIV-positive and 14 093 HIV-positive births are expected to occur from positive pregnant mothers. In 2008, there were an estimated 5 459 139 orphans; 886,820 of these children were orphaned due to AIDS.

Although some progress has been recorded in the health indicators in the country in general, major reproductive health indicators reveal a state of extremely poor health status. The average maternal mortality ratio for the period 1994-2000 was 871 deaths per 100,000 live births, which declined to 673 by 2005 (EDHS, 2000, 2005). Skilled attendance at birth is at a low rate of about 8%, and only 5% of babies born are delivered in health facilities. Only 10 % of mothers receive post-natal care. About 25,000 women die every year due to complications related to delivery, and 500,000 are left with complications, including obstetric fistula. It is estimated that abortions account for about 50 percent of total gynecological and obstetric admissions in the country.

The Government of Ethiopia (GoE) is well aware of the challenges that population issues present to the national efforts to achieve development of the economy and society and has clearly expressed these in the current development programme, the Plan for Accelerated and Sustained Development to End Poverty, 2006-2011 (PASDEP). The Government, in PASDEP, reiterates that rapid population growth remains a major barrier to poverty reduction in Ethiopia, as the annual addition of almost 2 million persons puts tremendous strains on the country's resource base, the economy, and the ability to deliver services. Other aspects of population identified with development in PASDEP are the pressure of population on environmental resources, education, health and family welfare.

In addressing population challenge through PASDEP, the Government renews its commitment to implement the ICPD PoA and MDGs through the existing national population strategy by, among others, making available services for spacing births and inroads into fulfilling the unmet demand for family planning services so as to achieve lower growth and smaller family sizes. Programs will also be implemented to improve the security and the volume of contraceptive supplies, to intensify information and communication efforts and to provide political leadership on population issues. PASDEP envisages the development of two major sub-programmes: a) a Population and Development Strategy (PDS) sub-program, which includes ensuring population and gender issues are systematically addressed within the framework of development programs on the basis of and understanding of population implications and data, complemented by the establishment of a National Population Framework to guide population activities at all levels and; b) an Advocacy sub-program, to create an enabling environment for the

adoption and implementation of population, reproductive health and gender-related policies and poverty reduction programs. To assure coordination of population programme activities, PASDEP proposes the establishment of a National Population Council (PASDEP, 2005:92-94).

If anything, PASDEP has provided a common platform for all actors and interested partners in population and development (including reproductive health, HIV/AIDS, STIs, gender equality and empowerment of women, youth empowerment, population dynamics and development, etc.) to play their respective roles. UNFPA has responded by pursuing its mandate in the country with the implementation of its 6th Country Programme of support to GoE (2007-2011), designed in harmony with the PASDEP cycle.

Gender: Women make up close to half (49.85%) of Ethiopia's population; but in spite of their numerical strength compared with men, their contribution to the overall social and economic development process is not being fully realized due to legal and customary discriminatory practices. FDRE has noted that women in Ethiopia suffer relative deprivations in many areas of life, which define their low status in society. In order to give women issues and their solutions a sharper focus, the Government had created the Women Affairs Office (WAO), accountable to the Prime Minister. It is notable that since its inception, WAO has been instrumental in the development of the National Policy on Ethiopian Women (1993) and the establishment of Women Affairs Department in line ministries. In 1996, GoE introduced the Social Welfare and Social Development Policy, which addresses welfare issues on children, youth, family, women, the elderly and the physically and mentally impaired.

The reproductive health problems of Ethiopian women, particularly the young ones, are related to harmful traditions, early marriage, abduction, female genital mutilation (FGM), gender inequalities, sexual coercion, rape and lack of access to user-friendly sexual and reproductive health services. Early marriage, marriage by abduction, and FGM are highly correlated with poor reproductive health. It is likely that young mothers suffer from severe complications during delivery that cause morbidity and mortality for both the mother and the child. The incidence of obstetric fistula among young girls is twice as much when compared to women of reproductive age.

Much more needs to be done to empower women to attain parity with men in education, political representation, opportunities in professional occupations and decision making in family matters. MDG 2 is set to ensure that by 2015, children everywhere, boys and girls alike will be able to complete primary schooling. In addition, MDG 3 addresses the promotion of gender equality and empowerment of women. The target is to eliminate the gender disparity in primary and secondary education, preferably by 2005 and to all levels of education no later than 2015.

The Role of UNFPA

UNFPA has assisted Ethiopia since 1973 through six country programmes (CPs). The current programme, which covers the period 2007-2010, was designed to assist the Government with:

- the integration of population and gender issues into the needs assessment for the MDGs and the Plan for Accelerated and Sustained Development to End Poverty 2006-2010 (PASDEP);
- the second Demographic and Health Survey as well as preparatory work for the 2007 population and housing census;
- increasing access to high-quality reproductive health information and services;
- implementation of the national gender strategy, in the context of PADEP, by strengthening institutional mechanisms and sociocultural practices that promote and protect the rights of women and girls; and
- achievement of the objectives of the ICPD PoA.

All post-ICPD UNFPA-supported programmes for Ethiopia have addressed similar challenges, with the MDGs dimension added in 2001.

Landscape of Population Organizations

Partnerships and Collaboration

UNFPA is the lead UN agency supporting the Government of Ethiopia to achieve the objectives of the ICPD PoA and the population related components of the MDGs. UNFPA has worked with a variety of partners in Ethiopia to promote the implementation of the ICPD PoA and MDGs frameworks. Partners include the United Nations Country Teams (UNCT), the Government of Ethiopia, the private sector, civil society organizations and other non-traditional partners. Within UNCT in Ethiopia, UNFPA has been prominent in terms of funding, technical support and partnership promotion, apart from the Joint Programme on HIV/AIDS by several UN agencies through HAPCO. These are: the 2007 Population and Housing Census Program; Joint UNFPA-UNICEF Program on A Right-Based Approach to Adolescent and Youth; Leave No Women Behind (LNWB) Program; and Joint UNFPA/UNICEF Trust Fund Programme, Abandonment of Female Genital Mutilation/Cutting: Towards Social Change.

Government acknowledged (ICPD+15 Report, 2009) the contributions by UNFPA, the U.S. and Germany totaling USD \$105,390,770 from 2004-08. Significant financial and technical inputs have also been provided by the following agencies in support of population activities including reproductive health in Ethiopia: the World Bank; Africa Development Bank; European Union; Austrian Development Cooperation; Belgian Development Cooperation; Development Cooperation of Ireland; Italian Cooperation; JICA; Royal Netherlands Embassy; Norwegian Embassy; Packard Foundation; SIDA; and WFP/EPRU.

The role of NGOs in promoting the ICPD PoA objectives and realizing the MDGs in the Ethiopia cannot be overemphasized. For example, the Family Guidance Association of Ethiopia (FGAE) has been promoting population issues, particularly family planning long before a national population policy was launched. There are now more than 70 national NGOs involved in population and reproductive health activities in Ethiopia. The Consortium of Family Planning NGOs (COFAP) is an umbrella organization, which has been in operation since 1993, providing institutional support to most of these NGOs.

In the past five years, UNFPA has engaged dozens of partners from the private sector and NGOs in the country to implement aspects of the country programme, namely: the Ethiopian Society for Population Studies (ESPS); Population Council; International Medical Corps; Action Contre la Faim; Integrated Service for AIDS Prevention and Support Organization (ISAPSO); Ethiopian Catholic Secretariat (ECS); Islamic Relief (IR); Kembatti Mentti Gezzimma-Tope (KMG); Medecin du Monde (MDM); Medecin Sans Frontiere-Holland (MSF-H); Mercy Corps (MC); Medical Relief International (Merlin); Samaritan Purse (SP); Save the Children-UK (SC-UK); Afar Pastoralist Development Association (APDA); Sisters Self-Help Association; DKT Ethiopia; Anti-malaria Association (AMA); Eleshaday Integrated Child Care & Community Development (EICCD); Wolliso Youth Development Association; Information and Development for Persons with Disabilities Association (IDPDA); Emmanuel Development Association (EMA); Network of Networks of HIV Positives in Ethiopia; Finote Amhara Region HIV Positive Women

Association; Ethiopian Orthodox Church, EOC/DICAC; Amhara Development Association (ADA); African Development Aid Association (ADAA); Bright Image for Generation (BIGA); Fayyaa Integrated Development Association; Hundee Oromo Grass Roots (HUNDEE); Mujejeguwa Loka Women Development Association; Mary Joy Aid through development; Network of Ethiopian Womens Associations (NEWA); New Life Community Organization (NLC); Organization for Social Services for AIDS (OSSA); Pro Pride; Relief Society of Tigray (REST); Tseotawi Tekat Tekelakay Mahber (TTTTM); Organization for Women in Self-Employment (WISE); Zema Setoch Lefitih; National Coalition for Women Against HIV/AIDS (NCWH); Missionaries of Charity Rehabilitation Center; Women's Association of Tigray; and CHAD ET (UNFPA, MTR Brief, 2009).

UNFPA admits the important role of these partners and reached the conclusion that without them, implementation of the successful Country Programmes over the years would have been difficult. According to a UNFPA report (2009), by involving them, development partners assure ownership and sustainability of programme activities; reach the target population far and wide; and present the Fund with an opportunity to promote the mandate of the agency, while contributing to development and the upholding of human rights. Apart from grants to partners for specific projects, UNFPA has also supported them with capacity building interventions over the years.

Population Coordination Mechanisms

The Population Policy of Ethiopia (1993) made provisions for a coordination mechanism, in the form of institutional structures, to support implementing the policy. The institutional structures consist of a National Population Council (NPC) together with its secretariat is strategic, and it involves two things: a) the establishment of a National Population Council (NPC) to be chaired by the Prime Minister, b) an Office of Population within the Office of the Prime Minister. It is the Office of Population that is charged with the responsibility for developing technical and programmatic guidelines for policy implementation in consultation with the NPC (Population Policy, 1993:38).

Given that population program implementation takes place mainly at the grass roots level, the policy suggests a close relationship between the Office of Population and other bodies with related functions at the regional, zonal and woreda levels. The composition of the NPC and its functions and those of the Office of Population are defined in the policy paper (ibid, p 39-53). In addition, the policy identifies the role of specific ministries in the implementation of the population policy, including Ministries of Education, Information, Health, Labour and Social Affairs, Housing and Urban Development, Justice, Agriculture, Culture and Sport, as well as related institutions such as Addis Ababa University, Central Statistical Authority and the Family Guidance Association of Ethiopia, among others.

Efforts have been made by UNFPA to address the issue of population program coordination, particularly the creation of institutional structures across the country. However, the proposed institutional arrangements/structures for population policy implementation have only been partially implemented. There have been significant changes in power relations between the President and Prime Minister, and

the Office of Population was moved first to the Office of the President and later to the Ministry of Finance and Economic Development. To date, the national body responsible for population policy and implementation, the National Population Council, has not been constituted. This makes the National Office of Population, wherever it is located, an anomaly. By its creation, the mission of the National Office of Population (NOP) is to facilitate the coordination of the activities of the various sectoral agencies (government and non-government) operating population and development related activities at different administrative levels (sectoral, regional, etc.).

The policy paper is clear on the issues of mode of operation and terms of reference of the National Population Council. Given that the country has embraced democratic principles, the Council itself should be empowered to determine the final form of its terms of reference in accordance with existing principles of governance. If need be, Council members should be given adequate exposure to the mode of operation of such institutions (known as National Population Committee, National Population Council or National Population Commission) in countries such as India, Tunisia, Botswana, Nigeria, Namibia and others. In these countries, population issues are high on the Government's development agendas and implementation, although to varying degrees of accomplishment, has enjoyed a high degree of institutional collaboration and success.

UNFPA provided technical and financial support to formulating a comprehensive Population Plan of Action to ensure structured implementation of the National Population Policy. The formulation of an Action Plan is necessary but not sufficient in ensuring policy implementation. The management of the Plan is critical to the realization of the objectives. The draft Action Plan proposes an institutional mechanism for coordination of population activities for the next five years, consisting of three Standing Committees of the House of People's Representatives, a Council of Ministers, National Population Council, supported by National Population Secretariat, and four Technical Committees in the thematic areas of reproductive health, population and development, gender and information, education and communications / behavior change communication. The Plan also identifies the various line Ministries together with their implementing responsibilities. As proposed in the Plan, the national coordination structure, including the Population Council and Technical Committees, will be replicated at the regional level. After approval of the Action Plan, the remaining challenge will be the constitution of the National Population Council, as provided for in the Policy and echoed in PASDEP, to facilitate the coordination of population activities in the country. The transformation of the Population Coordination Core Process in MOFED to the National Population Secretariat should be an integral part of the institutional restructuring for population program coordination.

Coordination through Sector Wide Approaches

The Government of Ethiopia has been employing Sector Wide Approaches (SWAs) to a commendable degree of success in three sectors: health, education and HIV/AIDS, and more recently gender. The Ethiopian Health Sector Development Program (HSDP) is a 20-year old framework to achieve universal access to essential primary health care services by 2017. Designed to serve as a framework for technical

and financial support to the health sector, the program is aimed at providing and extending access to primary health care services, enhancing the quality of such services and improving health sector management. It is part of the government's 20-year investment program, and its overall objective is to improve the health status of the population, resulting in:

- the productivity of the population;
- decreasing of household expenditure on health;
- increasing opportunities for productive investment of these resources; and
- contributing to the alleviation of poverty and support socioeconomic development.

UNFPA has since been involved in SWAPs in terms of formulation and operationalization.

During the first five year phase (1998 - 2002), the HSDP concentrated on the development of the health system infrastructure for improving the coverage and quality of health services and for sustainable decentralized level management and implementation. In addition to the activity components of HSDP I, the main emphasis of HSDP II (2003 – 2005) is the accelerated expansion of primary health care facilities (2004 – 2008) with the aim of accelerating physical infrastructure expansion as a base for improving and expanding basic health care services to rural Ethiopia and to enhance the health care system inputs towards the achievement of the MDGs.

The Health Sector Development Plan III (2005-2010) is recognized as the centerpiece of the country's health policy. Donor support is expected to follow the priorities and procedures specified in the plan, while Government and donors should continue to engage in dialogue about the contents and implementation of the plan. HSDP III focuses on institutionalization of the village health care delivery through the Health Services Extension Programme (HSEP) and accelerated expansion of health service delivery towards the achievement of MDGs by 2015. In addition, the Government has launched the Strategic Plan and Management for the Multi-sectoral HIV/AIDS response in the country for the period of 2004 - 2008.

SWAPs have been used to strengthen national ownership of sectoral planning and budgeting and are currently being employed to facilitate pooled funding among donors in support of decentralization and harmonization. One major constraint is governance. Based on the experience of the May 2005 elections, the World Bank and many donor partners discontinued direct budget support, but nevertheless found ways of financing vital basic services for poor citizens.

The Protection of Basic Services (PBS) project has been proposed to support the country's progress towards achieving the MDGs targets for human development, by ensuring continuity and steady growth in the delivery of basic services in health, education and water. In support of this project, the Government and all the partners, including UNFPA, agreed that money transferred to local levels for service delivery should not be diverted, and the Government will allow independent audits of local level expenditures.

Population and Development in Ethiopia: Key Challenges and Opportunities

Population and Development Challenges

The Government of Ethiopia is well aware of the challenges that population issues present to the national efforts to achieve development of the economy and society and has clearly expressed these in the current development programme, the Plan for Accelerated and Sustained Development to End Poverty, 2006-2011 (PASDEP). The Government, in PASDEP, reiterates that rapid population growth remains a major barrier to poverty reduction in Ethiopia, as the annual addition of almost 2 million persons puts tremendous strains on the country's resource base, the economy and the ability to deliver services. Other aspects of population identified with development in PASDEP are the pressures of population on environmental resources, education, health (including reproductive health and family planning) and family welfare.

If anything, PASDEP has provided a common platform for all actors and interested partners in population and development (including reproductive health, HIV/AIDS, STIs, gender equality and empowerment of women, youth empowerment, population dynamics and development, etc.) to play their respective roles. UNFPA has responded by pursuing its mandate in the country with the development of the 6th Country Programme of support to GoE (2007-2011), was designed in harmony with the PASDEP cycle.

Analysis of Challenges and Opportunities

An analysis of key challenges facing by UNFPA in the new environment is presented in the figure below.

Figure: Analysis of Opportunities, Constraints and Challenges Faced by Ethiopia's Country Office in Designing and Managing Programmes in the New Environment

<i>Initiative</i>	<i>Opportunities</i>	<i>Constraints</i>	<i>Challenges</i>	<i>Lessons learned</i>
1. Population related policies				
Government promulgated National Population Policy (1993)	Policy objectives in line with ICPD PoA and aspects of MDGs; the proposed coordinating mechanism offers opportunity for all sectors and agencies (led by UNFPA) to have a common platform for exchange of ideas, collaboration	The process of establishing the relevant institutions has been slow, with negative consequences on policy implementation	Establish and sustain the effective functioning of National Population Council and National Office of Population	Delay in taking action could stall the process

	and resource mobilization			
National Policy on Ethiopian Women (1993)	The broad strategies are adequate for addressing national concerns and implementing the ICPD PoA and gender-related MDGs Action Plan offers UNFPA opportunities to integrate its interventions	Weak human and institutional capacity to implement the Gender Action Plan	Building capacity of the Ministry of Women Affairs; strengthening local and sector capacity to mainstream gender into policies and plans	Advocacy by UNFPA for women's and girls' rights have proved successful in Ethiopia
Policy focus on youth in the National Population Policy (1993)	Population Policy (1993) strategies focusing on young people provides an opportunity to promote the 'Demographic Dividend,' which required intense efforts to provide reproductive health services and promote gender issues	Persistence of gender discrimination due to socio-cultural factors	Research and advocacy for the 'Demographic Dividend'	In order to realize the 'Demographic Dividend,' the Government and donors must focus on support for reproductive health and HIV/AIDS, quality education with skills and labor market flexibility
National policy and programme response to HIV/AIDS (1998)	Offers UNCT opportunity to implement a joint programme	Integration of HIV/AIDS into Primary Health Care	Promoting condom use among men and women	UNDAF provides opportunity for a Joint Program on HIV/AIDS
Health Policy for Ethiopia (1993)	Broader participation of implementing partners in the process	Limited participation by CSO implementing partners	How to attract the participation of CSOs in the CPAP process	Government ownership of CPAP was strong
2. UN Reform				
Resident Coordinators (RC) System	The RC system is critical to the implementation of the UN Reform; it provides a common ground for	The RC must be dynamic and command respect of the agencies; this	Harmonization of procedures by the different UN agencies; harmonization of	Pooling of resources could enhance programme

	<p>harmonization of donor funding, UNCT joint programming and management of joint projects</p>	<p>was a problem during the MDG Needs Assessment process in Ethiopia</p> <p>Only Ex-Com Agencies mandated to undertake joint programme development and implementation with partners</p>	<p>resource mobilization strategies</p>	<p>effectiveness</p>
Theme Groups	<p>UNDAF created five Theme Groups (Economic Growth; Good Governance; Humanitarian Response; Basic Social Services; HIV/AIDS) and identified three thematic areas as cross-cutting – Population, Gender and ICT</p> <p>All UN agencies were able to express their mandates and agency concerns, to the extent possible, within the theme groups and cross-cutting areas</p>	<p>The theme groups seemed to work together quite well within, but when brought together, there were differences of opinion, sometimes difficult to reconcile</p>	<p>Good governance is suspect by Government as being critical of ongoing political process</p> <p>Government yet to fully comprehend the meaning of ‘Human Rights’ in programming.</p>	<p>Good governance is critical to UN mandate</p> <p>National frameworks that identify Government priorities facilitated the work of the theme groups</p>
MDG Reporting	<p>First MDG report by Ethiopia was in 2004</p> <p>MDG reporting provides opportunities to evaluate progress and identify bottlenecks in programme delivery</p>	<p>MDG report uses aggregate national indicators, concealing internal variations by region, rural/urban residence, and socio-economic</p>	<p>Using MDG indicators to target vulnerable groups in the country is a major challenge</p>	<p>Need to disaggregate MDG indicators in order to facilitate targeted programming in favor of vulnerable population groups</p>

		groups		
Ex-Com/Specialized Agencies	Being mandated to work together and develop joint programmes within UNDAF, the Ex-Com agencies are ahead of the rest of UNCT in implementing the UN Reform Programme	There are no clear guidelines on how joint programmes should be managed on the ground	How to get other UN agencies on board in joint programme management	Limited experience so far
3. Poverty Reduction Strategy Papers / Poverty Reduction Strategies				
SDPRP1	SDPRP1 (2002-2004) was the starting point in addressing poverty within the context of the MDGs	Issues of population, gender and HIV/AIDS were identified but the framework fell short of integrating these issues into the proposed programme	Move away from merely presenting situation analysis of population, gender and HIV/AIDS, to actually integrating their respective strategies into the national framework	The lack of integration meant that it was difficult to monitor and evaluate achievements, particularly in the areas of population and gender
MDG Needs Assessment Synthesis	MDG Needs Assessment provided an opportunity to evaluate problems, identify possible interventions and their corresponding costs, provided a ground work for the development of a five-year planning framework and budgeting particularly for population and gender	The time allowed for the assessment was short; the Synthesis Report was not ready in time for the UNDAF formulation, even though the report was supposed to substitute for Common Country	The budget estimates for almost all the sectors assessed appeared to be on the high side; concern expressed as to how the resources required would be mobilized	The assessment provided Government the opportunity to claim ownership of the planning process with the support of partners Recommendations from the report were fed into Plan for Accelerated and Sustained Development to

		Assessment		End Poverty
Plan for Accelerated and Sustained Development to End Poverty (PASDEP)	<p>Government fully utilized the information from the MDG Needs Assessment Synthesis Report and other existing development frameworks and international agreements to formulate PASDEP</p> <p>The Plan integrates population, gender and HIV/AIDS into a national, medium-term development framework</p>	PASDEP seems to roll all the sectoral policies and programmes into a five-year framework without prioritization of activities	Given institutional and human capacity limitations, implementation of PASDEP to achieve set targets is a major challenge	PASDEP Policy Matrix, as in SDPRP1, should provide a guide to implementers in programme selection
4. SWAps				
Health Sector Development Programme (HSDP)	<p>The HSDP presents a good illustration of harmonization and aid alignment in support of the health sector in Ethiopia</p> <p>It provides the donors and UNCT, including UNFPA, a platform for resource alignment and basis for joint monitoring and evaluation of programme implementation and donor aid effectiveness</p>	The Code of Conduct for the implementation of HSDP III has been signed by some, not all, development partners	<p>The extent to which similar plans are developed for the other sectors, including Code of Conduct, remains to be seen (namely gender)</p> <p>A national Action Plan for population policy implementation is yet to be finalized</p>	Although slowly, HSDP shows that UN Reform is being implemented on the ground in Ethiopia
HIV/AIDS Strategic Plan	Government has launched the Strategic Plan and Management for the Multi-sectoral HIV/AIDS response in the country for the	Separating purely HIV/AIDS issues from reproductive health and	Synchronizing the numerous activities in the Country Programme Action Plan with	UNFPA country office's past experience with implementing partners in the area of HIV/AIDS

	<p>2004 – 2008</p> <p>Based on the Plan and PADEP programmes for HIV/AIDS, UNDAF has developed a UN Joint Programme on HIV/AIDS, containing the UNDAF Matrix and 2007 - 2011 milestones and 2007 activities</p>	gender issues	<p>UNDAF and the Plan itself</p> <p>Harmonizing the various activities on HIV/AIDS to avoid duplication and ensure coverage and managing the large number of actors and implementers in the field</p>	should be an advantage in future programs
Gender Action Plan	<p>The National Action Plan for Gender Equality (NAP-GE), 2006 - 2010 provides a programming focus for the implementation of the Policy on Women of Ethiopia promulgated in 1993</p> <p>PASDEP commends it and provides strategic direction for its implementation and all actors in the field of gender (including UNFPA) now have a common platform to bring their resources to bear on plan implementation</p>	<p>The Plan appears to be a shopping list of everything about gender and what needs to be done</p> <p>Although a 5-Year Plan, there are no indications of the timing of interventions, at least on an annual basis</p> <p>The Plan is almost silent on how the implementation will be coordinated at all levels of management. The lead agency, Ministry of Women's Affairs has weak capacity</p>	<p>UNFPA should play a lead role among the UNCT, given its mandate</p> <p>The Country Programme Action Plan identifies capacity shortages as an entry point for effective intervention by UNFPA in the implementation of the Gender Plan</p>	UNFPA has accumulated experience during the past programming activities in addressing gender issues in reproductive health and HIV/AIDS
5. Division of				

Labour				
National Capacity Development	Capacity building is critical to successful programme implementation and sustainability of programme activities	UNFPA and the Development Assistance Group in general have been investing in capacity building in Ethiopia over the years; but most of the nationals sent on fellowship training abroad tend to remain abroad after training and those who return often shift professional allegiance	High rate of staff turnover undermines capacity building efforts of the Development Assistance Group, including UNFPA.	Develop capacity of research and training institutions in the country and thereby train locally
Demand-driven Technical Assistance	<p>The UNFPA/GEO Country Programme Action Plan process started with a study of capacity of implementing partners and identification of potential partners</p> <p>This provided an opportunity to determine the extent of demand for technical support and strategies for providing such support</p>	Some of the Government implementing partners have weak capacity; yet, they must continue to be taken on board because they are Government institutions	<p>The need to strengthen capacity building through direct technical support</p> <p>In the longer term, the need to strengthen the capacity of training and research institutions in reproductive health, population and gender, so they can build capacity locally</p>	<p>Capacity built in the past eroded largely by high rate of staff attrition</p> <p>Some trained fellows abroad failed to return to Ethiopia; hence, training locally is now highly recommended by the Government</p>
Dialogue	UNFPA participated actively in the Development	During the MDG Needs Assessment,	Further dialogue will be needed in support of policy	Policy dialogue pursued with vigor is more fruitful

	<p>Assistance Group's promotion of broader participation in and national ownership of the country's strategies and policies</p> <p>UNFPA's country office successfully engaged the Government in policy dialogue to ensure the inclusion of population in the MDG Needs Assessment for Ethiopia in 2004</p>	<p>the Government insisted that there would be no room for policy review, though the National Population Policy promulgated in 1993 seemed overdue for a review</p>	<p>review and formulation of population Action Plan</p> <p>There is need for evidence-based research in support of future dialogue with Government</p>	<p>than confrontation</p>
Resource Mobilization	<p>UNFPA's country office mobilized resources successfully for the 2005 Demographic and Health Survey and the 2007 Population Census</p>	<p>Huge amount of resources needed for the 2007 census but initially donors seemed reluctant, ostensibly for governance-related reasons</p>	<p>Filling the resource gap for the 2007 census</p>	<p>Roundtable meeting should be supported by advocacy, in the light of some of the donors' concern about governance issues</p>

The Challenge of Integrating Population Issues into Policies and Plans

What is integration?

As it is generally known, integration is a systematic consideration of population factors (including the determinants and consequences of population dynamics) in the determination of development objectives and strategies. Integrated population and development planning involves the explicit consideration of population and its social, economic and demographic characteristics in the national (regional or local) development planning process (Ekanem & Arowolo, 1994).

UNFPA defines integration as explicitly taking into account in the planning process population factors in so far as they significantly influence or are influenced by other variables relevant to development plans (UNFPA, 1993). Based on this definition, the two basic goals of integration are: i) to promote the general quality of development planning; and ii) to promote awareness among both planners and policy-makers of the need to adopt population policies consistent with development.

One of the objectives of the ICPD PoA is to fully integrate population concerns into development strategies, planning, decision-making and resource allocation at all levels and in all regions, with the goal of meeting the needs, and improving the quality of life, of present and future generations. This will lead to the promotion of social justice and to the eradication poverty through sustained economic growth in the context of sustainable development. With regard to population, sustained economic growth and poverty, the PoA objective is to raise the quality of life for all people through appropriate population and development policies and programmes aimed at poverty eradication and achieving economic growth. Consistent with Agenda 21, the PoA objectives relating to population and environment, are to: i) ensure that population, environmental and poverty eradication factors are integrated in sustainable development policies, plans and programmes; and ii) reduce both unsustainable consumption and production patterns as well as negative impacts of demographic factors on the environment in order to meet the needs of current generations without compromising the ability of future generations to meet their own needs.

The Challenge of Integration

There are perhaps three major challenges facing the integration of population issues (population dynamics, gender, reproductive health, HIV/AIDS, youth, etc.) into development policies and plans in Ethiopia: poor knowledge of the relationship between population and development among planners, weak capacity of programme implementers (Government institutions and NGOs) and inability to mobilize adequate resources for population-related programmes.

The Challenge of Understanding (Experience from the MDG Needs Assessment, 2004)

The challenge of integrated population and development planning in Ethiopia became prominent during the process of MDG Needs Assessment (NA) initiated by Government and UN country team in 2004. The

MDG NA exercise was an eye opener; it provided an opportunity for UNFPA to demonstrate that population is central to development policy and planning.

When the exercise started in July 2004, the Government defined two broad sectors: i) the growth sector (economic growth, agriculture, rural development, urban development, private sector, infrastructure – roads, electricity, communication) and; ii) the social sector (health, education, water and sanitation, HIV/AIDS and gender). Although population was identified in the 1st Sustainable Development and Poverty Reduction Programme (2002) as crosscutting, along with HIV/AIDS and gender, it was not recognized as a separate component in the MDGs NA social sector. However, the UN country team Task Force, which was working closely with the Government in the MDGs NA, thought otherwise and started to draw attention to population as an issue in this exercise (Arowolo, UNFPA Mission Report, 2005).

UNFPA's approach: UNFPA hired a consultant on population and development to assist with the process. The consultant worked closely with the Office of Population in MOFED and produced evidence based information on the role of population in Ethiopia's social and economic development. On its part, the UNFPA office in Addis Ababa embarked upon policy and advocacy dialogue that involved local discourse at the highest level and international interventions, mainly from UNFPA headquarters and the Millennium Project in New York. The objective was to promote an understanding of the place of population in the MDGs Needs Assessment and the upcoming MDGs 10-Year Plan and counter the misconception expressed in official circles about the role of population in the MDGs NA and future planning processes in the country. It was an opportunity that UNFPA could not afford to miss.

Based on a preliminary analysis of population and development by the consultant, UNFPA, in collaboration with the National Office of Population, produced a background document titled: Basic data and information for integration of population factors into the MDGs Needs Assessment for Ethiopia (July 2004). Government appreciated this intervention by UNFPA, accepted the document and distributed it to all consultants and participating agencies (UNCT, World Bank and DAG). The document thereafter became a reference material for all consultants in the MGDs NA exercise. That marked the beginning of UNFPA's positive intervention in the MDGs NA process and the integration of population, gender and reproductive health.

The technical support provided by UNFPA to the MDG Needs Assessment also bore fruit in the preparation of Plan for Accelerated and Sustained Development to End Poverty, 2005-2010 (PASDEP). PASDEP is a good example of an integrated population and development plan—it integrates both the general and specific objectives of the population policy and restates them as 'broad Population Policy Targets' for Ethiopia. PASDEP also brings together all the existing frameworks that address population, health and reproductive health concerns (including HIV/AIDS) that are not specifically addressed in the 1993 population policy. Apart from the National Population Policy, related elements of the framework, presented in PASDEP include the National Reproductive Health Strategy, the Strategic Response for Prevention and Control of HIV/AIDS and the National Policy on Women.

Weak Institutional Capacity

The development of a National Action Plan for Population Policy implementation, which was supported by UNFPA, is a vital framework for population and development integration. In addition, in order to implement the Action Plan, the coordination mechanism proposed in the Population Policy should be established and functioning at national and regional levels. Without such a mechanism in place it is difficult to manage any population Action Plan. There are indications from Government that the National Population Council will soon be created, and this is expected to accelerate the move to population programme design and lead to the recognition of the National Office of Population as the Secretariat to the NPC and strengthen its capacity to facilitate the coordination of program implementation.

UNFPA, with technical backstopping from headquarters, provided substantial technical support to the incorporation of ICPD indicators in the Results and Resources Framework of the UN country team partnership in UNDAF. UNFPA ensured that key maternal health interventions such as EmOC, MSC programme for Health Officers and reproductive health commodities were considered as expenditure items under the MDG Performance Fund. UNFPA also participated in the Health Sector Development Programme (HSDP) III midterm review and ensured that key interventions on improving maternal health were incorporated, including access to skilled attendance at birth, family planning, EmOC and comprehensive abortion care services. In addition, gender mainstreaming and human rights based approaches were used for the first time in the HSDP document with a clear recommendation on gender mainstreaming for the HSDP IV planning in 2010. Nevertheless, population and development integration in the other sectors and at the regional level remain a challenge (UNFPA, 2009).

For the past four years, UNFPA has also been supporting the creation of a population database that will be accessible to planners, policy makers and researchers. The system will consist of a user and data-friendly database and a set of analytical methods to transform census data into usable information. The database will be organized to store both macro- and micro-level data. The latter can be retrieved and processed at small area levels using the latest relevant software packages for disaggregation. The already developed EthioInfo database (a localized version of DevInfo) is being upgraded to include the census data with financial support from UNFPA. Recently, UNFPA supported the generation, analysis and utilization of data on population dynamics, gender, young people, sexual and reproductive health and HIV/AIDS at the national and sub-national levels to develop and monitor policy and programme implementation, including the ICPD+15 review. Technical support included training in GIS, data processing and analysis, census data content edit specification, weighting, CSPRO training, website development and upgrading.

Challenge of Resource Mobilization

The absence of an effective coordination mechanism for population programming is the major constraint on resource mobilization for the population sector in Ethiopia. What UNFPA has been doing in the absence of a national population programme with a mechanism for coordination is simply to rally

interested donors around its Programme of support to the country. This issue is discussed in the next section of this paper.

Responding to the Challenge of Population Policy Implementation – UNFPA over the next 20-30 years

Medium-Term (Next Five Years)

In the next five years, Ethiopia like other countries, will be working towards the conclusion of the implementation of the ICPD PoA and MDGs. Having regard to the rather slow pace of implementation so far, the next five years call for a scale-up in policy implementation. This position was expressed by the Ministers responsible for population activities in Africa at the end of the ICPD+15 review conference in Addis Ababa, Ethiopia (UNECA, UNFPA, AUC, October 2009).

Considering the range of policy and implementation plan frameworks in Ethiopia, there can hardly be a better demonstration of expressed *political will* to address development challenges in the country; however, the wide gap between such expressions of political will and *actual implementation* suggests that the system (involving Government and development partners) should move away from paper work to action on the ground. As the lead agency on population issues, UNFPA obviously has a big role to play in the next five years. UNFPA should:

- support the development of Action Plans for policy implementation at national and regional levels;
- support the process of establishing the National Population Council and its Secretariat, the National Office of Population (NOP);
- support the process of establishing a coordination mechanism for population activities including reproductive health, HIV, gender, population and development, capacity building for training and research, etc;
- strengthen the capacity of NOP to facilitate the coordination of population activities at all levels, and capacity strengthening of the Ministry for Women’s Affairs for programme management; and
- strengthen the existing database for programme monitoring and evaluation.

In relation to a database, analytical work on the 2007 census of population and housing should be given high priority by UNFPA, to be followed by extensive dissemination and capacity strengthening for utilization of population data for development plan formulation and management.

The above interventions are strategic and should be cost-effective in comparison with operational activities that cost a lot of money and have little to show for it because Ethiopia’s population is big and spread over a large territory. If population activities are well coordinated, i) the Action Plan will provide a common platform for all agencies interested in population issues (reproductive health, HIV/AIDS, gender, children and youth, employment, data utilization, research and training, migration, urbanization, population and poverty, civil registration, etc.); ii) it will be easier for UNFPA and the Government to mobilize resources for all aspects of population; iii) collaboration among interested agencies will be better harmonized and should lead to appreciable reduction in transaction costs; and iv) it will be easier to set population outcomes, indicators, baselines and targets for a more effective programme monitoring and evaluation.

Longer-Term

Over the longer term, following the final review of the ICPD PoA and MDGs, UNFPA should continue to place emphasis on strategic interventions given its limited resources. This might entail a hard look at the mission statement in the context of what the ICPD PoA covers and the UN Reform.

At the end of the review of the ICPD PoA and MDGs in 2015, and given the reality of development challenges facing developing countries and population programme efforts so far, it is easy to predict a number of population challenges for Ethiopia. UNFPA may wish to considering possible strategies to address some of them. Assuming that the interventions suggested during the medium term are enacted successfully, the long term challenges are in the following areas:

- The need for capacity building for population policy implementation and for integrating population issues into policies and plans at all levels of governance;
- Research on population and development to provide evidence for advocacy, policy response and programme management, including monitoring and evaluation of the Action Plan;
- Constraint on economic development and poverty eradication resulting largely from high rates of population growth;
- High and increasing population densities causing environmental degradation and reduced agricultural productivity;
- High and increasing rate of urbanization and the pressure on infrastructure, social service delivery and employment creation;
- Increasing demand for reproductive health commodities and services (including family planning and HIV/AIDS prevention and treatment) in support of the fertility transition trend;
- The population will increase rapidly, but the labor force will increase more rapidly in the next 30 years posing the challenge of 'Demographic Dividend' and the need to intensify the provision of reproductive health services, education and skills development and employment;
- Rural to urban migration will grow in proportion and will challenge labor in rural agriculture and employment of millions of poorly skilled urban job seekers;
- The establishment and sustained functioning of a nationwide vital registration system will be needed for administrative, legal and statistical purposes, and should obviate the need for expensive periodic censuses;
- Migration out of Ethiopia will need to be addressed in terms of numbers and the social and economic implications; and
- The persistence of gender discrimination and its social and economic consequences should be addressed.

Resource Needs

Perhaps the best source of resource needs for population activities in Ethiopia is the report on the MDG Needs Assessment carried out in the last quarter of 2004. Before then, Government had decided that

Ethiopia’s Sustainable Development and Poverty Reduction Programme (SDPRP) should be aligned with the MDGs to ensure achievement of the latter by 2015. In order to develop such an MDGs-based SDPRP, the Government requested to collaborate with the UN country team and the UN Millennium Project to work closely in formulating and carrying out an in-depth, detailed MDGs Needs Assessment which would map out the path for achieving the MDGs by 2015 and form the first step in the development of this MDGs based SDPRP [Refer to Terms of Reference: Ethiopia Millennium Development Goals (MDGs) Needs Assessment Process].

Based on the MDG Needs Assessment, it is estimated that, covering all the 12 sectors of the economy identified for the exercise, it would cost an estimated 872,816.1 million ETB from FY 2005/06 to FY 2014/15 to implement the MDGs in Ethiopia, including capital and recurrent expenditures (MOFED, MDGs NA Synthesis, 2005). This translates to an average spending per capita/year of US\$107.8. Estimated total costs [in million ETB] of the population related MDG sector programs from FY2005/06 to 2014/15 are as follows:

<u>Sector</u>	<u>ETB</u>
Health	39,984.9 million
HIV/AIDS	111,737.7 million
Population	539 million
Gender	340 million

Information is not readily available on the reproductive component of the health cost; but HIV/AIDS could be an eye opener. In its ICPD+15 report, the Government expressed the need for more aid to support its ICPD and MDG programmes in the country (see box).

Box: Need for More External Assistance

If Ethiopia is to achieve the MDGs and ICPD PoA, a significant push is needed to mobilize resources from the international community. This is justified by the level of official development assistance Ethiopia currently receives (USD 14 per capita) which is substantially lower than that of other low-income countries, including those that have higher average per capita income and better indicators of human development. So the case for increasing the external finance flows to Ethiopia is very strong and challenging.

The unpredictability of external assistance and the inability to project financial inflows for scaling-up activities is a great challenge for proper operations of programs and projects. The dependability of external assistance on a number of national and external factors makes projection of the amount and sustainability of assistance a difficult task.

The recent dramatic increase in import prices, including oil prices, implies fewer resources for development projects, including population projects. This may lead to a reassessment of development priorities in Ethiopia. (ICPD+15 Report)

Recommendations for UNFPA

1. The UN 'Delivering as One' initiative demands a fundamental change—change in the institutional structure of the organization and radical change in how the business of its agencies is done both at headquarters and in the country. The UN country team in Ethiopia is cognizant of this issue, but how to manage the transition remains a challenge. UNFPA should clearly define its role at the country level and expectations from headquarters should be consistent with funding and programme management.
2. In accordance with its mandate, UNFPA should reflect on the challenges identified in the “medium term” section of this paper and determine which areas interventions of a strategic nature would be advisable, particularly the issues around capacity building, advocacy for establishment of institutional structures for policy implementation, implementation of the Action Plan, support to integration, establishment of a coordination mechanism for population activities and training and research.
3. The main challenge to social and economic development in Ethiopia is the high rate of population growth; but there is also an undercurrent of a much higher rate of growth of the labor force that the country will experience in the next 30 years or so. This requires massive investments in reproductive health commodities and services, education for skills development of the labor force and massive employment creation. UNFPA should identify its strategic interventions in relevant areas (especially reproductive health service expansion, gender interventions, prevention of HIV/AIDS, population research) in support of Ethiopia's 'Demographic Dividend.'
4. In the design of the next UNDAF for Ethiopia and successive Country Programmes, UNFPA should ensure that its interventions are backed by sensitive, clearly defined and measurable indicators to facilitate its Country Programme monitoring and evaluation and determination of the Fund's contributions to Joint Program outputs.
5. It is strategic for UNFPA to continue its support to the Ethiopian 2007 population census data analysis and dissemination. The Fund may wish to consider working with the Government and University system to produce a population census report series on specific subjects to promote understanding of population issues in relation to development among planners, policy makers and the public at large.
6. UNFPA should reduce the number of operational activities in numerous locations across the country, particularly in the area of reproductive health and gender, and instead, focus on collaborative work and strategic interventions in a few selected areas in order to address its mandate more effectively.

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