Ministry of Women, Children and Youth

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Changing Trends in Gender Equality in Ethiopia

Research Brief

Introduction

Women and children are often overrepresented among the vulnerable segments of the Ethiopian population. With the approval of the Sustainable Development Agenda in 2015, the Government of Ethiopia has stepped up efforts to fulfil Sustainable Development Goal 5, aiming at achieving greater gender equality and empowerment for all women and girls in the country. There is a need to define, measure and understand gender-related outcomes in Ethiopia for better targeting of policy action.

This research brief presents findings on trends in gender equality over the period from 2000 to 2016 through sex-disaggregated indicators, clustered into seven dimensions, as the basis for assessment of gender equality: (1) Nutrition, (2) Health and health-related knowledge, (3) Family planning, (4) Education, (5) Child protection, (6) Economic activity, use of time, and access to resources, and (7) Agency and autonomy.

The report uses children's and women's rights as the criteria for selecting the indicators and dimensions for measuring gender equality in Ethiopia. The process involved a review of gender equality studies in Ethiopia, and also existing legislation, national strategies, and policies available from the Ministry of Women, Children and Youth (MOWCY), UNICEF, UN Women, UNFPA, and the World Bank amongst others. The indicators were then defined consistent with existing SDG targets and rights stipulated in international conventions and declarations and through extensive consultations with national stakeholders and development partners in the country.

The main dataset for the analyses was the Ethiopian Demographic and Health Survey (EDHS) 2000, 2005, 2011 and 2016 editions, but some indicators were extracted from the Welfare Monitoring Survey (WMS) and World Bank ASPIRE database to fill the EDHS data gaps.

This brief sheds light on trends in gender equality over time and seeks to identify the geographic disparities and gaps in the measurement that should be addressed to accelerate equitable outcomes for girls, boys, women and men.

Key findings

Trend analyses of nutritional outcomes for children and adults show progress over the years in several aspects of wellbeing. Since 2000, the incidence of early initiation of breastfeeding has increased by more than 25 per cent for all children, reaching 73 and 71 per cent for girls and boys, respectively, in 2016. Exclusive breastfeeding rates have also increased for girls and boys, from 53 per cent and 48 per cent, respectively, in 2000 to 58 per cent and 57 per cent in 2016.

There is also a decline in stunting and underweight among girls and boys in Ethiopia. In 2016, 35 per cent of girls were stunted compared to 49 per cent in 2000. The stunting rates for boys were 41 per cent in 2016 and 50 per cent in 2000.

The incidence of underweight has nearly halved over the years for girls and boys, from 45 per cent and 46 per cent, respectively, in 2000, to 22 per cent and 25 per cent in 2016.

The rates of undernutrition for adults have also declined over the years. The rates of undernourished women were 19 per cent in 2016, compared to 25 per cent in 2000. For men the rates of undernourishment were 29 per cent and 26 per cent in 2011 and 2016, respectively.

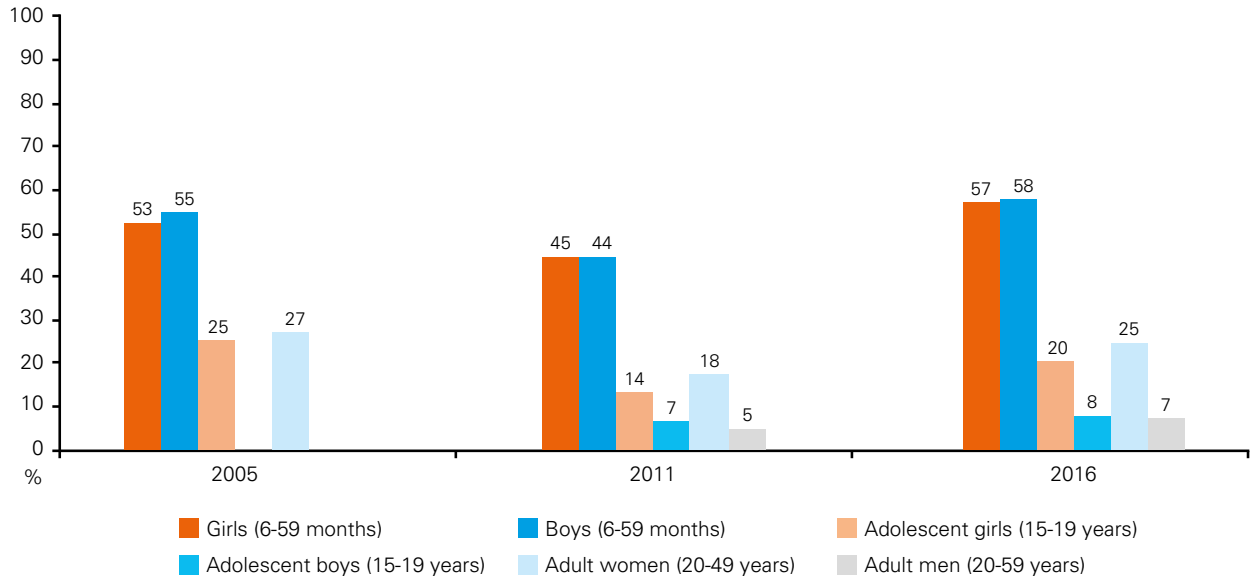
These improvements notwithstanding, there are inconsistencies in the progress achieved across the wealth spectrum. Over the years, the incidence of exclusive breastfeeding was more prominent in the richest quintile while the incidence of early initiation of breastfeeding was more equally distributed across all wealth quintiles. Furthermore, the proportion of the poorest children who were stunted or underweight in 2016 was almost double compared to the proportion of the richest children in the country.

1 National Policy on Ethiopian Women (1993); Constitution of the Federal Democratic Republic of Ethiopia (1995); Family Law (2000); Criminal Law (2005); National Gender Equality Strategy and Action Plan for Gender Equality (2006-2010); EU+ Joint Strategy on Nutrition for Ethiopia (2016-2020); National Identity Card Registration Proclamation No. 760/2012; Ethiopian Women Development and Change Package, National Strategy and Action Plan on Harmful Traditional Practices (2013), Sexual and Reproductive Health Strategy (2016-2015), the National Adolescent and Youth Health Strategy (2016-2020), the Health Sector Transformation Plan (2015/16-2019/20), the Education Sector Development Plan 2016-2020, and the National Human Rights Action Plan (2013).

2 Convention on the Rights of the Child (1989), Universal Declaration of Human Rights (1948), Convention on the Elimination of All Forms of Discrimination Against Women (1979), Convention on the Political Rights of Women (1953), and Declaration on the Elimination of Violence Against Women (1993).

3 The WMS was used to measure the incidence of FGM among girls aged 0-14 years, while the World Bank ASPIRE database was used to obtain data on labour market outcomes.

Figure 1 Trends in prevalence of iron deficiency/anaemia, by age and gender (%)



Source: Authors' calculations using EDHS data.

Progress in other nutritional outcomes has been slow and has even stalled. The percentage of girls who received a Minimum Acceptable Diet (MAD) increased by only 2 percentage points, from 5 per cent in 2005 to 7 per cent in 2016. The MAD rates for boys were 6 per cent in 2005 and 8 per cent in 2016. The percentage of girls and boys who received MAD intakes was nearly four times higher in urban areas than in rural areas. These disparities are also reflected in the wealth spectrum, in that six times more children in the richest wealth quintiles were fed a MAD in 2016 than children in the poorest quintile.

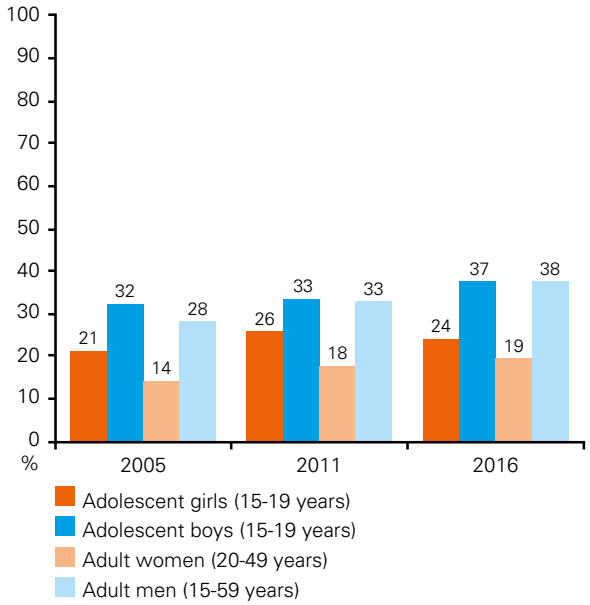
Gender inequality in anaemia prevalence among children and adults persists over the years (Figure 1). More than half of girls and boys under five in Ethiopia were anaemic in 2016, with little progress observed over the years considered. Adolescent girls were more than twice as likely as adolescent boys to be anaemic, while for adult women the likelihood was nearly three times higher compared to men. Anaemia prevalence is particularly high among children residing in rural areas and in Somali. The largest gender disparities were observed among adolescents in Afar and adults in Somali. Incidence of anaemia is also unequal across the wealth quintiles. In 2016, 68 per cent of children aged 6-59 months in the poorest wealth quintile suffered from iron deficiency, compared to 48 per cent of children in the richest quintile.

Progress can be observed in a number of health-related outcomes, but challenges remain. The percentage of fully immunized girls and boys under five reached 39 per cent and 38 per cent, respectively, in 2016, up from 16 per cent and 17 per cent in 2000. However, rural-urban discrepancies in immunization persist. In 2016, 36 per cent of rural children were immunized compared to 66 per cent of urban children. Immunization is also prone to wealth effects. In 2016, children from the richest wealth quintile were nearly three times more likely to be fully immunized (coverage at 58 per cent) compared to their peers from the poorest wealth quintile (coverage at 19 per cent).

Healthcare-seeking behaviour also improved between 2000 and 2011 but then stagnated. In 2016, an equal proportion, 27 per cent, of girls and boys suffering from diarrhoea, fever or cough, received professional healthcare attention. Progress has been slightly greater among girls (from 14% in 2000 to 27% in 2016), compared to 17% to 27% amongst boys. Healthcare-seeking behaviour rates are lower in rural areas compared to urban areas. Poorer households were found to seek professional healthcare less often than wealthier households. Similarly, lower rates of healthcare-seeking behaviour were found in Amhara, Oromia and Tigray.

Gender inequality in comprehensive knowledge about HIV/AIDS prevention and transmission has widened over the decade 2005- 2016 among both adolescents and adults (Figure 2). The share of adolescent girls (24 per cent) and adult women (19 per cent) who had comprehensive knowledge about HIV/AIDS in 2016 was smaller compared

Figure 2 **Trends in knowledge about HIV/ AIDS prevention and transmission, adolescents and adults, by gender (%)**



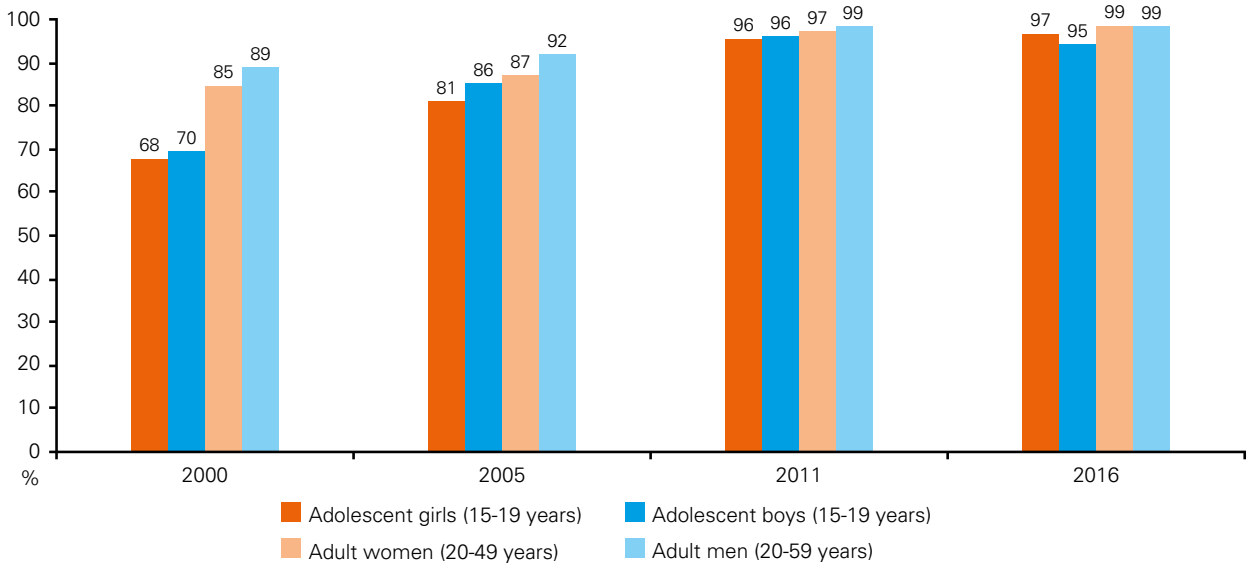
Source: Authors' calculations using EDHS data.

to their male counterparts. Trend analysis shows that improvements in this area over the decade occurred for all groups, especially adult men. A significantly higher percentage of adolescent boys in Harari and Dire Dawa and adult men in Dire Dawa, Gambela, and Amhara had comprehensive knowledge about HIV/AIDS prevention and transmission compared to their female counterparts. Harari and Amhara had persistent high inequality rates in health-related knowledge over the decade with no major improvements. Knowledge of HIV/AIDS remains low in Somali across all the groups analysed. Knowledge of HIV/AIDS also varies across the wealth quintiles. In 2016, 10 per cent of girls and 29 per cent of boys in the poorest quintile had comprehensive HIV/AIDS knowledge compared to 38 per cent of girls and 49 per cent of boys in the richest wealth quintile.

Adolescent girls and adult women are at twice the risk of HIV infection as adolescent boys and adult men. However, the trend in HIV infection is on a downward path. In 2016, 0.4 per cent and 0.1 per cent of girls and boys, respectively, had HIV/AIDS, compared to 0.7 per cent and 0.1 per cent of girls and boys in 2005. Similarly, 1.2 per cent and 0.6 per cent of adult women and men, respectively had HIV/AIDS in 2016. In 2005, however, these rates were 1.9 per cent and 0.9 per cent for women and men. However, HIV/AIDS prevalence in urban areas is consistently higher than in rural areas, reaching seven times higher in 2016, 2.9 per cent compared to 0.4 per cent, respectively. Over the decade 2005-2016, prevalence was higher in Addis Ababa, Gambela, and Harari than in the rest of the country.

Major progress has been achieved in the area of family planning over the period 2000 -2016. Prevalence of knowledge about modern contraception increased among adolescent girls and boys, from 68 per cent and 70 per cent, respectively, in 2000, to 97 per cent and 95 per

Figure 3 **Trends in knowledge of modern contraception methods, per cent of adolescents and adults who know at least one method, by gender (%)**



Source: Authors' calculations using EDHS data.

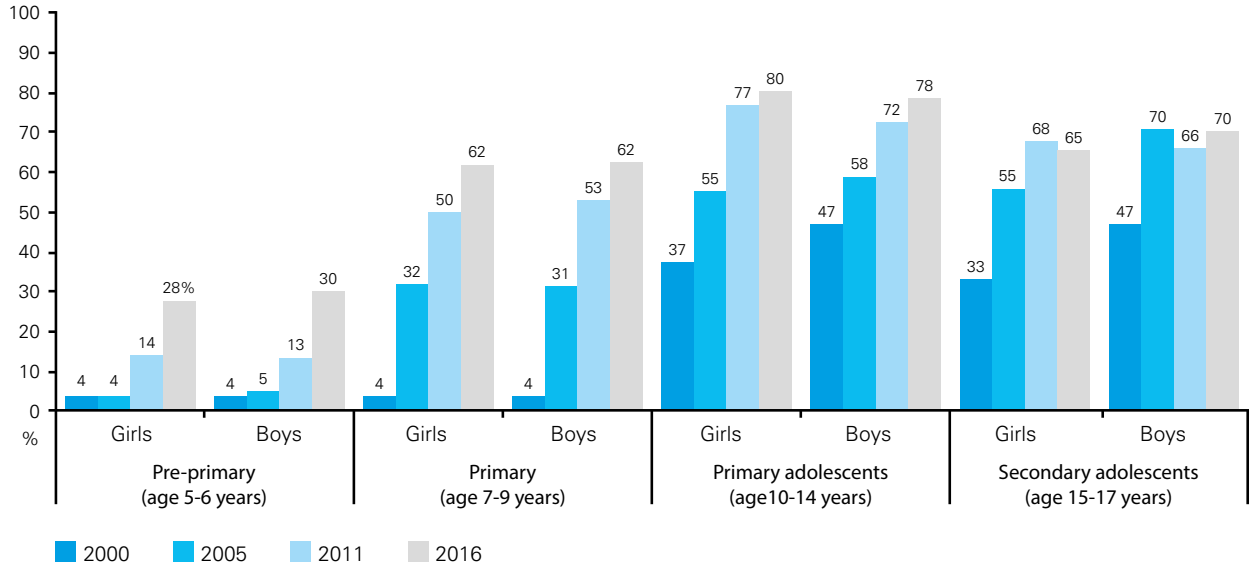
cent in 2016 (Figure 3). It is encouraging to see that the gap in knowledge of contraception has narrowed across the wealth quintiles. In 2016, 88 per cent of adolescent girls and 89 per cent of adolescent boys from the poorest quintile had knowledge about contraception compared to nearly 100 per cent of adolescent girls and boys from the richest quintile. Knowledge among adult women and men also steadily increased, reaching nearly all of the adult population in 2016. In the country, Afar, Somali, Gambela, Benishangul-Gumuz and SNNPR showed the greatest improvement in knowledge of modern contraception over the years

Progress in the education sector has been remarkable, especially in increasing school attendance rates across school cycles and narrowing the gender gap. Between 2000 and 2016, attendance rates for pre-primary, primary, and secondary education increased radically. The gender gap in primary school attendance has been eliminated. What is more intriguing is that the school attendance rate of adolescent girls (aged 10-14 years) exceeded that of their male peers, 80 per cent compared to 78 per cent, respectively (Figure 4). The gender gap in secondary school attendance has narrowed to a five-percentage-point difference in favour of boys. Across regions, Amhara, Tigray, SNNPR, and Benishangul-Gumuz made the most significant progress in narrowing the gender gap in secondary school attendance rates over the 16-year period.

The share of children who attended the right grade for their age nearly doubled from 31 per cent in 2000 to 61 per cent in 2016.

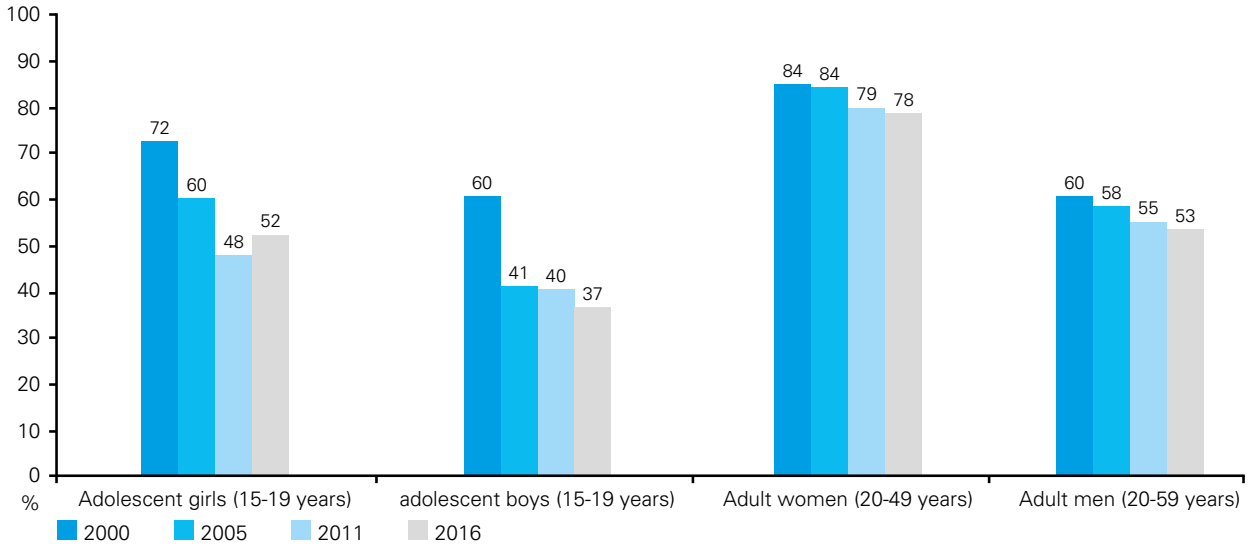
Despite these improvements, there are gaps across regions, gender, and wealth quintiles. In 2016, 28 per cent of girls and 30 per cent of boys aged 5-6 years attended pre-school education compared to 4 per cent for each in 2000, denoting slightly greater progress among boys. While progress in primary school attendance among 7-9-year-olds was equal among both girls and boys – rising from 4 per cent in 2000 to 62 per cent in 2016, among 10-14-year-olds progress was greater among girls (from 37 per cent in 2000 to 80 per cent in 2016). School attendance rates among secondary school-age children show greater progress among girls, too, although for both girls aged 10-14 years and 15-17 years, school attendance rates are lower compared to those of boys of the same age. In addition, in 2016, pre-primary and primary school attendance rates were significantly lower in rural areas and in Somali, Afar, and Oromia. In Afar, Harari, and Somali gender inequality in secondary school attendance increased over the 16-year period. School attendance rates across all school cycles varied in line with household wealth. In 2016, 18 per cent of children aged 5-6 years from the poorest quintile attended pre-school compared to 60 per cent of their peers belonging to the richest wealth quintile. The school attendance - wealth discrepancy persists across primary and secondary education. Iliteracy rates among

Figure 4 Trends in school attendance, by age and gender (%)



Source: Authors' calculations using EDHS data.

Figure 5 Trends in illiteracy, adolescents and adults (%)



Source: Authors' calculations using EDHS data.

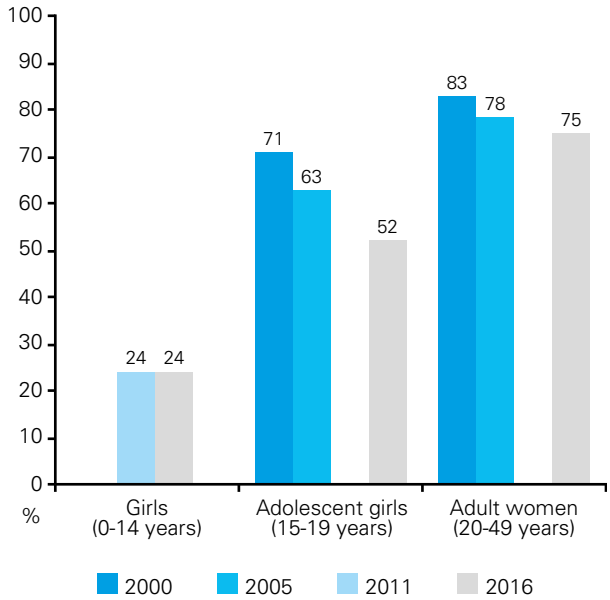
adolescents and adults have steadily declined since 2000, but remained high in the country overall, particularly for adult women (see Figure 5). Illiteracy rates are higher in Somali, SNNPR, and Afar. Gender inequality in adult literacy has been the highest in Gambela since 2000, while Somali had the widest gender gap in adolescent literacy in 2016. Adolescent illiteracy rates have declined most in Amhara among girls, and Oromia among boys. At the same time, Tigray has seen the highest decline in illiteracy rates among adult women and men. Moreover, illiteracy is associated with household wealth, and is more prevalent among adolescents in the poorer wealth quintiles. For instance, in 2016, 78 per cent of adolescent girls in the poorest wealth quintile were illiterate compared to 27 per cent of their peers in the richest wealth quintile.

Child protection indicators show that progress in eliminating child marriage and teenage pregnancy was slow between 2000 and 2016. Even though child marriage rates halved between 2000 and 2016, from 20 per cent to 11 per cent, respectively, in Afar nearly a third of 15-17-year-olds were already married in 2016. Overall, the incidence of teenage pregnancy also declined, from 16 per cent in 2000 to 13 per cent in 2016. However, these rates are not equally distributed across the country. For instance, in 2016, teenage pregnancy rates in Somali and Afar were 19 per cent and 23 per cent, respectively, while in Addis Ababa and Dire Dawa the rates were just 3 per cent. The child marriage rate of girls in the poorest quintile was 27 per cent in 2016 compared to 4 per cent among girls in the richest wealth quintile.

More than a third of adolescent girls experienced some form of violence – physical, psychological or sexual – during 2016. The incidence of violence was significantly higher in urban areas, among girls in poorer wealth quintiles, and among those residing in Addis Ababa, Amhara, and Harari.

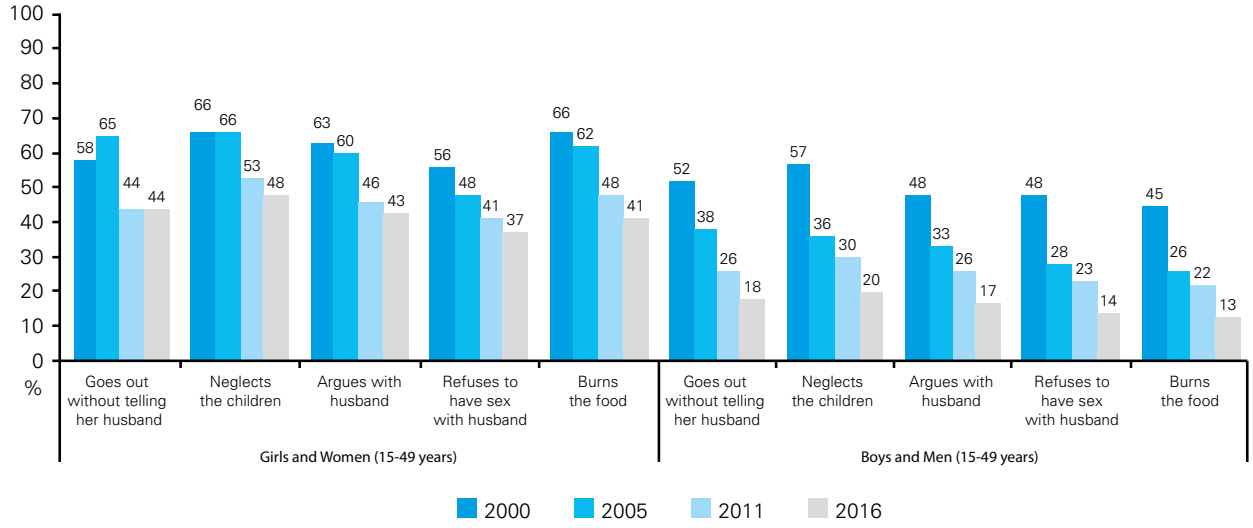
The incidence of female genital mutilation (FGM) among girls aged 15-19 declined from 71 per cent in 2000 to 52 per cent in 2016 (Figure 6), but in Somali remained as high as 96 per cent and in Afar at 87 per cent. The incidence of FGM among 0-14-year-old girls remained at 24 per cent between 2011 and 2016.

Figure 6 Trends in FGM incidence among adolescent girls and women (%)



Source: Authors' calculations using EDHS data; figures for girls 0-14 years extracted from WMS statistical reports 2011 and 2016.

Figure 7 Trends in attitudes towards GBV, adolescents and adults (%)

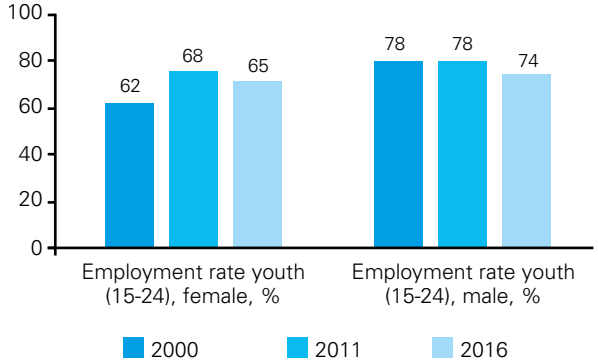


Source: Authors' calculations using EDHS data.

In 2016, the incidence of FGM among adolescent girls in the richest quintile was 43 per cent and 73 per cent for girls in the poorest quintile.

Changes in attitudes towards FGM have seen improvements over the years. Only 17 per cent of adolescent girls in 2016 shared the opinion that FGM should be continued or were undecided about it compared to 65 per cent in 2000. An even lower percentage of adolescent boys (13 per cent) supported the practice of FGM or were unsure about it in 2016. Across regions, Amhara, SNNPR, and Benishangul-Gumuz achieved the greatest progress in changing attitudes towards FGM, while in Somali and Afar more than half of adolescents in 2016 thought that the practice should be continued. Attitudes have also changed drastically among adolescents in rural areas. Evidence of attitudes towards FGM across wealth quintiles shows that poorer individuals were generally more in favour of the practice.

Figure 8 Trends in employment, by age group and gender (%)



Source: World Bank, ASPIRE database.

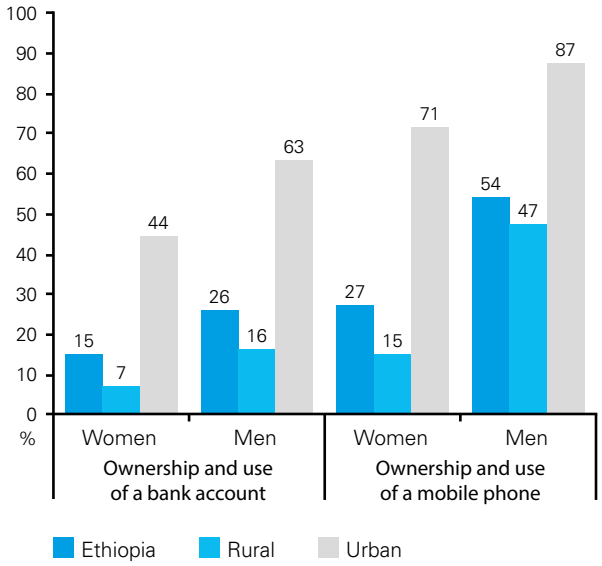
Attitudes towards gender-based violence (GBV) show a wide gender gap. Significantly fewer men (between 13 and 20 per cent) shared the opinion that wife-beating is justified in certain situations compared to between 37 and 44 per cent of adolescent girls and adult women, respectively (Figure 7). In 2016, wife-beating was widely justified among men in Amhara, and women in Oromia, Afar, Tigray, and SNNPR.

Trend analysis of labour market outcomes of female and male youth (15-24 years) shows that the gap in employment between male and female had narrowed over the years. The women's employment rate increased from 62 per cent in 2000 to 65 per cent in 2016 (Figure 8). At the same time, employment rates among male youth declined, from 78 per cent in 2000 to 74 per cent in 2016.

Fewer women own a bank account or a mobile phone compared to men, especially in rural areas. Only 15 per cent of women owned and used a bank account in 2016 compared to 26 per cent of men (Figure 9). Similarly, 27 per cent of women owned and used a mobile phone compared to 54 per cent of men. With the exception of Addis Ababa, Dire Dawa, Tigray, and Harari, the incidence of bank account ownership was very low among women.

In Ethiopia, fewer women have control over land and/or own a house compared to men. In 2016, only 15 per cent of women own real estate and/or land alone. At the same time, 36 per cent and 35 per cent of men, respectively, owned a house

Figure 9 Ownership and use of bank accounts and mobile phones, 2016 (%)



Source: CSA EDHS 2016 report

and/or land alone. Across the country, a notable proportion of women residing in Amhara, Oromia, Addis Ababa and Tigray had title deeds on land and/or house they owned with their names on them. The data shows that legal control over assets was low for both men and women in rural areas, Afar, Gambella, and especially Somali.

Women's participation in decision-making increased over the period 2005-2016 (Figure 10). From 2005 to 2016, growing proportions of women participated in decisions about their own health, making large household purchases, and visiting family or relatives. An increasingly higher percentage also participated in decisions as to how their partner's/husband's earnings would be spent. This trend is visible across all regions, except Somali, SNNPR, and Afar, where there is a lower incidence of women's participation in decision-making.

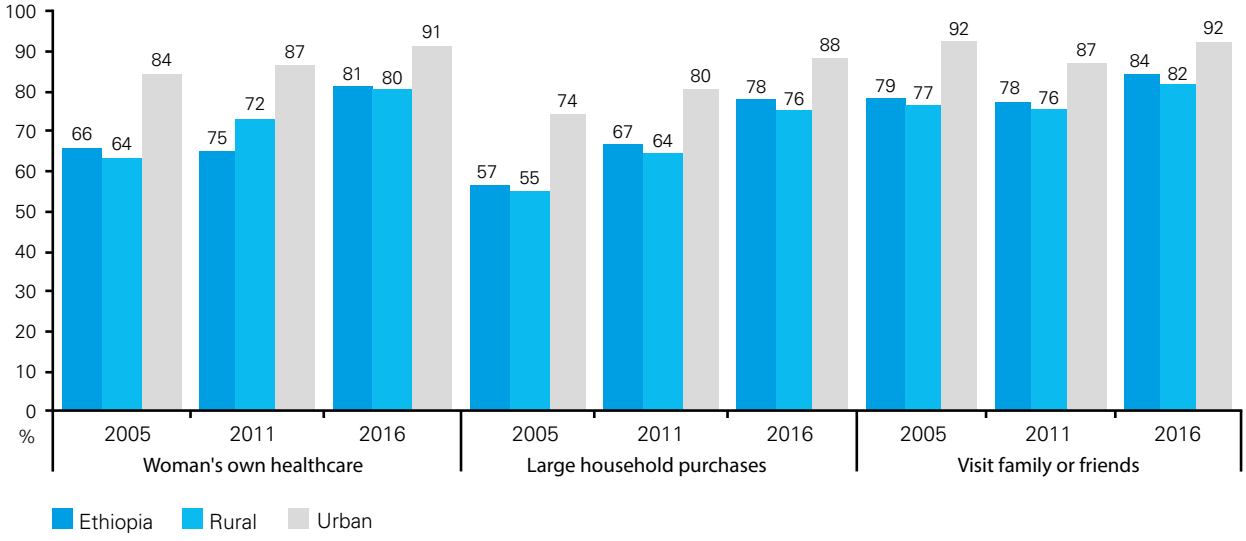
Recommendations

Overall, gender equality has seen improvements in Ethiopia between 2000 and 2016, but a myriad of issues persist. Based on the study, three sets of recommendations are proposed in order to design policy and programme interventions to enhance gender equality and to improve the quality of measurement and monitoring for future evaluations.

Policy and programme interventions. Findings from a range of different indicators of wellbeing consistently show that there are clusters of population that lag behind in the fulfilment of their basic needs and rights.

- Higher vulnerabilities are observed in rural as compared to urban areas across many indicators, age groups, and years. Tackling vulnerabilities in rural areas, especially *anaemia, immunization, health-seeking behaviour, child marriage, ownership of assets,* will significantly enhance the situation of girls and women.
- The gender equality gap varies widely across regions. Progress in narrowing it has been steady in Addis Ababa, but slower progress or even regress was

Figure 10 Trends in women's decision-making power in the household, by area of residence (%)



Source: Authors' calculations using EDHS data.

noted in Afar, Tigray, Somali, SNNPR, Amhara, Harari, Dire Dawa, Gambela, Benishangul-Gumuz. Some key areas where high gender inequality was observed are:

- Anaemia level for adolescent girls and women in Afar and Somali
- Gender gap in school attendance in Afar, Harari and Somali
- High gender inequality in adult literacy in Gambela and in adolescent literacy for Somali
- High incidence of child marriage, teenage pregnancy and FGM in Somali and Afar
- Widespread justification of wife-beating among men in Amhara and women in Oromia, Afar, Tigray and SNNPR
- Lower incidence of women's participation in household decision-making in Somali, SNNPR and Afar.

A regional focus in tackling gender inequality is recommended.

- Incidence of violence – physical, psychological or sexual – is higher in urban areas and in Addis Ababa, Amhara and Harari. Awareness-raising campaigns are encouraged for these areas, in addition to the establishment of legal and other institutional mechanisms to respond to gender-based violence cases in an integrated manner.
- Household wealth is associated with gender equality across most indicators of wellbeing. Specifically, gender inequality is wider in the poorest wealth quintiles and progress among these population groups has been consistently slower. These findings suggest that interventions designed to redistribute wealth will have a positive impact on enhancing gender equality.
- With the exception of stunting among children under 5, underweight among adolescents and adults, and a few other indicators including education among children, results show that girls and women are less likely to realize their rights and fulfil their basic needs compared to their male counterparts. In addition, girls and women are affected by several gender-related vulnerabilities, such as low coverage rates of antenatal care and skilled birth attendance, anaemia, experience of gender-based violence, female genital mutilation, early marriage, and teenage pregnancy. Addressing all of these issues is a precondition to enhancing gender equality across other indicators and domains of wellbeing.

Improving the measurement of indicators and data collection for future monitoring and evaluation.

- Assessing the trends in gender equality revealed a myriad of challenges with data availability, quality and consistency. Amendments and improvements to data collection tools are therefore necessary for future evaluation and monitoring.
- The EDHS data can only be disaggregated at regional level. It is recommended that disaggregation should include rural and urban areas within subregions, considering their size in order to understand disparities within regions.
- The EDHS focuses mainly on the nutritional status of children under 5 and individuals aged 15 years and above, implying that no information is collected for children aged 5-14 years. It is recommended that anthropometric data be collected for children aged 5-14 years and data on food frequency and diversity for children older than 23 months. The indicator of food security – albeit measured at household level – is an important nutritional indicator, also shedding light on external shocks and availability of food.
- The EDHS captures a limited number of health indicators for population groups older than 5 years. For monitoring purposes, it is important to gain an insight into accessibility to both preventive and curative care, availability, affordability, and quality of healthcare services at all levels, for all age groups.
- Information about child protection (including teenage pregnancy, child marriage, age at first sexual intercourse, and child labour) is asked only for children aged 15-17 years. These vulnerabilities also occur among children of a younger age, but these are not captured by current data. This hinders

our understanding of the scale and occurrence of these vulnerabilities among the entire child population. Therefore, it is recommended that data on child protection[4] should also be collected for children of a younger age, with due attention to ethical considerations.

- The measurement of domestic violence relates to women but excludes men. It is recommended that the EDHS module on domestic violence include measurement of violence against boys and men to better capture variations in this phenomenon across gender lines.
- The quality of education is not adequately measured in the EDHS. It is recommended that a module on school facilities should be added to the EDHS, which would include questions about the school infrastructure and facilities, WASH in schools, teacher absenteeism, as well as facilities for management of menstrual hygiene.
- EDHS data are cross-sectional and not ideal for capturing changes that occur over time. In other words, EDHS cross-sectional samples offer insights into generic changes in the patterns of gender equality over time and not into the persistence of these dimensions among individuals. This limits the design and applicability of programmes that might target those most vulnerable to gender inequality in the country. There is a need for panel data in which individuals are followed over time so that dynamic changes in gender equality indicators can be observed and monitored.

Areas for further research

The quantitative focus of this study was useful to gain an insight into the scale of gender inequality in Ethiopia. Further research is necessary to carry out in-depth analytical work to better understand the underlying causes behind these findings. Additional qualitative data would be valuable in delving further into the how and why of the following findings.

- Higher prevalence of poor nutritional outcomes amongst boys and men compared to girls and women;
- The low coverage of maternal services, including antenatal care and skilled birth attendance, and child healthcare services such as immunization;
- Lower incidence of knowledge about HIV/AIDS prevention and transmission and MTCT knowledge amongst adolescent girls and adult women compared to adolescent boys and adult men;
- The high incidence of unmet need for family planning in rural areas;
- The high incidence of FGM in some regions such as Somali and Afar and the factors associated with high prevalence;
- Higher incidence of violence – physical, psychological or sexual – towards adolescent girls in urban areas and Addis Ababa, Amhara and Harari;
- High prevalence of justification of wife-beating among men in Amhara, and women in Oromia, Afar, Tigray, and SNNPR;
- Low incidence of women's participation in decision-making in Somali, SNNPR, and Afar;
- Association of household wealth with gender equality

Acknowledgements

This brief draws on the full research report entitled: Gender Equality, Women Empowerment and Child Wellbeing in Ethiopia (2019). The research was commissioned by the Ministry of Women, Children and Youth (MOWCY) and UNICEF Ethiopia and undertaken by the Social Policy Research Institute (SPRI).

The brief has been reviewed by Ellen Alem, Vincenzo Vinci and Ana Gabriela Guerrero Serdan from UNICEF Ethiopia Social Policy Section and Seleshi Tadesse, Director of the Women's Mobilization and Participation Directorate at MOWCY. For further details, please contact ealem@unicef.org.

4 Data on teenage pregnancy, child marriage and age at first sexual intercourse should be collected from the age of 12 years, while data on child labour should be collected from the age of 5 years.

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