

TERMS OF REFERENCE (TOR) FOR INDIVIDUAL CONSULTANT/CONSULTANCY FIRM

ETHIOPIA DHS 2000–2024/25 QUARTER-CENTURY ANALYTICAL PROGRAM

Updated Crosswalk Between the Ministry of Health TOR and the Expanded 12-Chapter Analytical Program

September 2026

Aynalem Adugna, PhD¹ • Bethlehem Fekade, MSc² • Bekele Belayhun, PhD³

¹Research Scientist, State of California ²IPHC ³Director, Evidence and Learning

Purpose. Update a 12-chapter EDHS analysis already in progress against the TOR, and the analytical, triangulation, policy-verification, and MoH-facing reporting work.

Note: We claim completion only where a certified analytical output or verified policy source directly answers the TOR.

1. What the TOR requires

The TOR calls for a gender-sensitive, youth-centered in-depth analysis of all five regular EDHS rounds—2000, 2005, 2011, 2016, and 2024–25—covering maternal health services, maternal morbidity and mortality, family planning and unmet need, adolescent and youth health, and health-related GBV/harmful practices. It explicitly asks for determinants, disparities, interpretation of contradictory findings, method mix and discontinuation, child marriage and teenage pregnancy, the three-delay model, regional maternal-health burden, FGM medicalization, policy alignment, and actionable follow-up research.

The TOR also requires the analysis to go beyond numerical description: confidence intervals and statistical significance should be used to interrogate ambiguous findings; national averages should be unpacked geographically and socioeconomically; data quality and reporting differences should be examined; and EDHS findings should be triangulated, where appropriate, with routine HMIS and program reports. The final consultancy package includes deep-dive reports, an analytical framework and indicator list, dummy tables, a draft/final analytical report, policy briefs/fact sheets, a decision-maker presentation, validation workshop, and final actionable recommendations.

A DE-RISKED CONSULTANCY: THE ANALYTICAL FOUNDATION ALREADY EXISTS

Before the Ministry TOR was received, a 10-chapter independent quarter-century analysis of Ethiopia's demographic and health transition was already nearing completion. The TOR did not initiate this analytical program; it extended it. Its additional gender-, youth-, reproductive-health-, triangulation-, policy- and action-oriented requirements became Chapters 11 and 12. This document therefore presents a mature evidence platform that can move rapidly to validation and final contractual packaging.

Chronology and readiness. The analytical work began as an independent, 10-chapter, book-length program covering fertility, childhood mortality, family planning, maternal health, vaccination, nutrition, exclusive breastfeeding, pregnancy-related deaths, women's education, and gender norms/agency. After receiving the Ministry TOR, we cross-walked its requirements against the existing platform, then added Chapters 11 and 12 to close the TOR-specific requirements and translate the evidence into action.

This draft is intentionally decision-focused. It distinguishes population estimates from routine service indicators; preserves survey and questionnaire comparability cautions; avoids unsupported regional maternal-mortality estimates; and treats cross-sectional associations as correlates, not causal, unless temporal ordering is defensible.

Evidence base: Ministry of Health TOR; validated Chapters 1–12.17; dedicated Chapter 11 GBV and FGM analyses; MoH 2017 EFY Annual Performance Report.

Executive Summary

Ethiopia entered the 2024–25 EDHS after a quarter century of major demographic and health-system change. The central conclusion is not that progress has stopped. Rather, success has changed the nature of the problem. National expansion produced large gains in fertility transition, contraceptive access, maternal-service use and child survival, while newer analyses show that the remaining burden is increasingly concentrated by geography, life stage, service pathway and social context.

Success changes the nature of the problem.

Fertility fell from 5.5 births per woman in 2000 to 4.0 in 2024–25, but contemporary regional regimes remain widely separated. Modern contraceptive prevalence among currently married women rose from 6.30% in 2000 to 35.25% in 2016 and was 34.46% in 2024–25, indicating a post-2016 plateau. A formal decomposition attributes only 5.62 percentage points of the full 28.16-point increase to measured compositional change; the larger 22.54-point residual represents behavioral/structural change not explained by the measured composition and must not be interpreted as causal program attribution.

Maternal-service coverage expanded dramatically. Skilled birth attendance is approximately 64.1% and facility delivery 61.4% in 2024–25, but regional gaps remain very large. The continuum analysis shows why contact alone is no longer an adequate success criterion: women can enter ANC and still be lost before adequate ANC, facility delivery or timely postnatal care. Routine HMIS independently identifies substantial attrition from ANC1 to ANC8 and subsequent stages.

Adolescent childbearing has declined, yet remains geographically concentrated. The TOR cites a 2024–25 national level of 10%, ranging from about 2% in Addis Ababa to 23% in Afar. Dedicated analyses show rising contraceptive protection and falling unmet need among married adolescents, but pre-pregnancy modern-method exposure among adolescents who became pregnant remained very low in calendar-observable surveys.

GBV and FGM are not residual conceptual topics: both now have dedicated empirical analyses. Recent emotional, physical or sexual IPV declined from 27.0% in 2016 to 20.3% in 2024–25, while recent physical or sexual IPV declined from 19.7% to 14.9%. FGM has undergone substantial but uneven intergenerational decline; among daughters aged 0–14, prevalence fell from 17.1% in 2016 to 13.0% in 2024–25, while conditional medicalization among cut daughters rose from 1.9% to 4.5%.

Strategic conclusion: universal national commitments should be retained, but implementation must become more geographically and pathway-specific — precision public health without abandoning universalism.

Why This Consultancy Can Start Near the Finish Line

The Ministry is not being asked to finance an analytical program that still has to discover its data architecture, harmonize five EDHS rounds, learn the historical regional geography, or determine whether key indicators can be replicated. Those foundations were built during the independently developed 10-chapter quarter-century book project. When the TOR arrived, it functioned primarily as an extension and refocusing of an already mature program.

The central proposition for MoH

Ten chapters supplied the longitudinal evidence engine. Chapter 11 absorbed and extended the TOR's gender, youth, maternal-health, family-planning, GBV and FGM requirements. Chapter 12 converted the accumulated evidence into geographic prioritization, monitoring, EDHS-HMIS-program triangulation, policy alignment, research priorities, and ranked recommendations. In practical terms, the TOR became two additional chapters rather than a new project starting from zero.

Stage	What already existed/was added	What this means for the consultancy
Independent foundation: Chapters 1–10	Five-round EDHS trend reconstruction, replication/QC, regional harmonization, survey-weighted analyses, spatial and equity work across ten demographic and health domains.	The highest-risk analytical infrastructure has already been built and tested.
TOR extension: Chapter 11	Integrated maternal health/morbidity, family planning, adolescent/youth, GBV, FGM, inferential and TOR-specific deep dives.	The TOR's major empirical workstreams are already completed or bounded within defensible DHS limits.
Evidence-to-action extension: Chapter 12	Executive synthesis, geographic and life-course matrices, monitoring, HMIS/program triangulation, policy verification, research agenda and ranked recommendations.	The project is already positioned for MoH decision use, not merely academic reporting.
Contractual finish line	Final dissemination of products, stakeholder validation, agreed revisions and issuance.	Awarding the consultancy to us buys rapid completion and validation of a mature evidence package rather than a long analytical start-up.

This readiness does not eliminate the need for Ministry ownership or stakeholder validation. It changes the risk profile: the core question is no longer whether the analysis can be done, but how quickly the existing evidence can be validated, refined with Ministry inputs, and converted into the final contractual products.

1. Twelve Findings That Should Shape the Next Decade

#	Finding	Decision meaning
1	The demographic transition is real but unfinished.	National fertility decline coexists with high-fertility regional regimes.
2	National averages increasingly conceal the management problem.	Regional, socioeconomic, and life-course heterogeneity is now central.
3	Ethiopia contains multiple fertility regimes.	Addis Ababa is near replacement-level conditions while Somali and Afar remain high-fertility settings.
4	Family planning has moved from expansion to a plateau problem.	The post-2016 mCPR pattern requires attention to continuation, method choice, unmet need and reach.
5	Maternal health has moved from first contact to pathway completion.	ANC entry does not guarantee adequate ANC, facility delivery or PNC.
6	Effective coverage matters more than contact alone.	Service use must be paired with quality, referral and completion.
7	Neonatal mortality is an increasingly important residual child-survival challenge.	As older-child mortality falls, the first month of life becomes more prominent.
8	EBF is principally a persistence problem.	High early exclusivity falls sharply across completed months 0–5.
9	Undernutrition requires mechanism-specific multisectoral action.	Health services alone cannot resolve food, infection, care and structural pathways.
10	Education is powerful but not sufficient for gender transformation.	Agency and gender norms remain context dependent.
11	Implementation must be geographically differentiated.	The same national intervention will have different marginal value across settings.
12	Data systems must move from reporting to decision intelligence.	EDHS, HMIS and program evidence should be triangulated, not forced to agree.

Evidence base: Chapter 12.2 and validated chapter syntheses.

2. Analytical Approach and Interpretation Rules

The analysis uses the five regular Ethiopia DHS rounds specified by the TOR: 2000, 2005, 2011, 2016 and 2024–25. Not every indicator exists with identical wording, routing or universe in every round. Trend claims were therefore made only after survey-specific item, denominator and comparability audits.

- **Survey design:** weighted estimates with clustering and stratification incorporated where appropriate; design-weighted cases are not interpreted as population counts.
- **Validation:** official national or regional DHS estimates were replicated first where feasible; extension analyses proceeded after the indicator construction was validated.
- **Geography:** historical SNNPR is reconstructed where required for longitudinal comparability, while the contemporary 14-region geography is retained for current planning.
- **Inference:** confidence intervals, design-based tests, and adjusted models are used selectively. **Sparse outcomes are not forced into unstable models.**
- **Causality:** decomposition components and cross-sectional associations are not interpreted as causal program effects.
- **Rare events:** maternal death and fistula/leakage analyses **prioritize measurement validity and precision over elaborate modeling.**
- **Triangulation:** EDHS measures population outcomes and inequalities; HMIS measures operational contacts/performance; program reports characterize implementation context.

Key comparability cautions

Domain	Rule used in this report
Maternal mortality	Pregnancy-related mortality ratios from earlier rounds are not presented as a single trend with the revised 2024–25 maternal mortality ratio.
Fistula/leakage	2016 symptom-based prevalence is contextual only; 2024–25 current/ever/obstetric-linked leakage uses different routing and definitions.
Unmet need	Legacy and revised DHS variables require cautious long-run interpretation.
FGM	2011 is excluded from the comparable FGM trend architecture because a comparable module was not certified.
GBV	Domestic-violence-specific weights and module universes are used; health-sector contact does not imply complete survivor-centered care.

Evidence base: MoH TOR; Chapter 11 validation scripts; Chapter 11.15 GBV; Chapter 11.16 FGM.

3. Maternal Health: From Expansion to Effective Continuity

Maternal health is one of Ethiopia’s clearest examples of first-generation expansion succeeding and thereby exposing a second-generation problem. Skilled care and facility delivery expanded dramatically, but remaining gaps increasingly concern continuity, quality, referral, and geography.

Indicator / signal	2000 or earlier benchmark	2024–25 / current signal	Interpretation
Skilled ANC (TOR background)	27%	78%	Large expansion in skilled contact.
Facility delivery (TOR background)	5%	61%	Transformation in place of delivery.
Skilled birth attendance	—	~64.1%	Substantial coverage, but far from universal.
Facility delivery	—	~61.4%	National average masks major regional inequality.
Facility delivery: Addis Ababa	—	~97.9%	Near-universal current coverage.
Facility delivery: Afar	—	~33.2%	Large residual exclusion.

The SNNPR successor-region analysis further demonstrates why historical administrative units can conceal current program realities. Central Ethiopia performs above the reconstructed pooled SNNPR on most maternal-care indicators, while South Western and Southern Ethiopia generally lag, particularly in continuum completion and skilled/facility delivery.

The continuum is the management unit

The analytical framework links ANC to facility delivery and timely postnatal care along the same maternal-care pathway. This changes the management question from 'Did a woman ever enter care?' to 'Where did she leave the pathway?' The 2017 EFY MoH Annual Performance Report independently reinforces this interpretation: routine ANC1 contact was very high, yet ANC8 was 37%, skilled birth attendance 80%, and early PNC 78%, with the report explicitly identifying dropout and missed opportunities.

Maternal-health priority: manage ANC → delivery → PNC as one pathway and make the largest point of attrition visible at region, woreda, facility/catchment, and population level.

Evidence base: TOR; Chapters 4, 11 and 12.3; MoH Annual Performance Report 2017 EFY.

3.1 Maternal Mortality, Morbidity and the Limits of DHS

Maternal mortality requires particularly disciplined interpretation. The quarter-century program distinguishes pregnancy-related mortality from the revised maternal-mortality definition used in 2024–25. The pregnancy-related mortality ratio declined from 871 per 100,000 live births in 2000 to 412 in 2016 and 169 in 2024–25. The 2024–25 maternal mortality ratio under the revised definition is 141 per 100,000 live births (95% CI 87–195). These should not be merged into a single definition-invariant MMR trend.

The TOR correctly recognizes that EDHS does not support stable regional maternal-mortality estimates. The appropriate regional response is therefore to examine maternal-health service pathways, risk-factor distributions, access, referral and emerging-region constraints rather than manufacture regional MMR league tables.

Maternal morbidity: fistula/leakage

The dedicated morbidity work reconstructed and validated EDHS fistula/leakage measures. The 2016 symptom item reproduced the published national estimate: 0.43% (95% CI 0.30–0.57; 70 events) versus the reported 0.4%. The 2024–25 questionnaire separately identifies current leakage, previous leakage, and whether onset followed delivery or stillbirth. Because the questionnaire structure changed, we do not interpret the 2016 and 2024–25 indicators as a measured temporal increase or decline.

The production analysis is intentionally descriptive: we report national prevalence and carefully limited age, residence, education, wealth, and parity stratification with event counts and precision diagnostics; **we avoid multivariable rare-event models and regional rankings.**

Measurement principle: when the event is rare, better measurement and explicit uncertainty are more valuable than a statistically elaborate but unstable model. Given the outcome's rarity and the resulting sparse event counts, we did not fit multivariable logistic regression models for the fistula/leakage indicators. Instead, the analysis emphasizes design-weighted prevalence estimates, confidence intervals, event-count diagnostics, and carefully limited stratification, thereby prioritizing measurement validity and statistical stability over potentially unstable multivariable estimates.

Evidence base: Chapter 8; Chapter 11.5 validation and production analyses; 2024–25 EDHS mortality definitions.

3.2 Three Delays: What EDHS Can and Cannot Support

The TOR asks for analysis using the three-delay model. EDHS can contribute to this framework, but it cannot directly observe every delay in a maternal death pathway. The defensible use is therefore a proxy-and-boundary framework, not retrospective assignment of individual deaths to a delay.

Delay	EDHS-supported signals	What EDHS does not directly establish	Program use
Delay 1: decision to seek care	ANC use/timing; place of delivery; education; wealth; residence; selected autonomy/norm measures	Emergency recognition, household deliberation and exact decision time preceding a maternal death	Identify populations in which care-seeking barriers and social constraints remain concentrated.
Delay 2: reaching appropriate care	Residence/geography; facility delivery; selected access-barrier questions where available	Travel time at emergency, road condition, ambulance availability at event, referral transit time	Overlay EDHS geography with referral/transport and HMIS program evidence.
Delay 3: receiving adequate care	Facility delivery/skilled attendance; PNC; pathway completion as indirect service-contact measures	Clinical readiness at exact event, treatment delay, blood/surgery availability, provider performance for the death	Use HMIS/readiness/MPDSR and facility data; do not infer quality from EDHS contact alone.

This framing closes the conceptual TOR requirement while preserving the data limits. Maternal deaths are too sparse for credible region-specific three-delay attribution from DHS alone. The three-delay framework should therefore organize interpretation across EDHS, HMIS, referral-system evidence, and MPDSR, rather than treating it as a single survey variable.

Evidence base: MoH TOR; Chapter 12 maternal-health and triangulation frameworks.

4. Family Planning: From Expansion to a Plateau

Modern contraceptive use among currently married women increased from 6.30% in 2000 to 35.25% in 2016 and was 34.46% in 2024–25. The full-period increase was therefore 28.16 percentage points, but essentially all that expansion occurred before 2016. The current policy problem is not a failure of the historical transition; it is how to restart progress while protecting voluntarism, continuation, and method choice.

Period	mCPR change	Interpretation
2000 → 2016	+28.95 pp	Rapid expansion.
2016 → 2024–25	–0.79 pp	Plateau / offsetting forces.
2000 → 2024–25	+28.16 pp	Large long-run transformation.

Formal decomposition

The decomposition separates statistical change associated with measured population composition from a residual behavioral/structural component. Over 2000–2024/25, measured composition accounted for +5.62 percentage points and the behavioral/structural residual for +22.54 points. Within measured composition, background characteristics contributed +5.03 points, information exposure +1.84 points, and reproductive goals –1.44 points. Because full-period overlap was limited, trimming sensitivity reduced the estimated composition contribution to roughly 4.68–5.04 points.

The decomposition is descriptive of statistical change. It is not causal attribution, and the residual is not a program-effect estimate.

Evidence base: Chapter 11 contraceptive change decomposition; Chapter 12.4.

4.1 Unmet Need, Discontinuation, Method Choice and Service Quality

The TOR appropriately asks what lies behind limited recent progress. The completed family-planning portfolio goes beyond prevalence to unmet need, discontinuation and reasons, method mix, source, informed choice, decision-making and future use. These dimensions matter because the same national mCPR can arise from very different combinations of demand, initiation, continuation, switching and service reliability.

Among currently married adolescents aged 15–19, modern contraceptive prevalence rose from 3.0% in 2000 to 32.7% in 2024–25, while unmet need declined from 36.9% to 14.6%. Yet among adolescents who had begun childbearing and whose index pregnancy was observable in contraceptive calendars, modern-method exposure one month before conception remained only 3.1% in 2005, 3.4% in 2011, 4.3% in 2016, and 3.0% in 2024–25. These are not contraceptive-failure rates; the denominator is the number of pregnancies.

Routine-system triangulation

The MoH 2017 EFY report records contraceptive acceptance rising from 68% in 2011 EFY to 79% in 2017 EFY and more than 17.6 million women recorded as receiving a modern method. This does not contradict the EDHS mCPR plateau: annual service acceptance includes new and repeat users and uses operational

denominators. The divergence redirects attention toward continuation, repeat contacts, switching, reach to non-users and denominator quality.

Family-planning objective: move from maximizing acceptance volume to sustained, voluntary, high-quality and geographically equitable contraceptive choice.

Evidence base: Chapter 11 FP analyses and adolescent manuscript; Chapter 12.4 and 12.17; MoH APR 2017 EFY.

5. Adolescent and Youth Health: Protecting the Transition to Adulthood

The adolescent and youth analysis treats teenage pregnancy as the product of linked transitions rather than an isolated fertility outcome. The relevant pathway includes child marriage, school continuation or exit, contraceptive access and use, reproductive autonomy, household context, and geography.

Signal	Finding	Program meaning
Teenage childbearing, 2024–25	10% nationally (TOR); ~2% Addis Ababa, 23% Afar	A national average cannot guide implementation intensity.
Married adolescent mCPR	3.0% in 2000 → 32.7% in 2024–25	Protection expanded substantially among married adolescents.
Married adolescent unmet need	36.9% in 2000 → 14.6% in 2024–25	Large improvement, but residual need remains.
Pre-pregnancy modern-method exposure	~3–4% among calendar-observable adolescent pregnancies across 2005–2024/25	Pregnancies that occurred were overwhelmingly preceded by no modern-method exposure; not a failure-rate estimate.

The MoH program context is already geographically differentiated. The 2017 EFY report documents Smart Start scale-up, with approximately 13,780 health extension workers trained in RISE woredas, a multisectoral teenage-pregnancy reduction roadmap, and locally adapted counseling tools, while also acknowledging gaps in youth-friendly service quality, coverage, stigma, and coordination.

Youth objective: delay unwanted pregnancy while protecting education, agency, health and second chances.

5.1 Child Marriage, Pregnancy, Education and Agency

For policy, child marriage and teenage pregnancy should be treated as interacting processes rather than parallel indicators. Early marriage can change exposure to pregnancy, expectations about childbearing, schooling continuity, economic dependency, partner power and access to contraception. At the same time, the relationship is not reducible to marriage status alone: regional context, education, household resources and agency modify the pathway.

The broader analytical program adds two cautions. First, education is a major health resource but does not automatically transform gender power. Chapter 10 demonstrates that associations between formal education, gender norms, partner fear and agency vary across regions and local environments. Second, agency is multidimensional: a woman or adolescent may have strength in one domain while remaining constrained in another.

Program translation

- Prevent child marriage and adolescent pregnancy as linked health, education, and social-protection objectives.
- Protect school continuation before pregnancy and create re-entry/second-chance pathways after pregnancy or marriage.
- Make contraceptive services accessible to married and unmarried adolescents without assuming that nominal service availability equals practical access.
- Measure agency and partner dynamics directly where possible rather than using education as a proxy for empowerment.
- Prioritize geographic settings where early childbearing, service gaps, and social constraints overlap.

Evidence base: Chapters 10, 11 and 12.5/12.8/12.11; TOR.

6. Gender-Based Violence: Burden, Inequality, Consequences and Response

The dedicated EDHS domestic-violence analysis uses the DV-specific survey weight and certified item-level recodes. The comparable recent-IPV analytic denominator was 4,720 women in 2016 and 6,857 in 2024–25. Recent IPV refers to the preceding 12 months.

Indicator	2016	2024–25	Change / interpretation
Any recent emotional, physical, or sexual IPV	27.0%	20.3%	–6.72 pp; 95% CI for decline 3.56–9.88; $p<.001$
Recent physical or sexual IPV	19.7%	14.9%	–4.81 pp; 95% CI –7.51 to –2.12; $p<.001$
Overall interpretation	High burden	Lower, but still consequential	About 1 in 5 eligible women reported at least one recent IPV form in 2024–25.

The direction of change is favorable, but the residual burden remains substantial. The analysis also examines contemporary socioeconomic and regional inequalities, adjusted correlates, directly measured injuries, help-seeking sources, and doctor contact. Cross-sectional correlates are not called causal drivers; region is treated as context rather than causal exposure.

The EDHS does not provide a validated mental-health outcome for this analysis. Sexual violence is a form of violence, not automatically a measured downstream sexual-health consequence. Contact with a doctor indicates health-sector help-seeking, not proof that a complete survivor-centered response was delivered.

Evidence base: Chapter 11.15 - GBV analysis and certified v1.3 script.

6.1 GBV Response: Population Burden and Administrative Service Counts Tell Different Stories

Triangulation with MoH program data is especially important for GBV because service counts and prevalence measure different processes. The 2017 EFY Annual Performance Report records 42,878 GBV survivors receiving care nationally, up from 34,021 in the previous year (+26%). Over the same period, the health-system response expanded: 13 new integrated one-stop centers were established, bringing the reported national total to 95, alongside training, service mapping, and response guidance.

The increase in recorded survivors cannot be interpreted as an increase in national GBV prevalence. It can reflect violence incidence, disclosure, improved access, service expansion, reporting completeness, or several of these simultaneously. MoH itself identifies underreporting and poor GBV data quality as challenges.

GBV monitoring rule: EDHS estimates population burden; HMIS counts recorded service response. Neither should be substituted for the other.

Priority actions

- Sustain prevention while making survivor-centered clinical response a health-system responsibility.
- Protect time-sensitive response to sexual violence and strengthen referral networks.
- Use service counts for workload/access and response monitoring, not prevalence estimation.
- Retain privacy, safety, and denominator discipline in all GBV measurement.

Evidence base: Chapter 11.15; Chapter 12.6 and 12.17; MoH APR 2017 EFY.

7. Female Genital Mutilation: Substantial but Uneven Intergenerational Transformation

FGM is one of the most extensively analyzed harmful-practice domains in the completed program. The work includes quarter-century national and regional/cohort reconstruction, direct mother–daughter linkage, education-transition analysis, wealth/residence/norm gradients, 14 prespecified inferential tests, sensitivity analyses, and a dedicated medicalization addendum.

The central conclusion is substantial but uneven transformation. Declining adult prevalence partly reflects cohort replacement, while direct mother–daughter linkage shows that non-transmission is already widespread in many families in which the mother herself experienced FGM. Maternal rejection of FGM is strongly associated with non-transmission; education, wealth, residence and region reveal persistent social and geographic differentiation.

Formal interaction tests did not establish that education-transition, wealth, residence, or maternal-norm gradients strengthened between 2016 and 2024–25. This distinction matters: inequality can persist without evidence that it is widening.

Evidence base: Chapter 11.16 integrated FGM summary; FGM intergenerational Phase I/II manuscripts.

Intergenerational signal	2016	2024–25	Interpretation
Uncut daughters age 10–14 of cut mothers	63.6%	67.3%	Higher discontinuation among younger daughters.
Uncut daughters age 15–19 of cut mothers	53.9%	54.2%	Conservative near-complete discontinuation is similar across surveys.
Uncut + formally educated daughters of cut, uneducated mothers	52.0% adjusted	52.8% adjusted	Large established intergenerational break; change not significant.
FGM discontinuation among daughters crossing educational divide	61.1% adjusted	61.9% adjusted	Education transition accompanies substantial non-transmission; change not significant.

7.1 FGM Medicalization: Declining Prevalence Can Coexist With a Provider Shift

Measure among daughters age 0–14	2016	2024–25	Change
FGM prevalence	17.1% (14.7–19.6)	13.0% (10.7–15.4)	–4.1 pp; p=.018
Conditional medicalization among cut daughters	1.9% (0.6–3.3)	4.5% (2.5–6.5)	+2.5 pp; p=.039
Absolute medically performed FGM	0.3% (0.1–0.6)	0.6% (0.3–0.9)	+0.3 pp; p=.170

The apparent paradox is real but specific. FGM became less common among girls, while health-professional participation became more common among the procedures that remained. The absolute population burden of medically performed FGM increased only slightly, and the change was statistically uncertain. Thus, the evidence supports a compositional shift toward medicalization, not a statistically established rise in population-level medicalized FGM.

The decomposition of the absolute medicalized-FGM burden reinforces this interpretation: declining FGM prevalence contributed approximately –0.078 percentage points, while changing provider composition contributed approximately +0.332 points, yielding a net point estimate of +0.253 points. Because medically performed events remain rare, uncertainty is substantial.

FGM policy implication: elimination strategies must address both continued demand and the health-system boundary that prohibits professional participation. Medicalization is not harm reduction.

Evidence base: Chapter 11.16, Table 11.16.6 and medicalization addendum.

8. Gender, Education and Agency: Why Social Context Still Matters

The quarter-century analysis we conducted does not treat education as a universal switch that automatically produces reproductive autonomy or gender-equitable norms. Chapter 10 analyzes multiple domains of agency and gender norms and demonstrates that education–power relationships vary geographically and by local context.

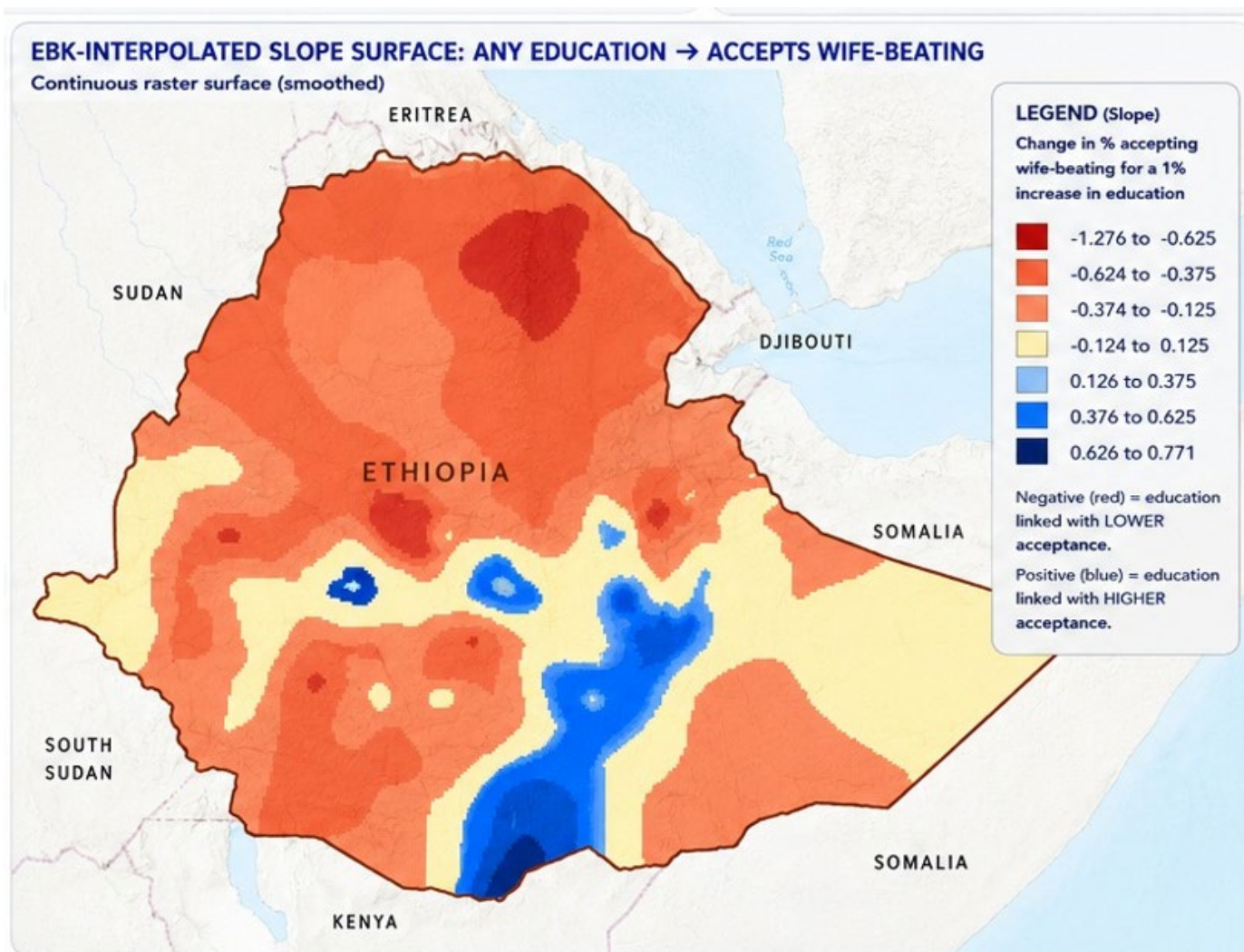
Partner fear provides one example of major change with persistent contextual variation. The validated negative factor 2 (NEG2) – fearing a spouse or partner at least sometimes - measure declined markedly in Oromia from 80.1% in 2016 to 56.5% in 2024–25 (still the highest of any region in 2024–25), and in Harari from 65.3% to 28.8%. These large declines should not be read as evidence that gender-power constraints have disappeared, nor should education alone be assumed to explain them.

The spatial analysis uses matched denominators at the EDHS cluster level and geographically weighted regression (GWR) to examine how the local relationship between women’s formal education and acceptance of wife beating varies across Ethiopia. Unlike ordinary least squares (OLS), which estimates a single national association and therefore assumes that the education–norm relationship is spatially constant, GWR estimates location-specific relationships, revealing where education is more strongly associated with lower acceptance

of wife beating, where that association is weak, and where it reverses direction; empirical Bayesian kriging (EBK) is then used to interpolate these local slopes into a continuous spatial surface. The policy meaning is straightforward: the same level of education can coexist with different gender-norm environments. Programs should therefore identify where education translates into agency and where local institutions, norms, partner dynamics or structural barriers interrupt that translation.

Education is part of the health-system operating environment — a resource for comprehension, navigation and agency — but it is not a substitute for gender transformation.

Evidence base: Chapters 9, 10, 12.7 and 12.8.



Local relationships between women's education and acceptance of wife beating vary markedly across Ethiopia. In this map, GWR-derived local slopes, interpolated using EBK, show broad areas where greater educational exposure is associated with lower acceptance of wife beating (red), alongside localized areas where the relationship is weak or reversed (yellow to blue). The spatial heterogeneity reinforces a central finding of this analysis: education does not translate uniformly into more gender-equitable norms; its influence is conditioned by local social and institutional environments.

INTERPRETIVE BOX FOR THE MAP: THE TWO MEANINGS OF A WEAK LOCAL GRADIENT

The tan areas of the map indicate locations where the local association between women's education and acceptance of wife-beating is relatively weak. Such weak slopes should not automatically be interpreted as evidence that education is unimportant. They can arise through at least two substantively different mechanisms.

1. Addis Ababa - normative saturation. Rejection of wife beating is already widespread across educational groups, leaving relatively little variation for education to explain. When women with less education and women with more education both overwhelmingly reject the norm, the education gradient necessarily becomes small. Here, a weak association may therefore represent **success rather than failure**: the more gender-equitable norm has diffused beyond the highly educated population. The same hypothesis warrants examination for other negative gender-norm indicators, including partner fear (NEG2): where an undesirable norm or experience has already become uncommon across educational groups, education may show only a weak remaining gradient.

2. Surrounding rural woredas - contextual resistance. In predominantly rural areas just outside Addis Ababa, a similarly weak slope may mean something different. Established community norms and social institutions may remain more accepting of wife beating, potentially reducing the extent to which an individual woman's formal education translates into rejection of the norm. Education is present, but its association with attitudes may be attenuated by the surrounding normative environment. Here, a weak slope may indicate **contextual resistance rather than normative saturation**.

Interpretive implication. Similar colors on the map can therefore conceal different mechanisms. A weak education gradient can occur because a desirable norm has already become widespread, or because prevailing local norms constrain the normative influence associated with education. Distinguishing these mechanisms requires examining the local **level** of wife-beating acceptance together with the local **education slope**, rather than interpreting the slope alone.

9. EDHS + HMIS + Program Triangulation: What Divergence Reveals

The TOR asks that ambiguous or conflicting findings be interpreted with routine HMIS and program evidence. The completed empirical triangulation applies a common architecture: EDHS population signal → HMIS operational signal → program implementation/context → convergence/divergence → interpretation → management action.

Finding	EDHS signal	HMIS/program signal	Interpretation
FP plateau	mCPR ~35% since 2016	CAR 68%→79%; high service volume	Utilization can rise without population prevalence rising.
Maternal coverage	SBA ~64%; facility delivery ~61%	HMIS SBA 62%→80%; ANC4+ 70%→86%; PNC 78%	Both show expansion; routine coverage is not population coverage.
Maternal continuum	Incomplete ANC→delivery→PNC	Large ANC1→ANC8 and later-stage attrition	Strong convergence on pathway failure.
AYH	Teen childbearing highly geographic	Smart Start, HEW training, roadmap, localized tools	Overlay need and implementation intensity; do not equate them.
EBF	58.1%; steep decline by month 5	No comparable HMIS EBF prevalence; substantial support activity	Program activity does not establish behavioral persistence.
GBV/FGM	Population survey burden/trends	GBV service counts; FGM program architecture	Administrative response and prevalence must remain separate.
Agreement across sources increases confidence. Disagreement increases the need for diagnosis. Neither should be ignored.			

Evidence base: Chapter 12.17; MoH APR 2017 EFY and official program documents.

10. Equity and Geographic Prioritization: No Singular National Story

Across fertility, maternal health, breastfeeding, gender norms, adolescent childbearing and FGM, geography repeatedly organizes the remaining inequality. This does not justify a good-region/bad-region league table. It requires diagnosing the dominant local constraint and the most affected population.

Geographic signal	Illustrative evidence	Planning implication
Fertility regimes	2024–25 TFR: Addis Ababa ~2.3; Somali ~6.5; Afar ~5.9	Different stages of demographic transition require different FP/reproductive-health strategies.
Maternal care	Facility delivery ~97.9% Addis vs ~33.2% Afar	National expansion must be paired with place-specific access/referral strategies.
Adolescent childbearing	~2% Addis vs 23% Afar (TOR)	Youth programming intensity should follow need and mechanism.
EBF	Adjusted regional estimates range roughly from 77.9% Tigray to 28.9% Somali	Breastfeeding persistence is strongly contextual.
FGM	Intergenerational discontinuation ranges from near-universal in some contemporary samples to very low in others	National decline does not eliminate local transmission systems.
Gender norms	Large regional differences and local education–norm coupling/decoupling	Education-only strategies are insufficient.

Prioritization should be recursive: national → region → zone/woreda → facility/catchment → population subgroup. Universal national guarantees remain the floor; implementation intensity and mechanism should vary according to burden, pathway failure and expected marginal gain.

Evidence base: Chapters 1, 4, 7, 10, 11.16 and 12.10.

11. Child Survival, Nutrition and Breastfeeding: The Broader Life-Course Context

Although the TOR centers on reproductive, maternal, adolescent, and gender-related outcomes, our broader quarter-century evidence clarifies why these domains cannot be managed in isolation. Under-five mortality declined from approximately 168 deaths per 1,000 live births in 2000 to 51 in 2024–25; infant mortality declined from 97 to 39 and neonatal mortality from 49 to 25. The residual burden is increasingly concentrated in the neonatal period and in mechanisms that require quality and continuity rather than first contact alone.

Exclusive breastfeeding provides a parallel behavioral pathway. National EBF is 58.1% (95% CI 53.2–63.0), close to the official 57.3%, but the age profile reveals the management problem: approximately 85.2% at age 0 months versus 26.2% at 5 completed months. The adjusted odds of EBF decline sharply with infant age (AOR per month 0.59; 95% CI 0.51–0.68).

This supports a life-course interpretation of maternal and reproductive health. Postpartum care is simultaneously a maternal-survival opportunity, a family-planning opportunity, a breastfeeding-support opportunity, and the opening stage of infant survival. Fragmented program indicators can therefore obscure the value of the same contact.

Life-course objective: protect and expand capability at each transition — adolescent girl → young woman → pregnancy → delivery/postpartum → mother and infant → child/next generation.

Evidence base: Chapters 2, 6, 7, and 12.11.

12. Strategic Priorities for the Health Sector

Horizon	Rank	Recommendation
Immediate	1	Institutionalize an evidence-to-action review cycle combining EDHS, HMIS, and program context.
Immediate	2	Make maternal continuum completion, referral, and effective coverage core performance questions.
Immediate	3	Respond to the FP plateau through unmet need, discontinuation, side-effect management, switching, and method choice.
Immediate	4	Prioritize below national averages using region → woreda → catchment → population diagnosis.
Immediate	5	Shift breastfeeding support toward persistence through months 1–5.
Immediate	6	Establish a cross-sector adolescent transition compact linking pregnancy prevention, child marriage, schooling and agency.
Medium term	7	Strengthen survivor-centered GBV readiness and next-generation FGM prevention with zero medicalization.
Medium term	8	Design communication, consent, navigation, and digital systems for educational diversity.
Medium term	9	Institutionalize EDHS + HMIS + program triangulation.
Medium term	10	Strengthen neonatal quality and mechanism-specific undernutrition response.
Medium term	11	Treat practical agency as part of effective coverage.
Structural	12	Develop linked, privacy-governed health-data architecture.
Structural	13	Embed a life-course intervention framework across programs.
Structural	14	Create a national learning system for heterogeneity, positive deviance and implementation research.
Structural	15	Align resource allocation with need, pathway failure, and expected marginal gain while retaining universal guarantees.

Evidence base: Chapter 12.16.

13. Monitoring and Accountability, 2027–2030–2035

Monitoring should distinguish benchmarks from targets. Where indicator definitions or denominators are not yet standardized, 2027 should function as a measurement-consolidation year rather than create false precision. Validate routine data against population surveys, not treat them as interchangeable.

Priority	Core monitoring question	Primary source logic
Maternal continuum	Where are women lost between ANC, delivery and early PNC?	HMIS for short-cycle pathway performance; EDHS for population/equity validation.
Family planning	Is service activity producing sustained voluntary use among those wanting to avoid/postpone pregnancy?	HMIS/LMIS + EDHS prevalence, unmet need, discontinuation and method mix.
Adolescent health	Are highest-need adolescents being reached before pregnancy and school exit?	Age-disaggregated routine data + EDHS population outcomes + education/program data.
GBV	Are survivors reaching timely, complete response while population burden declines?	EDHS prevalence + HMIS service response; never equate the two.
FGM	Are cohort transmission and medicalization both declining?	EDHS cohort/daughter outcomes + professional/program monitoring.
EBF	Is support repeated through the months when exclusivity is lost?	Program/HMIS contact process + EDHS/targeted survey outcome.
Accountability test: What changed? For whom? Where? Was the pathway completed? Did the equity gap narrow? Who owns corrective action?		

Evidence base: Chapter 12.13.

14. Priority Research and Data Agenda

The follow-up research agenda should answer questions that EDHS cannot resolve rather than reproduce prevalence estimates that EDHS already measures well. Priority questions include:

- What mechanisms sustain the post-2016 contraceptive plateau — discontinuation, switching, demand, commodity reliability, service reach or combinations?
- At which point in the maternal continuum do losses occur locally, and which quality/referral constraints explain them?
- What facility and referral failures underlie severe maternal morbidity and preventable deaths?
- Why does EBF erode so sharply across months 1–5 despite substantial breastfeeding-support activity?
- Which local mechanisms explain why similar educational attainment produces different gender-norm and agency environments?
- How do partner dynamics and fear alter contraceptive, maternal-care and help-seeking pathways?
- Which adolescent transition pathways link child marriage, school exit, contraceptive non-use and pregnancy?
- Where are FGM intergenerational discontinuation and medicalization changing most rapidly, and why?
- How does program implementation intensity relate to population outcomes after accounting for denominator, timing, and geographic mismatch?
- Which routine indicators can be validated against EDHS strongly enough for subnational decision use?

Research should be commissioned against a decision date: what decision cannot be made confidently from EDHS, HMIS, and existing program evidence, what additional evidence would change that decision, and how soon must the answer be available to matter?

15. Conclusion: From National Expansion to Precision Public Health

The quarter-century evidence we assembled supports a clear interpretation. Ethiopia has moved the population-health frontier: fertility declined; contraceptive use expanded; skilled and facility-based maternal care increased; child mortality fell; IPV and FGM show important favorable change; and intergenerational transitions are visible in domains that once appeared resistant to change.

The unfinished agenda is nevertheless substantial. Progress is uneven across place and population. The family-planning transition has plateaued nationally. Maternal-service entry does not guarantee pathway completion or quality. Adolescent childbearing remains highly concentrated geographically. GBV remains consequential despite decline. FGM is falling, but medicalization among remaining procedures requires explicit attention. Education expands opportunity without automatically eliminating gender-power constraints.

The next phase should therefore retain universal commitments while changing the operating question. Instead of asking only whether national coverage increased, decision-makers should ask:

Which population, in which place, is being left behind, at which point in the health or behavioral pathway, and what intervention is most likely to change that trajectory?

That is the practical meaning of precision public health in this report. It is not abandonment of universalism. It is using better evidence to determine where universal commitments require differentiated implementation, additional intensity, different mechanisms, or stronger accountability.

Between 2000 and 2024/25, Ethiopia succeeded in moving the population-health frontier. The task for the next decade is to move those who remain behind that frontier.

Evidence Map and Principal Source Documents

This ≤30-page report is a condensation. Detailed statistical tables, model specifications, diagnostics, sensitivity analyses, figures, and extended references remain in our quarter-century book chapters and technical annexes.

Report domain	Primary underlying analytical source
Maternal health	Chapters 4, 8, 11.3–11.6; Chapter 12.3; maternal continuum and morbidity production outputs.
Family planning	Chapter 3; Chapter 11 FP/unmet-need/discontinuation/decomposition analyses; Chapter 12.4.
Adolescent/youth	Chapter 11 adolescent childbearing/contraception analyses; Chapter 12.5 and 12.11.
GBV	Chapter 11.15 polished analysis and certified v1.3 production script; Chapter 12.6.
FGM	Chapter 11.16 integrated summary; intergenerational Phase I/II manuscripts; medicalization analysis.
Gender/agency	Chapters 9–10; Chapter 12.7–12.8.
Triangulation	Chapter 12.14 framework and Chapter 12.17 empirical TOR triangulation annex.
Policy/monitoring	Chapter 12.9–12.16.

Principal external/official documents

- Ministry of Health, Ethiopia. Terms of Reference for the EDHS 2024 consultancy.
- Ethiopian Statistical Service and ICF. Ethiopia Demographic and Health Survey reports and 2024–25 key indicators/detailed report materials.
- Ministry of Health, Ethiopia. Annual Performance Report of 2017 EFY (2024/25).
- Ministry of Health, Ethiopia. National Adolescents and Youth Health Strategy 2021–2025.
- Ministry of Health, Ethiopia. FP2030 Ethiopia Government Commitment.
- Ministry of Health, Ethiopia. National Nutrition Program.
- Government of Ethiopia. National Costed Roadmap to End Child Marriage and FGM/C 2020–2024.

Verify policy-document numbering and exact pillar/result-area references against the Ministry-approved versions in force at final submission. Stakeholder validation remains a separate contractual step after this analytical report is frozen.

Draft status: analytical condensation prepared. Next production steps are technical annex assembly, policy brief/fact sheets, decision-maker PowerPoint, and validation-workshop package.

Four Stories Worth Carrying into the MoH Discussion

The results tables in our quarter-century, 10-chapter work, establish the evidence shared below in story form. The four stories show why the pre-existing analytical program adds value beyond reproducing published indicators: it identifies patterns that change the management question.

1. Two pairs of FGM 'twins'

Somali and Afar form an intuitive high-FGM pair: among women aged 15–19 in 2024–25, prevalence was 92.8% and 83.9%.

The more revealing pair is Tigray and Gambella—far apart and socially different, yet both historically low (12.6% and 9.7%).

Similar outcomes can arise in very different environments; no single factor explains Ethiopia's FGM geography.

3. EBF: initiation is not the main problem

National exclusive breastfeeding is about 58.1%, yet the age profile falls from about 85.2% at age 0 months to 26.2% by 5 completed months. The actionable story is persistence: postpartum support must continue through the months when exclusivity is being lost, not end with initiation counseling.

2. Tigray's child-mortality reversal

The harmonized regional trend analysis identified Tigray as the only region where neonatal, infant, and under-five mortality all increased between 2016 and 2024–25. EDHS cannot establish causation. But the reversal shows exactly why a favorable national trend cannot substitute for regional surveillance and recovery-focused investigation.

4. One country, several transitions

In 2024–25, fertility was about 2.3 births per woman in Addis Ababa versus about 6.5 in Somali and 5.9 in Afar; facility delivery was about 97.9% in Addis Ababa versus about 33.2% in Afar. These are different stages of transition within one country—an empirical case for geographically differentiated implementation.

Bid-readiness message: these are not hypothetical analyses proposed for later. They are examples of findings already produced by the 10-chapter foundation and the two TOR-extension chapters.

2. Our quarter-century work: Analytical program now available

Chapter	Primary analytical domain
Chapter 1	Fertility
Chapter 2	Childhood Mortality
Chapter 3	Family Planning
Chapter 4	Maternal Health Care and Continuum
Chapter 5	Childhood Vaccination
Chapter 6	Childhood Nutrition
Chapter 7	Exclusive Breastfeeding
Chapter 8	Pregnancy-Related Deaths
Chapter 9	Women's Education
Chapter 10	Gender Norms, Agency and Spatial Analysis
Chapter 11	Gender, Youth and Reproductive Health: integrated TOR-facing analyses
Chapter 12	From Evidence to Action: strategic priorities, monitoring, triangulation, research and ranked recommendations

The decisive point for consultancy readiness is chronological: the Ministry TOR arrived after the 10-chapter analytical foundation had already been built. The TOR therefore became an extension of the existing program, not its starting point. Chapter 11 absorbed and extended the gender, youth and reproductive-health requirements; Chapter 12 translated the accumulated evidence into policy, monitoring, triangulation, research and accountability instruments.

LIST OF ACRONYMS AND ABBREVIATIONS

Acronym	Meaning
ANC	Antenatal Care
ANC4+	Four or More Antenatal Care Contacts
ANC8+	Eight or More Antenatal Care Contacts
AYH	Adolescent and Youth Health
CI	Confidence Interval
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Survey
DHIS2	District Health Information Software 2
DV	Domestic Violence
EBF	Exclusive Breastfeeding
EDHS	Ethiopia Demographic and Health Survey
EBK	Empirical Bayesian Kriging
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GBV	Gender-Based Violence
GIS	Geographic Information System
GWR	Geographically Weighted Regression
HEW	Health Extension Worker
HMIS	Health Management Information System
IMR	Infant Mortality Rate
IPV	Intimate Partner Violence
IYCF	Infant and Young Child Feeding
LARC	Long-Acting Reversible Contraception
mCPR	Modern Contraceptive Prevalence Rate
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
NNMR	Neonatal Mortality Rate
OLS	Ordinary Least Squares
PHC	Primary Health Care
PNC	Postnatal Care
PRMR	Pregnancy-Related Mortality Ratio
SBA	Skilled Birth Attendance
SDG	Sustainable Development Goal
SNNPR	Southern Nations, Nationalities, and Peoples' Region
SRH	Sexual and Reproductive Health
TOR	Terms of Reference
U5MR	Under-Five Mortality Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Interpretive note. EDHS indicators describe population-level health conditions, behaviors and inequalities, whereas HMIS indicators primarily describe routinely reported health-service activity. The two systems are complementary and should be triangulated rather than expected to produce numerically identical estimates.

4. Updated TOR × Certified Work × Closure Crosswalk

What this crosswalk tells us

Version 3.0 reflects a decisive change in status. Items that earlier versions correctly identified as substantive gaps—FGM/GBV, adolescent/youth analysis, maternal morbidity, the three-delay framework, contraceptive-change decomposition, and empirical HMIS/program triangulation—have now been completed or substantively closed within the defensible limits of EDHS.

A. Maternal morbidity is completed within measurement limits. Chapter 11.5 provides a dedicated fistula/leakage analysis with questionnaire/routing validation, prevalence estimation, precision diagnostics, limited stratification, and explicit cross-survey comparability boundaries. Rare-event multivariable modeling was intentionally not forced where event counts could not support stable inference.

B. Family-planning analytical requirements are substantially complete. Long-run contraceptive trends, unmet need, discontinuation, method mix, client choice, and formal contraceptive-change decomposition are now available. The post-2016 plateau is treated as a problem of offsetting forces rather than uninterrupted growth, and the decomposition is interpreted statistically rather than causally.

C. The policy-translation architecture is complete analytically. Chapter 12 now contains an executive synthesis, evidence-to-action matrix, geographic prioritization matrix, life-course framework, monitoring framework, research agenda, ranked actionable recommendations, verified policy alignment, and an empirical EDHS-HMIS-program triangulation annex. A separate MoH-facing analytical report below the 30-page TOR ceiling has also been prepared.

D. FGM/GBV is a major completed analytical workstream. Chapter 11.15 provides a dedicated GBV analysis of burden, inequalities, adjusted correlates, directly measured injury, and help-seeking/health-sector contact. Chapter 11.16 and related FGM analyses provide quarter-century and cohort trends, regional differentiation, direct mother-daughter linkage, 14 inferential findings, and a dedicated medicalization analysis. No new FGM/GBV empirical package remains to be created.

E. Adolescent/youth and three-delay requirements are no longer substantive gaps. Dedicated adolescent analyses, child-marriage/teenage-pregnancy integration, youth-centered interpretation, and an explicit three-delay proxy-and-boundary framework are now incorporated into the TOR-facing evidence base and MoH report.

F. Empirical triangulation and policy verification are substantively closed. Chapter 12.17 compares EDHS population signals with official HMIS/program evidence, while the verified Chapter 12.12 distinguishes currently approved policies from successor policies still under revision or consultation. The remaining work is therefore contractual finalization: derivative dissemination products, stakeholder validation, incorporation of agreed revisions, and issuance of the final package.

Status rule: COMPLETED = the TOR analytical requirement is directly addressed by a certified output; SUBSTANTIVELY CLOSED = the analytical requirement is satisfied within the defensible limits of EDHS and only administrative/final-document confirmation may remain; IN PRODUCTION = the evidence is complete but a dissemination product is still being assembled; PENDING STAKEHOLDER ACTION = completion depends on external validation or approval.

3. Updated TOR × Certified Work × Closure Crosswalk

TOR requirement	Current evidence / work	Updated status	What remains for full TOR alignment
Five-round EDHS trend validation (2000, 2005, 2011, 2016, 2024–25)	Five-round architecture, replication/QC, harmonization, and indicator-specific comparability rules are embedded across the book, Chapter 11, and the MoH-facing final analytical report.	COMPLETED / major strength	No new analysis required. Preserve indicator-specific non-comparability notes in final packaging.
Maternal health service trends	Chapters 4 and 11 cover ANC, skilled care, delivery, PNC, continuum, regional and socioeconomic inequalities; the ≤30-page MoH report now condenses these findings.	COMPLETED	Final dissemination/validation only.
Maternal mortality / pregnancy-related mortality trends	Chapter 8 and the MoH-facing report provide the national quarter-century synthesis, distinguish pregnancy-related mortality from the revised maternal-mortality definition, and avoid unsupported regional MMR estimation.	COMPLETED within DHS limits	Retain the definition/comparability warning; do not present non-comparable MMR measures as a single trend.
Maternal mortality risk factors / determinants	The final synthesis uses maternal-care pathways, fertility, socioeconomic risk factors, service-access evidence, and the three-delay framework while explicitly recognizing sparse maternal-death events.	SUBSTANTIVELY CLOSED within DHS limits	No unstable rare-event model should be added merely to satisfy a methodological label; use pathway/risk-factor evidence and state limits.
Three-delay model	The MoH-facing final analytical report now includes an explicit Delay 1/2/3 table mapping EDHS-supported proxies, identifying what EDHS cannot observe directly, and linking missing dimensions to HMIS/referral/MPDSR evidence.	COMPLETED	No additional analytical gap. Retain proxy-and-boundary interpretation.
Maternal morbidity	Chapter 11.5 completed fistula/leakage reconstruction, questionnaire/routing validation, national prevalence estimation, precision diagnostics, and limited stratification; the MoH report explains why multivariable rare-event modeling was not fitted.	COMPLETED within measurement limits	Preserve non-comparability and rare-event cautions in the final report.
Regional maternal-health burden / high-MMR regions including DRS	Extensive regional service-use, continuum, successor-region, and geographic-prioritization analyses identify high-burden settings without fabricating regional MMR estimates.	COMPLETED within DHS limits	Continue framing as regional maternal-health burden and pathway determinants rather than regional MMR.
Teenage pregnancy / childbearing trend	Dedicated adolescent analyses now provide five-round national and regional childbearing trends, disparities, and policy interpretation; the MoH report incorporates the current 2024–25 geography.	COMPLETED	Final presentation/annex selection only.
Determinants of teenage pregnancy	Dedicated adolescent analyses examine social, geographic, marital, educational, contraceptive, and reproductive correlates using survey-weighted methods and bounded causal interpretation.	COMPLETED / TOR-facing synthesis available	No new core analysis required; retain cross-sectional interpretation where applicable.
Child marriage × teenage pregnancy	The completed adolescent/youth work integrates child marriage, schooling, contraceptive protection, pregnancy, agency, and socioeconomic pathways, and the MoH report translates these into a joint prevention framework.	COMPLETED / integrated analysis	Final packaging should preserve the linked life-course interpretation.

TOR requirement	Current evidence / work	Updated status	What remains for full TOR alignment
Contraceptive prevalence trends	Validated long-run FP analyses show mCPR among currently married women at 6.30% (2000), 35.25% (2016), and 34.46% (2024/25), explicitly identifying the post-2016 plateau.	COMPLETED	Final dissemination only.
Contraceptive use by age, education, wealth, residence and region	Background-characteristic analyses and harmonization audits are embedded across the family-planning work and incorporated into the TOR-facing synthesis.	COMPLETED / major strength	No material analytical gap remains.
Determinants of contraceptive use	Family-planning determinant analyses and the formal decomposition address the requested background, information/service, fertility-experience, and reproductive-goal domains using consistent universes where required.	COMPLETED / substantively closed	Retain denominator and causal-attribution cautions.
Relative contributions to change in contraceptive use	Formal 2000–2024/25 decomposition completed: composition versus behavioral/structural residual, with background, information exposure, reproductive-goal components, and overlap/sensitivity diagnostics.	COMPLETED	Present explicitly as statistical decomposition, not causal/program attribution.
Unmet need: levels, trends and differentials	Unmet-need levels, trends, and socioeconomic differentials are reproduced/validated and integrated with the family-planning plateau interpretation.	COMPLETED / substantively closed	Retain legacy-versus-revised definition caution for long-run comparisons.
Discontinuation and reasons	Dedicated discontinuation and reason analyses are completed and linked to continuation, side-effect management, and service quality in Chapter 12.	COMPLETED	Final concise table selection only.
Method switching	Switching is incorporated in the completed discontinuation/event-history architecture and in the FP quality/monitoring interpretation.	SUBSTANTIVELY CLOSED	If the final annex requires a standalone transition table, extract it from the completed FP outputs; this is packaging, not a new analytical workstream.
Method mix / quality of care / client choice	Method-specific use, informed choice, source, continuation, switching, and service-quality dimensions are available and integrated into the plateau diagnosis.	COMPLETED / substantively closed	Final TOR-facing condensation only.
Adolescent and youth health	Chapter 11 now contains dedicated adolescent/youth analyses; Chapter 12.5 and 12.11 provide youth priorities and a life-course framework; the MoH report integrates the findings.	COMPLETED / major TOR workstream	Final dissemination and stakeholder validation only.
Gender-sensitive / youth-centered analytical lens	Chapter 10 provides multidimensional agency/gender-norm analyses; Chapter 11 integrates gender/youth throughout; Chapter 12 and the MoH report translate these into program decisions.	COMPLETED as analytical lens	Apply consistently in all final dissemination products.
GBV prevalence, patterns and drivers	Chapter 11.15 provides a dedicated EDHS domestic-violence analysis of burden, forms, regional/socioeconomic inequalities, and adjusted correlates using DV-specific weights and certified item recodes.	COMPLETED	No empirical gap remains; retain cross-sectional “correlate” rather than causal “driver” language where appropriate.
GBV health consequences and help-seeking	Chapter 11.15 analyzes directly measured injury, help-seeking sources, and doctor/health-sector contact, while explicitly avoiding unsupported mental-health inference and distinguishing contact from quality of care.	COMPLETED within EDHS measurement limits	No new analysis required; preserve measurement boundaries.

TOR requirement	Current evidence / work	Updated status	What remains for full TOR alignment
FGM prevalence, trends, drivers and medicalization	Chapter 11.16 and related analyses provide quarter-century prevalence/cohort trends, regional differentiation, mother-daughter linkage, education/wealth/residence/norm analyses, 14 inferential findings, and a dedicated medicalization analysis.	COMPLETED / major analytical workstream	No empirical gap remains; final packaging should preserve cohort and medicalization distinctions.
Equity/disparity analysis	Region, residence, age, education and wealth are recurring dimensions throughout the analytical program; Chapter 12.10 converts heterogeneity into a geographic prioritization matrix.	COMPLETED / major strength	Apply the same disaggregation discipline in final dissemination products.
Resolve ambiguous/conflicting findings	Replication-first validation, denominator/QC audits, confidence intervals, harmonization, sensitivity analysis, explicit non-comparability rules, and source triangulation are now demonstrated across multiple TOR domains.	COMPLETED as methodology and practice	Document any stakeholder-raised anomaly during validation and adjudicate transparently.
HMIS + program-report triangulation	Chapter 12.17 now provides empirical EDHS-HMIS-program triangulation using official MoH/HMIS and program evidence for family planning, maternal health, AYH, EBF/nutrition, GBV and FGM.	COMPLETED / substantively closed	Internal MoH datasets may refine the annex but are not required to establish the triangulation logic.
Policy alignment	Chapter 12.12 v2.0 has been verified against the latest publicly verifiable national policy architecture: HSDIP-II direction, approved AYH 2021–2025 strategy, current National Policy on Ethiopian Women, and current National Population Policy, with successor-policy status explicitly distinguished.	SUBSTANTIVELY CLOSED	Administrative check only: replace provisional references if MoH/MoWSA/MoPD provide controlled final successor documents before submission.
Policy interpretation / actionable recommendations	Chapter 12.1–12.17 provides executive synthesis, evidence-to-action and geographic matrices, monitoring, triangulation, research agenda, and 15 ranked recommendations; the ≤30-page MoH analytical report has now been drafted.	COMPLETED analytically	Dissemination products and stakeholder validation remain.
Relevant follow-up research	Chapter 12.15 provides a decision-driven 2027–2035 research/data agenda focused on questions EDHS cannot resolve.	COMPLETED	Prioritization can be refined during stakeholder validation.
Monitoring / indicator list	Chapter 12.13 provides a 2027–2030/2035 framework with indicator, numerator, denominator, disaggregation, source, frequency, responsibility, benchmark and defensible targets.	COMPLETED / exceeded TOR indicator-list requirement	Any numeric target tied to a successor policy should be reconciled if a controlled final policy is issued before submission.
Concept note / analytical framework / indicator list	The integrated Chapter 11 architecture plus Chapter 12 life-course, evidence-to-action, geographic, monitoring and triangulation frameworks exceed the original analytical-framework requirement.	COMPLETED / exceeded	Package the relevant components as an annex if the contract requires a standalone inception artifact.
Dummy tables / analysis plan	The analytical plan has been executed and most dummy outputs are now populated tables with validated production results.	COMPLETED / exceeded	No new dummy shells are needed for completed analyses.
Deep dive: FP and unmet need	Completed Chapter 3/11 family-planning evidence includes long-run prevalence, unmet need, discontinuation, method	COMPLETED analytically	Final deep-dive formatting/annex extraction only, if contractually required as a separate file.

TOR requirement	Current evidence / work	Updated status	What remains for full TOR alignment
	choice and formal change decomposition; Chapter 12.4 translates priorities.		
Deep dive: maternal health including mortality	Chapters 4, 8 and 11 cover service use, continuum, mortality, morbidity and the three-delay framework; Chapter 12.3 and the MoH report translate priorities.	COMPLETED analytically within DHS limits	Final deep-dive formatting/annex extraction only.
Deep dive: FGM and GBV	Dedicated Chapter 11.15 GBV and 11.16 FGM analyses now address prevalence/burden, patterns, correlates, health consequences/help-seeking where measured, cohort transition and medicalization.	COMPLETED analytically	Condense and cross-reference in final dissemination products; no new empirical package is required.
Draft/final analytical report	A separate MoH-facing analytical report capped below the 30-page TOR ceiling has now been prepared from the certified evidence base.	DRAFT COMPLETED / finalization pending validation	Complete stakeholder review, incorporate agreed revisions, and issue the final validated version.
Policy briefs / fact sheets / PowerPoint	The evidence base, 15 ranked recommendations, verified policy alignment, and ≤30-page report now provide a stable source for derivative decision products.	IN PRODUCTION / source evidence frozen	Create the policy brief/fact sheets and decision-maker PowerPoint from the same frozen source to maintain numerical and message consistency.
Validation workshop / workshop report	Internal analytical validation is extensive and the report/deep-dive evidence base is ready for stakeholder review.	PENDING STAKEHOLDER ACTION	Conduct MoH/UNFPA/CORHA validation, document comments and decisions, revise the report, and issue the workshop report/final package.
Final actionable recommendations	Chapter 12.16 ranks 15 recommendations as Immediate, Medium-term and Structural and identifies responsible actors and accountability milestones; the MoH report carries them forward.	COMPLETED analytically	Validate with MoH/UNFPA/CORHA and incorporate agreed changes into the final package.

5. TOR Closure Status

The analytical gaps identified in earlier versions of the TOR crosswalk have now been closed or substantively closed. Dedicated analyses have been completed for FGM/GBV, adolescent and youth health, maternal morbidity, contraceptive-change decomposition, and the three-delay framework; empirical EDHS-HMIS-program triangulation has been completed; national-policy alignment has been verified against the latest publicly verifiable instruments; and the MoH-facing analytical report has been prepared within the 30-page ceiling.

The remaining tasks are contractual finalization activities rather than substantive analytical gaps: producing the policy brief/fact sheets and decision-maker PowerPoint, preparing and conducting the stakeholder validation workshop, incorporating agreed comments, and issuing the final validated report and workshop package.

Current overall status: analytical work substantially complete; remaining work is dissemination, stakeholder validation, and final contractual packaging.

6. Recommended MoH positioning

Our strongest and most accurate response on the MoH TOR is: the substantive analytical program is substantially complete, the major TOR empirical requirements have been directly answered or bounded within defensible DHS limits, and the remaining work is concentrated in contractual dissemination, stakeholder validation, and final issuance. This report should therefore be presented as a mature evidence package entering validation—not as an analytical program with major empirical gaps.

This preserves the distinction between the independently developed 12-chapter analytical program and the Ministry’s consultancy deliverables while accurately reflecting current readiness. It avoids two opposite errors: understating completed work by carrying forward obsolete “gap” labels and overstating contractual completion before the policy brief/fact sheets, PowerPoint, stakeholder validation, workshop documentation, and final revisions are finished.

7. Bottom line

The substantive analytical requirements are now completed or substantively closed across maternal health, family planning, adolescent/youth health, FGM/GBV, equity, triangulation, policy interpretation, monitoring and research. The remaining work is production and validation: derivative decision products, stakeholder review, decision documentation, incorporation of agreed revisions, and issuance of the final contractual package. Traceability remains the governing rule: every TOR requirement should point to a certified analytical output or a clearly identified contractual finalization step.

Declaration of Generative AI and AI-Assisted Technologies. During the preparation of this report, the authors used OpenAI to assist with analytical planning, report organization, language refinement, methodological exposition, and presentation of the quarter-century 12-chapter study findings.