REPRODUCTIVE HEALTH at a GLANCE

ETHIOPIA

April 2011

Country context

In recent years, Ethiopia has been one of the fastest growing economies in Africa with robust growth performance and considerable development gains from 2003 to 2007. Over the past two decades, there has been significant progress in key human development indicators: primary school enrollments have quadrupled, child mortality has almost been cut in half, and the number of people with access to clean water has more than doubled. More recently, poverty reduction has accelerated. The poverty headcount, which stood at 46 percent in 1999 and 2000, fell to 39 percent in 2004/5.[1] Two-fifths of the population still subsists on less than US $1.25 per day.[2]

Ethiopia's large share of youth population (44 percent of the country population is younger than 15 years old[2]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3] In Ethiopia, the literacy rate among females ages 15 and above is 23 percent.[2] Fewer girls are enrolled in secondary schools compared to boys with a 72 percent ratio of female to male secondary enrollment.[2] Four-fifths of adult women participate in the labor force [2] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Ethiopia ranks 149 of 157 countries in the Gender-related Development Index.[4]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Ethiopia: MDG 5 status

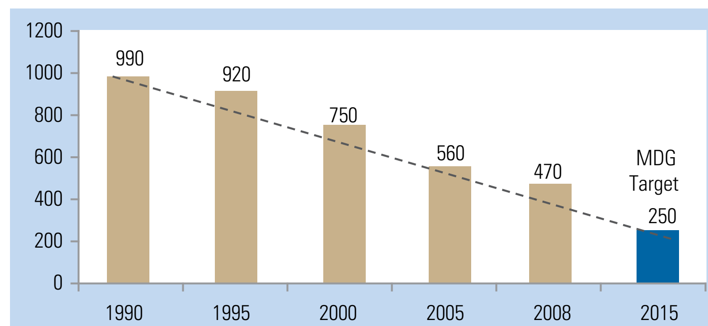
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	470
Births attended by skilled health personnel (percent)	18
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	32
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	104
Antenatal care with health personnel (percent)	71.4
Unmet need for family planning (percent)	33.8

Source: Table compiled from multiple sources
[a]The 2005 DHS estimated maternal mortality ratio at 673. Data collection for DHS 2010/11 is underway..

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Ethiopia has been making progress over the past two decades on maternal health but it is not on track to achieve its 2015 targets.[5]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank support for Health in Ethiopia

The Bank's ***Country Assistance Strategy Progress Report*** under preparation (P118836) was approved by the Bank's Executive Board on November 4, 2010.

Current Project:
P106228 ET-Ethiopia Nutrition SIL (FY08) ($30m)

Pipeline Project: P124821 maET: Nutrition coordination capacity dev Approval date 1/5/2011
P123531 Ethiopia Health MDG support operation Appraisal date 5/24/2011

Previous health project: P098031 ET-Multi-Sectoral HIV/AIDS II (FY07)

THE WORLD BANK

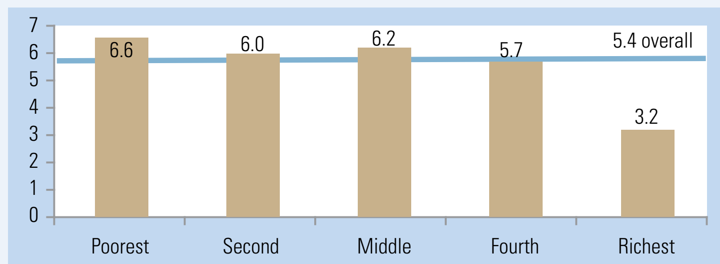
msh Management Sciences for Health

Key challenges

High Fertility

Fertility remains high. Total fertility rate (TFR) fell slightly from 6.4 births per woman in 1990 to 5.4 in 2005.[6] TFR is very high (over 6) among women in the lower three wealth quintiles while it is 3.2 among women in the highest quintile (Figure 2).[6]

Figure 2 ▪ Total fertility rate by wealth quintile



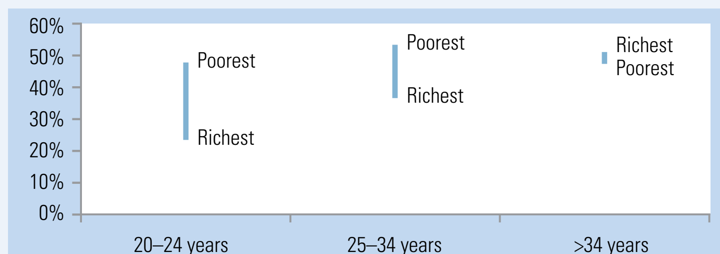
Source: DHS Final Report, Ethiopia 2005

Disparities exist between women in rural areas at 6.0 births per woman compared to 2.4 for those in urban areas, and vary by education levels at 6.1 births per woman with no education, and 2 with secondary education or higher.

Adolescent fertility rate is high (104 reported births per 1,000 women aged 15–19 years) affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 7]

Early childbearing is more frequent among the poor. While 48 percent of the poorest 20–24 years old women have had a child before reaching 18, only 23 percent of their richer counterparts did (Figure 3). Furthermore, reduction in early childbearing mostly has taken place among the rich where younger cohorts of girls are less likely than older cohorts to have a child early in life.

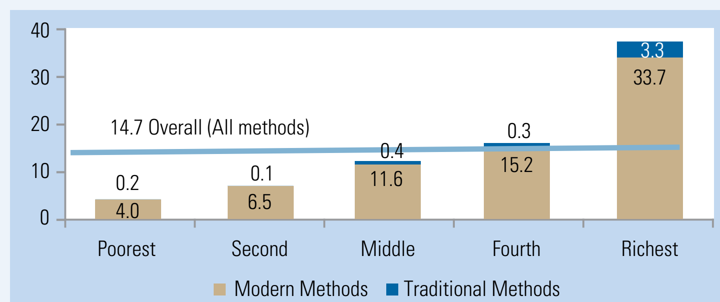
Figure 3. ercent women who have had a child before age 18 years by age group and wealth quintile



Source: DHS Final Report, Ethiopia 2005 (author's calculation)

Over a tenth of women use contraception. Current use of contraception among married women is 14 percent.[6] Injectables are the most commonly used method among married women at 10 percent followed by the pill at 3 percent. Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: it is high among women with secondary education or higher (46 percent), urban women (42 percent) and 34 percent among women in the highest wealth quintile (Figure 4).

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS Final Report, Ethiopia 2005

Unmet need for contraception is high at 34 percent indicating that women may not be achieving their desired family size.[8] The abortion law reform, expanded in 2005, now gives women more options in seeking safe abortion services. Still, 6 in 10 abortions in Ethiopia are unsafe.[9]

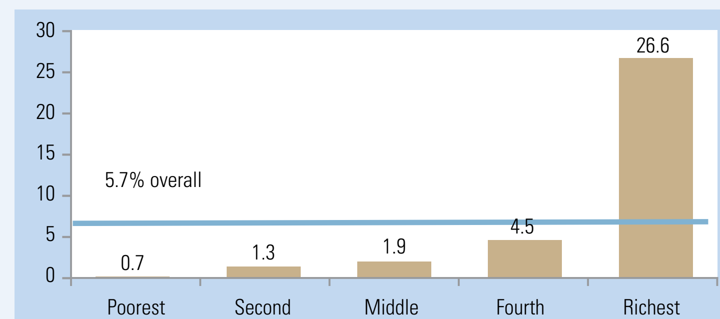
Opposition to use (24 percent) and wanting more children (17 percent) are the predominant reasons women do not intend to use modern contraceptives in future. Further, 13 percent cited fear of side effects or health concerns.[6] Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

More pregnant women use antenatal care than delivery with health personnel.. Over two-thirds of pregnant women received antenatal care with 31 percent having received the recommend four visits. However, only 16 percent of the deliveries were attended by skilled health personnel.[10]

While 27 percent of women in the wealthiest quintile delivered with skilled health personnel, less than a percent of women in the poorest quintile obtained such assistance (Figure 5). Additionally,

Figure 5 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



DHS Final Report, Ethiopia 2005

two percent of women with no education delivered with skilled health personnel as compared to 58 percent of women with secondary education or higher. Further, 63 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[11]

Two-thirds or more women who indicated problems in accessing health care cited concerns regarding concerns that no provider is available, inability to afford the services, long distance, transport difficulties, or no other person to complete household chores (Table 1).[6]

Table 1 ■ Barriers in accessing health care (women age 15–49)

Reason	%
At least one problem accessing health care	95.7
Concern no provider available	80.5
Getting money for treatment	75.6
Concern no female provider available	72.5
Having to take transport	71.6
Concern there may be no one to complete household chores	69.3
Distance to health facility	67.7
Not wanting to go alone	61.4
Getting permission to go for treatment	34.5

Source: DHS final report, Ethiopia 2005

Human resources for maternal health are limited with only 0.02 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.24 per 1,000 population.[2]

The high maternal mortality ratio at 470 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[5]

The 2008 EmONC assessment revealed 51 percent of hospitals provide comprehensive EmONC and only 9 provide basic EmONC services.[12]

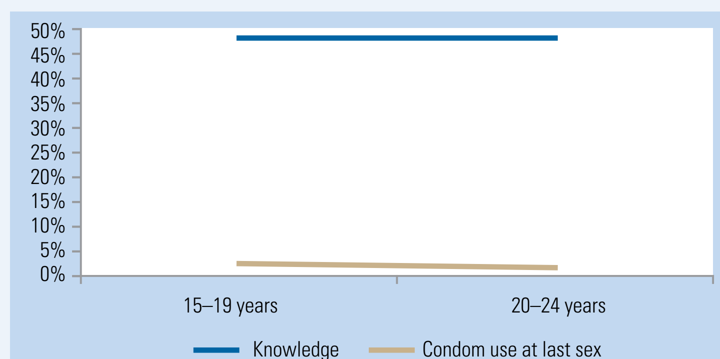
STIs/HIV/AIDS is public health concern

HIV prevalence if relatively low but women are one of the most vulnerable groups. The adult population that has HIV is 1.4 percent in 2005 but the prevalence among females is significantly higher than among males (1.9 percent and 0.9 percent, respectively).[6]

Knowledge of mother to child prevention methods is limited. A fifth of women know that HIV can be transmitted through breast milk and that the likelihood of passing HIV from mother to child can be reduced by drugs.[6]

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While 45 percent of young women are aware that using a condom in every intercourse prevents HIV, only 2 percent of them report having used condom at last intercourse (Figure 6).

Figure 6 ■ Knowledge behavior gap in HIV prevention among young women



Source: DHS Final Report, Ethiopia 2005 (author's calculation)

Development partners support for reproductive health in Ethiopia

USAID: Integrated health care; health care system capacity building

SIDA: Reducing child and maternal mortality

CIDA: Technical assistance and monitoring for MCH

GIZ: Health center development

WHO: HIV/AIDS; making pregnancy safer; women's health

UNFPA: Integrated approach to sexual and reproductive health and rights

UNICEF: Campaign for vulnerable children – HIV/AIDS

Marie Stopes: Family planning; abortion; post-abortion care; HIV/STIs; male circumcision; maternal health

FHI: Increasing contraceptive use and lowering STIs

IPAS: Expand access to high quality abortion services

Engender Health: HIV/AIDS; reproductive health care; contraceptives; gender norms; combating early marriage and adolescent pregnancy

IntraHealth International: Community-based approaches to maternal and child health and HIV/AIDS services

IPPF: Family planning; abortion care; MCH; STIs; HIV/AIDS

Pathfinder International: Integrated services for FP, MNH, and HIV/AIDS

Technical notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- The government has enacted guidelines to mainstream gender in all sectors including health to ensure and promote gender equality and empowerment, enhancing equal opportunities in the participation of social and economic development undertakings and increasing utilization of health service by women.

Reducing high fertility

- Address the issue of opposition to contraceptive use by promoting the benefits of small family size. Increase family planning awareness and utilization through involvement of community members particularly men, through regular media campaigns. Enlist community leaders and women's groups and emphasize community-based distribution.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel. Ensure the availability of at least three family planning options for all households.
- Strengthen post-abortion care and link it with family planning services.

Reducing maternal morbidity and mortality

- Make available quality antenatal care, prioritizing the poor and those in harder to reach rural areas. During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.
- Promote institutional delivery through provision of maternal services free of charge in public facilities.
- Strengthen referral system for maternal health services.
- Scale-up of basic and comprehensive EmONC services.
- Increase the rate of births attended by skilled attendant by scaling up training programs for health officers, midwives, and emergency surgeons.

Reducing STIs/HIV/AIDS

- Strengthen knowledge and skills of health personnel so that they are able to accurately inform and counsel adolescents and youth on vulnerability to HIV/AIDS/STIs.
- Educate youth and raise awareness in the greater community to increase knowledge of HIV/AIDS and STI risks, prevention, and treatment options, and to reduce stigma.
- Include PMTCT as part of routine antenatal care and make antiretroviral drugs available to women who need them.

References:

1. World Bank Ethiopia Country Brief, available at *http://go.worldbank.org/WA1RL12OL0*.
2. World Bank. 2010. World Development Indicators. Washington DC.
3. World Bank, Engendering Development: Through Gender Equality in Rights, Resources, and Voice. 2001.
4. Gender-related development index. Available at *http://hdr.undp.org/en/media/HDR_20072008_GDI.pdf*.
5. Trends in Maternal Mortality: 1990–2008: Estimates developed by WHO, UNICEF, UNFPA, and the World Bank
6. Central Statistical Agency [Ethiopia] and ORC Macro. 2006. *Ethiopia Demographic and Health Survey 2005.*
7. WHO 2011. Making Pregnancy Safer: Adolescent Pregnancy. Geneva: WHO. http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/index.html.
8. Samuel Mills, Eduard Bos, and Emi Suzuki. Unmet need for contraception. Human Development Network, World Bank. *http://www.worldbank.org/hnppublications*.
9. Guttmacher Institute. Facts on Unintended Pregnancy and Abortion in Ethiopia. April 2010. *http://www.guttmacher.org/pubs/FB-UP-Ethiopia.pdf*.
10. Annual performance report Federal Ministry of Health 2009/10.
11. Worldwide prevalence of anaemia 1993–2005: WHO global database on anaemia/Edited by Bruno de Benoist, Erin McLean, Ines Egli and Mary Cogswell. *http://whqlibdoc.who.int/publications/2008/9789241596657_eng.pdf*.
12. Ethiopia national baseline assessment for emergency obstetric care, 2008.

Correspondence Details

This profile was prepared by the World Bank (HDNHE, PRMGE, and AFTHE) and Management Science for Health (MSH). For more information contact, Samuel Mills, Tel: 202 473 9100, email: smills@worldbank.org. This report is available on the following website: *www.worldbank.org/population*.

ETHIOPIA REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2005	5.4
Adolescent fertility rate (births per 1,000 women ages 15–19)	2005	104
Contraceptive prevalence (% of married women ages 15–49)	2010	32
Unmet need for contraceptives (%)	2005	33.8
Median age at first birth (years) from DHS	—	—
Median age at marriage (years)	2005	16.5
Mean ideal number of children for all women	—	—
Antenatal care with health personnel (%)	2010	71.4
Births attended by skilled health personnel (%)	2005	5.7
Proportion of pregnant women with hemoglobin <110 g/L	2008	62.7
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	990
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	920
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	750
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	560
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	470
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	250
Infant mortality rate (per 1,000 live births)	2008	69
Newborns protected against tetanus (%)	2008	84
DPT3 immunization coverage (% by age 1)	2010	86
Pregnant women living with HIV who received antiretroviral drugs (%)	2010	8.1
Prevalence of HIV, total (% of population ages 15–49)	2007	2.1
Female adults with HIV (% of population ages 15+ with HIV)	2007	59.6
Prevalence of HIV, female (% ages 15–24)	2007	1.5

Indicator	Year	Level
Population, total (million)	2007	73.7
Population growth (annual %)	2008	2.6
Population ages 0–14 (% of total)	2008	45.0
Population ages 15–64 (% of total)	2008	51.6
Population ages 65 and above (% of total)	2008	3.2
Age dependency ratio (% of working-age population)	2008	88.7
Urban population (% of total)	2008	17.0
Mean size of households	2005	5
GNI per capita, Atlas method (current US$)	2008	280
GDP per capita (current US$)	2008	317
GDP growth (annual %)	2008	11.3
Population living below US$1.25 per day	2005	39
Labor force participation rate, female (% of female population ages 15–64)	2008	80.8
Literacy rate, adult female (% of females ages 15 and above)	2004	22.8
Total enrollment, primary (% net)	2008	79
Ratio of female to male primary enrollment (%)	2008	89.4
Ratio of female to male secondary enrollment (%)	2008	72.3
Gender Development Index (GDI)	2008	149
Health expenditure, total (% of GDP)	2007	3.8
Health expenditure, public (% of GDP)	2007	2.2
Health expenditure per capita (current US$)	2007	9.2
Physicians (per 1,000 population)	2010	0.029
Nurses and midwives (per 1,000 population)	2010	0.291

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2005	6.6	6.0	6.2	5.7	3.2	5.4	3.4	2.1
Current use of contraception (Modern method)	DHS	2005	4.0	6.5	11.6	15.2	33.7	13.9	–29.7	0.1
Current use of contraception (Any method)	DHS	2005	4.2	6.6	12.0	15.5	37.0	14.7	–32.8	0.1
Unmet need for family planning (Total)	DHS	2005	33.1	37.9	36.8	36.2	24.1	33.8	9.0	1.4
Births attended by skilled health personnel (percent)	DHS	2005	0.7	1.3	1.9	4.5	26.6	5.7	–25.9	0.03

National policies and strategies that have influenced Reproductive health

- Enactment of the National Health policy in 1993 that stipulates delivery of health care services in a decentralized and equitable manner
- The development and implementation the of National Reproductive Health Strategy 2006–2015
- Introduction of abortion guidelines in 2006
- The launching of the accelerated training of health officers, initiation of the Masters program on Emergency surgery and obstetrics for health officers and provision of a one month in-service training on clean and safe delivery for health extension workers include the efforts being undertaken to tackle the HRH constraints.
- The Government has introduced a guideline to allow women to receive free maternal health services.
- The launching of campaign on Accelerated Reduction of Maternal and newborn death led by Africa Union
- Reproductive health strategy for adolescents and youth is being finalized