

Taking Stock and Looking Ahead: Ethiopia’s Quarter Century of Change in Demography and Health, 2000-2025, and Prospects to 2050

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My name is **Aynalem Adugna**, and today I will be presenting:
“Taking Stock and Looking Ahead: Ethiopia’s Quarter Century of Change in Demography and Health, 2000–2025, and Prospects to 2050.”

This work reflects:

Over three decades in demographic research and public health
Including **20 years teaching** in a U.S. university, **10 years at the California Department of Social Services**, and **Four and a half years of applied public health work at the California Department of Public Health**

But importantly, this is also a **personal and professional return**—an opportunity to engage directly with Ethiopia’s public health system at a critical moment.

Purpose of the presentation

This presentation has **two main objectives**:

1. Taking Stock (2000–2025)

To provide a **data-driven assessment** of Ethiopia’s progress across eight key areas:

Family planning
Fertility
Child mortality
Maternal health
Immunization
Nutrition
Breastfeeding
Pregnancy-related mortality

2. Looking Ahead (to 2050)

To identify:

Where progress is **likely to continue**

Where it may **slow or stall**

And where **targeted interventions** could accelerate gains

Why this matters

Ethiopia's experience over the past 25 years represents:

One of the most significant demographic and public health transitions in sub-Saharan Africa.

Understanding this transition is critical for:

Policy planning

Resource allocation

And **prioritizing high-impact interventions**

A central idea running through this presentation is:

These indicators do not operate independently—they are **deeply interconnected**.

For example:

Family planning influences fertility

Fertility influences maternal health

Maternal health influences child survival

Nutrition and breastfeeding cut across all domains

Over the past 25 years, Ethiopia has quietly achieved one of the most important public health transformations in Africa. The question now is not whether progress has occurred—but how to sustain and accelerate it over the next 25 years.

Toward the end,

I will highlight **two critical areas** that have the potential to accelerate progress across all domains:

Exclusive breastfeeding

Women's education and empowerment

Taking Stock: Definition

A careful evaluation of the current state of a system by **reviewing evidence** accumulated over time to assess progress, identify remaining challenges, and inform future policy decisions.

In the context of today's presentation, taking stock means looking back over the last quarter-century to evaluate **what has changed:**

- fertility decline
- improvements in maternal health services
- reductions in child mortality
- changes in nutrition and breastfeeding indicators
- Etc.

Before we move into the content, let me briefly clarify what I mean by **“taking stock.”**

In this context, I am not using it in a financial or accounting sense.

“Taking stock”, as applied here, simply means:

Looking carefully at where we are today, based on evidence collected over time.

It is a way of asking:

What progress have we made?

What has improved?

What challenges remain?

In this presentation, “taking stock” **specifically means:**

Looking back over the past **25 years in Ethiopia** using EDHS data to understand how key health and demographic indicators have changed.

So **when we say “what has changed,” we are referring to:**

Fertility decline
Expansion of maternal health services
Reductions in child mortality
Changes in nutrition and breastfeeding
And other related indicators

But equally important:

Taking stock is not only about progress—it is also about identifying **gaps and missed opportunities**.

And this is what allows us to move to the second part of the presentation:
Looking ahead—what needs to happen next.

In simple terms, “taking stock” means:

Where were we? Where are we now? And what still needs to improve?

With that definition in mind, let us review some background information about Ethiopia’s overall population size and how it changed over the last quarter-century, followed by a look at the table of contents for today’s presentation

Background

Ethiopia's modern demographic data system began with the first national population and housing census conducted in 1984. That census estimated the country's population at approximately 42 million people. A decade later, the 1994 national census recorded a population of nearly 53 million, indicating rapid population growth during the late twentieth century.

During this period, Ethiopia's demographic profile reflected characteristics typical of many low-income countries. Fertility rates were estimated to exceed six children per woman, while infant and child mortality remained high, and maternal mortality was among the highest in the world. Limited access to health services, low contraceptive prevalence, and widespread rural poverty contributed to high population growth rates and substantial health challenges.

By the late 1990s, Ethiopia's population had grown to an estimated 65 million people, increasing demand for health services, education, and social infrastructure. At the same time, global health initiatives and national policy reforms began emphasizing expanded access to reproductive health services, maternal health care, and child survival interventions.

Background

Background..Contd.

According to estimates from the United Nations Population Division and the World Bank, Ethiopia's population increased from roughly 65 million in the late 1990s to approximately 77 million by the 2007 national census and to more than 100 million by the mid-2010s [9]. This rapid demographic expansion placed increasing pressure on the country's health system, education sector, labor markets, and natural resources while also highlighting the urgency of expanding access to reproductive health services and maternal and child health programs.

Population growth has continued into the present decade. Recent international demographic estimates suggest that Ethiopia's population exceeded 120 million in the early 2020s and is projected to reach approximately 128–130 million by 2026, making it the second most populous country in Africa after Nigeria and one of the largest in the world.

Background..Contd.

65 million (2000) - 130 million (2025): The journey

Table of Contents (Quarter-century trends in)

Family Planning	Fertility	Mortality	Skilled Provider Attended Deliveries
Vaccination	Child Nutrition	Breastfeeding	Pregnancy-related deaths

Before we move into the data, let me briefly outline how the presentation is organized.

The Population anchor

As shown at the top:

Ethiopia's population has grown from approximately **65 million in 2000** to about **130 million in 2025**.

This doubling of population provides the **context for everything that follows**:

Increased demand for health services

Greater pressure on systems

And greater importance of effective policy

The presentation examines **eight key topic areas in four domains**, organized into a logical sequence:

Domain 1. Reproductive and demographic drivers

Family planning

Fertility

These shape **population growth and birth patterns.**

Domain 2. Survival outcomes

Mortality (child survival)

Skilled birth attendance

These reflect the performance of the **health system in saving lives.**

Domain 3. Child health and development

Vaccination

Child nutrition

Breastfeeding

These influence not just survival, but **healthy growth and development.**

Domain 4. Maternal outcomes

Pregnancy-related mortality

This represents one of the most important indicators of **health system effectiveness.**

These are not separate topics.

They are **interconnected parts of one system.**

For example:

Family planning → affects fertility

Fertility → affects maternal risk

Maternal care → affects child survival

Nutrition and breastfeeding → affect both survival and development

For each domain, I will:

Show **quarter-century trends (2000–2025)**

Briefly interpret **what has changed**

Highlight **policy implications**

Look ahead toward **2050**

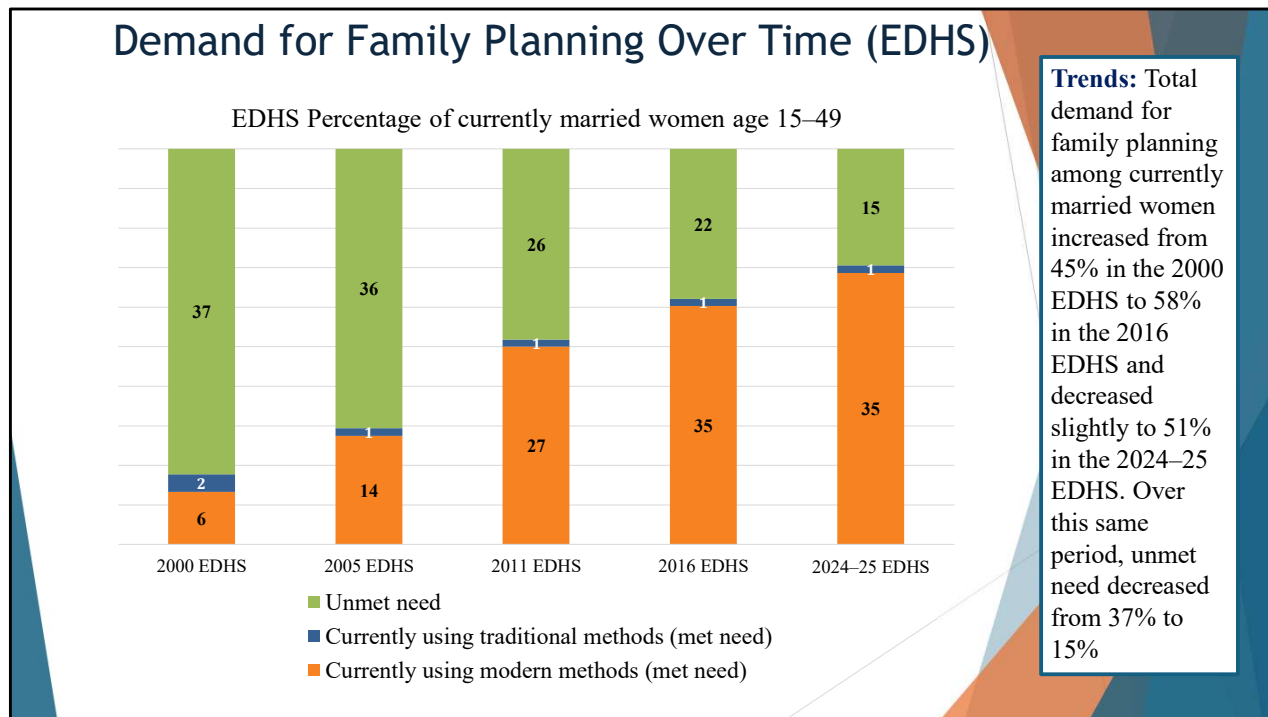
At the end, I will bring all eight areas together and highlight:

Two critical priorities that can accelerate progress across all domains.



▶ FAMILY PLANNING

Family Planning



Key trend summary

Over the past quarter-century, Ethiopia has made **substantial progress in expanding access to family planning services**, but the trend is **not strictly linear**.

Total demand increased from **45% in 2000**

Peaked at **58% in 2016**

Then **declined modestly to 51% in 2024–25**

At the same time, **unmet need declined dramatically**, from **37% in 2000 to 15% in 2024–25**, representing one of the most important reproductive health gains during this period.

Decomposition of change (what is driving the trend)

1. Rapid expansion of modern contraceptive use

Modern method use increased from **6% in 2000 to 35% by 2016**

This reflects major investments in:

Primary health care expansion

Health Extension Program (HEP)

Community-based distribution of contraceptives

By 2024–25, modern use remains high at **~35%**, indicating **sustained gains**,

though growth has plateaued.

Collapse in unmet need

Unmet need declined from **37% → 15%**

This is a **structural transformation**, not a marginal improvement

It reflects:

Increased **physical access to services**

Improved **awareness and demand**

Greater **acceptability of family planning**

This is one of the clearest indicators of **health system effectiveness**.

Minimal role of traditional methods

Traditional method use remains very low (**~1–2% across surveys**)

This indicates a **strong shift toward modern contraceptive methods**, which are more effective

Interpreting the recent decline (2016 → 2024–25)

The slight decline in total demand from **58% to 51%** is important and should be interpreted carefully.

Possible explanations include:

Changes in fertility preferences (desired family size stabilizing)

Measurement differences in the most recent EDHS

Potential **service disruptions or access constraints**

Plateau in reaching **hard-to-reach populations**

This does **not negate progress**, but signals a **transition from expansion to saturation phase**.

Equity considerations

Despite national gains, disparities remain:

Rural vs urban differences

Regional variation in **service access**

Lower use among:

Adolescents

Less-educated women

Remote populations

This suggests the next phase must be **equity-focused rather than expansion-focused**.

Link to broader demographic transition

These trends are directly linked to:

Declining fertility rates

Improved **birth spacing**

Reductions in **maternal and child mortality**

Family planning is therefore not a standalone intervention—it is a **driver across multiple health outcomes**.

Forward-looking implication (bridge to “Prospects to 2050”)

Looking ahead:

Further gains will depend on:

Reaching **remaining unmet need (15%)**

Expanding **method choice**

Strengthening **adolescent reproductive health services**

Ethiopia is entering a phase where:

The challenge is no longer access alone, but **sustained demand, quality, and equity**

In closing

The past 25 years show that Ethiopia can expand access to family planning at scale; the next 25 years will determine whether those gains can be deepened, sustained, and equitably distributed.

Policy Takeaways

1. Close the remaining unmet need gap (15%)

Target **rural, low-income, and adolescent populations** where unmet need persists; shift to **precision public health**.

2. Integrate family planning with women’s education (WE)

Girls’ secondary education and women’s empowerment are **high-impact levers** for sustained fertility decline.

3. Strengthen long-acting and reversible methods (LARCs)

Expand access to **implants and IUDs** to improve effectiveness, continuation, and birth spacing.

4. Protect gains through supply chain and workforce stability

Ensure **reliable commodity supply** and continued support for the **Health Extension Program**.

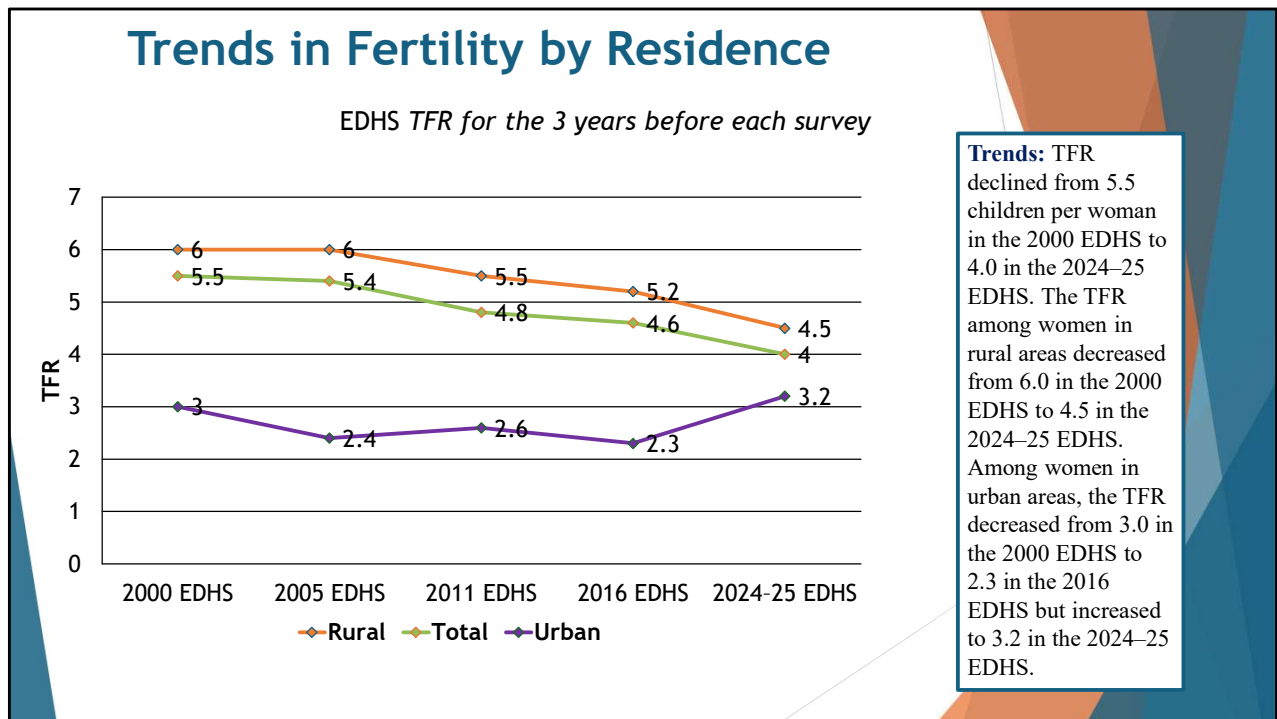
5. Prioritize adolescents and first-time users

Conclusion: Future progress depends on reaching **young women early** with accessible, acceptable services.

The next phase of Ethiopia’s family planning success depends on shifting from broad expansion to targeted, equity-driven impact.



Fertility



This slide presents trends in **Total Fertility Rate (TFR)** for Ethiopia over the past quarter century, disaggregated by **rural, urban, and total population**, based on EDHS estimates for the three years preceding each survey.

Sustained national fertility decline

Ethiopia’s total fertility rate declined from **5.5 children per woman in 2000** to **4.0 in 2024–25**.

This represents a **substantial but incomplete fertility transition**, reflecting:

Increased access to **family planning services**

Improvements in **female education**

Declines in **child mortality**, reducing the need for high fertility

However, a TFR of 4.0 indicates that Ethiopia remains **well above replacement level (≈ 2.1)**.

Significant decline in rural fertility

Rural fertility declined from **6.0 to 4.5 children per woman**.

This is particularly important because:

Rural areas account for the **majority of Ethiopia’s population**

Fertility decline in rural settings signals **deep structural change**

Drivers include:

Expansion of the **Health Extension Program**

Increased **contraceptive access**

Gradual shifts in **fertility preferences**

Urban fertility is low but shows variability

Urban fertility declined from **3.0 in 2000** to **2.3 in 2016**, but increased to **3.2 in 2024–25**.

This pattern suggests:

Urban areas had **earlier fertility transition**

The recent increase may reflect:

Migration effects (influx of higher-fertility populations)

Economic or social disruptions

Delayed fertility (timing effects)

Even with the increase, urban fertility remains **substantially lower than rural fertility**.

Interpretation (what this means)

Ethiopia is undergoing a **gradual, uneven fertility transition**:

Early transition in urban areas

→ slower but steady transition in rural areas

Fertility decline has been **policy-driven (family planning, health system expansion)** but also shaped by **social determinants**, especially women's education.

Looking Ahead to 2050 (Fertility Outlook)

Ethiopia's fertility trajectory will be central to its demographic future.

TFR is expected to **continue declining**, potentially reaching:

~3.0 or lower nationally by 2050

Urban areas may approach **replacement fertility**

Rural areas will likely remain **above replacement for longer**

The pace of decline will depend on:

Expansion of **modern contraceptive use**

Reduction in **unmet need**

Growth in **female secondary education**

Delays in **age at marriage and first birth**

Without accelerated progress, fertility decline may **stall above replacement**, sustaining rapid population growth.

Policy Takeaways — Fertility Dynamics

1. Accelerate fertility decline through targeted family planning

Focus on **high-fertility rural regions** where the majority of births occur.

2. Prioritize girls' secondary education (WE strategy)

Female education is the **strongest long-term driver of fertility decline**.

3. Reduce rural–urban disparities

Expand **equitable access to reproductive health services** in underserved areas.

4. Address adolescent fertility

Delay **age at first birth** through education and youth-focused services.

5. Integrate fertility policy with economic development

Urbanization, employment, and education policies must align with demographic goals.

6. Strengthen data systems to monitor fertility dynamics

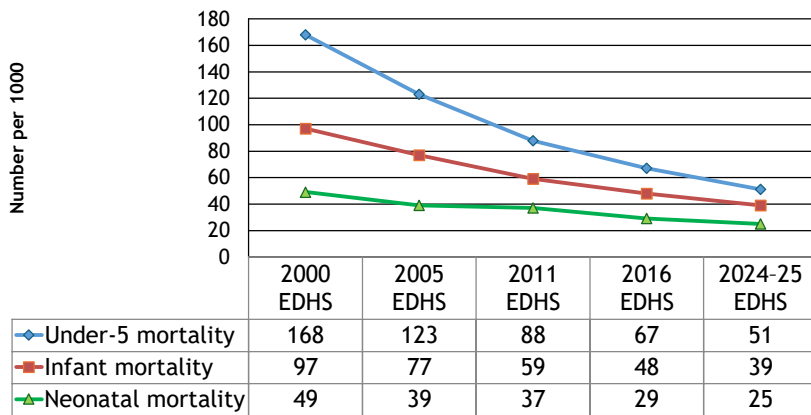
Track **subnational trends**, not just national averages.



Mortality

Trends in Early Childhood Mortality Rates

EDHS Deaths per 1,000 live births in the 5-year period preceding the survey



Neonatal mortality: The probability of dying within the first month of life.
Post-neonatal mortality: The probability of dying between the first month of life and the first birthday (computed as the difference between infant and neonatal mortality).

Infant mortality: The probability of dying between birth and the first birthday.
Child mortality: The probability of dying between the first and the fifth birthday.
Under-5 mortality: The probability of dying between birth and the fifth birthday

Trends: Neonatal mortality decreased from 49 deaths per 1,000 live births in the 5 years preceding the 2000 survey to 25 deaths per 1,000 live births in the 5 years preceding the 2024–25 survey. The infant mortality rate also showed a substantial decline, falling from 97 deaths per 1,000 live births in the 5 years preceding the 2000 survey to 39 deaths per 1,000 live births in the 5 years preceding the 2024–25 survey. Similarly, under-5 mortality dropped from 168 deaths per 1,000 live births in the 5 years preceding the 2000 survey to 51 deaths per 1,000 live births in the 5 years preceding the 2024–25 survey.

This slide presents trends in **three key child survival indicators** in Ethiopia—**neonatal mortality, infant mortality, and under-five mortality**—measured as deaths per 1,000 live births in the five years preceding each EDHS survey.

These three indicators reflect different stages of early life:

Neonatal (0–28 days) → birth and immediate postnatal care

Infant (0–1 year) → early survival and infection control

Under-five (0–5 years) → overall child health environment

Dramatic decline in under-five mortality

Under-five mortality declined from **168 deaths per 1,000 live births in 2000** to **51 in 2024–25**.

This represents a **~70% reduction**, one of the most significant public health achievements in Ethiopia over the past quarter century.

Drivers include:

Expansion of **primary health care services**

Increased **immunization coverage**

Improved **nutrition and breastfeeding practices**

Better **management of childhood illnesses (IMCI)**

Substantial reduction in infant mortality

Infant mortality declined from **97 to 39 deaths per 1,000 live births**.

This reflects improvements in:

Postnatal care

Infection prevention and treatment

Breastfeeding practices

Household-level health behaviors

The decline indicates that gains are not limited to early childhood broadly, but extend into the **first year of life**, a critical vulnerability period.

Slower but steady decline in neonatal mortality

Neonatal mortality declined from **49 to 25 deaths per 1,000 live births**.

While this is a significant improvement, the rate of decline is **slower compared to under-five mortality**.

This reflects a well-documented global pattern:

As overall child mortality declines, **neonatal deaths make up a larger share of remaining deaths**.

Neonatal mortality is more resistant to decline because it depends heavily on:

Quality of care at birth

Skilled birth attendance

Emergency obstetric care

Newborn care practices

Shift in mortality composition

Over time, Ethiopia has transitioned from:

High mortality across all childhood stages

to:

Concentration of mortality in the neonatal period

This means:

Future reductions in under-five mortality will depend increasingly on **neonatal survival improvements**

What it all means

Ethiopia has moved from a **high-mortality environment** to a **rapidly improving child survival system**.

This reflects:

Strong performance of **community-based health programs**

Effective scaling of **low-cost, high-impact interventions**

However, the next phase of progress will be **more difficult**, requiring:

Higher-quality clinical care

Better health system integration

Focus on the **most vulnerable period—birth and the first month of life**

Looking Ahead to 2050 (Child Survival Outlook)

Child mortality is expected to continue declining, but at a **slower pace**.

Key projections:

Under-five mortality may fall below **30 per 1,000** by 2050

Neonatal mortality will become the **dominant component** of child deaths

Future progress will depend on:

Improving quality of care at birth

Expanding **skilled birth attendance and facility delivery**

Strengthening **referral and emergency care systems**

Addressing **persistent undernutrition**

Maintaining high **immunization coverage**

Without targeted focus on neonatal care, overall mortality decline may **stall**.

Policy Takeaways — Childhood Mortality

1. Shift focus to neonatal survival

Future gains depend on reducing deaths in the **first month of life**.

2. Improve quality—not just access—to care

Expand **quality of facility-based delivery and newborn care**.

3. Strengthen the continuum of care

Link services across:

Pregnancy

Delivery

Postnatal period

Early childhood

4. Sustain immunization and child health programs

Maintain high coverage of **vaccines and IMCI interventions**.

5. Address nutrition as a survival issue

Undernutrition remains a key driver of child mortality.

6. Reduce geographic and socioeconomic disparities

Target **high-burden regions and vulnerable populations**.

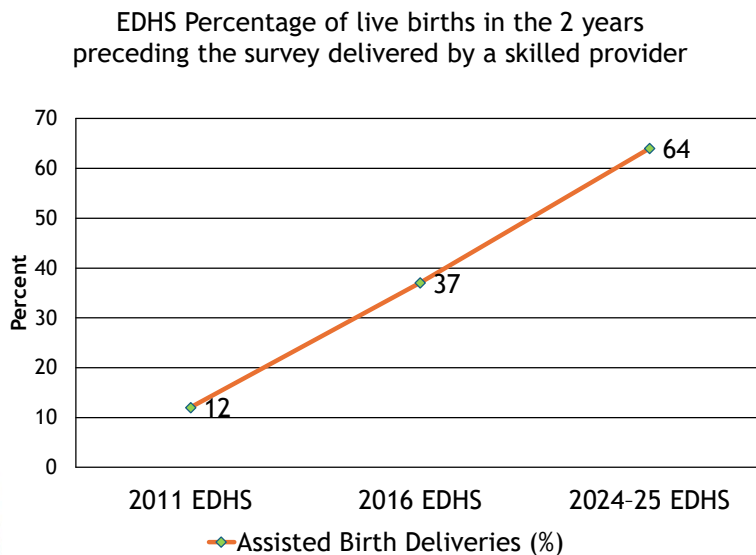
7. Invest in health system capacity

Skilled workforce, referral systems, and infrastructure are critical.



SKILLED PROVIDER-
ASSISTED
▶ DELIVERIES

Trends in Assisted Birth Deliveries in Ethiopia



Trends: The percentage of women with a live birth in the 2 years preceding the survey whose delivery was assisted by a skilled provider has increased over time, rising from 12% in 2011 to 64% in 2024–25.

This slide presents the percentage of live births in the two years preceding each survey that were **assisted by a skilled health provider**—a key indicator of **maternal health service utilization and safe delivery practices**.

Skilled birth attendance includes deliveries assisted by:

- Doctors
- Nurses
- Midwives
- Trained health professionals

Trend 1: Rapid and substantial increase in skilled birth attendance

Skilled birth attendance increased from **12% in 2011** to **37% in 2016**, and further to **64% in 2024–25**.

This represents one of the **fastest improvements across all eight indicators** in this analysis.

This rapid increase reflects:

- Expansion of **health facilities**
- Growth of the **Health Extension Program**
- Increased **community awareness and demand for facility delivery**
- Improved **referral systems and maternal care outreach**

Trend 2: Transition from home-based to facility-based delivery

In 2011, the vast majority of births occurred **outside the formal health system**.

By 2024–25, the majority of births are now **assisted by skilled providers**.

This represents a major structural shift:

From **traditional/home-based delivery systems**

→ to **facility-based, medically assisted childbirth**

This transition is critical because skilled attendance at birth is one of the **strongest determinants of maternal and neonatal survival**.

Trend 3: Strong link to maternal and neonatal outcomes

The increase in skilled birth attendance directly contributes to:

Reduction in **maternal mortality**

Reduction in **neonatal mortality**

Improved **management of complications during childbirth**

Increased access to **emergency obstetric care**

This indicator is therefore central to explaining:

Trends in **pregnancy-related mortality**

Trends in **neonatal survival**

Trend 4: Rapid progress—but not yet universal coverage

At **64%**, Ethiopia has made major progress—but has not yet achieved:

Universal access (≈90%+)

Full equity across regions and populations

Remaining gaps are likely concentrated among:

Rural populations

Lower-income households

Hard-to-reach geographic areas

What it all means

Ethiopia has moved into a **new phase of maternal health transition**:

From limited access

→ to expanding coverage

→ now toward **quality and equity**

The rapid gains demonstrate the effectiveness of:

Community-based health systems

Government commitment to maternal health

Integration of services across levels of care

However, the next phase will require:

Improving **quality of care at facilities**

Strengthening **continuity of care (ANC → delivery → postnatal)**

Looking Ahead to 2050 (Maternal Health Outlook)

Skilled birth attendance is expected to continue increasing, potentially reaching: **80–90% by 2050**, if current trends are sustained

Future progress will depend on:

Improving quality of care, not just increasing access

Expanding **emergency obstetric and newborn care (EmONC)**

Strengthening **referral and transport systems**

Addressing **rural–urban disparities**

Increasing **facility readiness and staffing**

As coverage increases, the key challenge becomes:

Ensuring that **facility delivery translates into improved outcomes**

Policy Takeaways — Skilled Birth Attendance

1. Move from coverage to quality of care

Ensure that increased facility delivery leads to **better maternal and neonatal outcomes**.

2. Strengthen emergency obstetric care systems

Invest in **referral systems, transport, and facility capacity**.

3. Target underserved populations

Focus on **rural and hard-to-reach areas** where gaps remain.

4. Integrate maternal care continuum

Link:

Antenatal care

Skilled delivery

Postnatal care

5. Invest in the health workforce

Expand and support **midwives, nurses, and skilled providers**.

6. Improve facility readiness and infrastructure

Ensure consistent availability of:

Equipment

Supplies

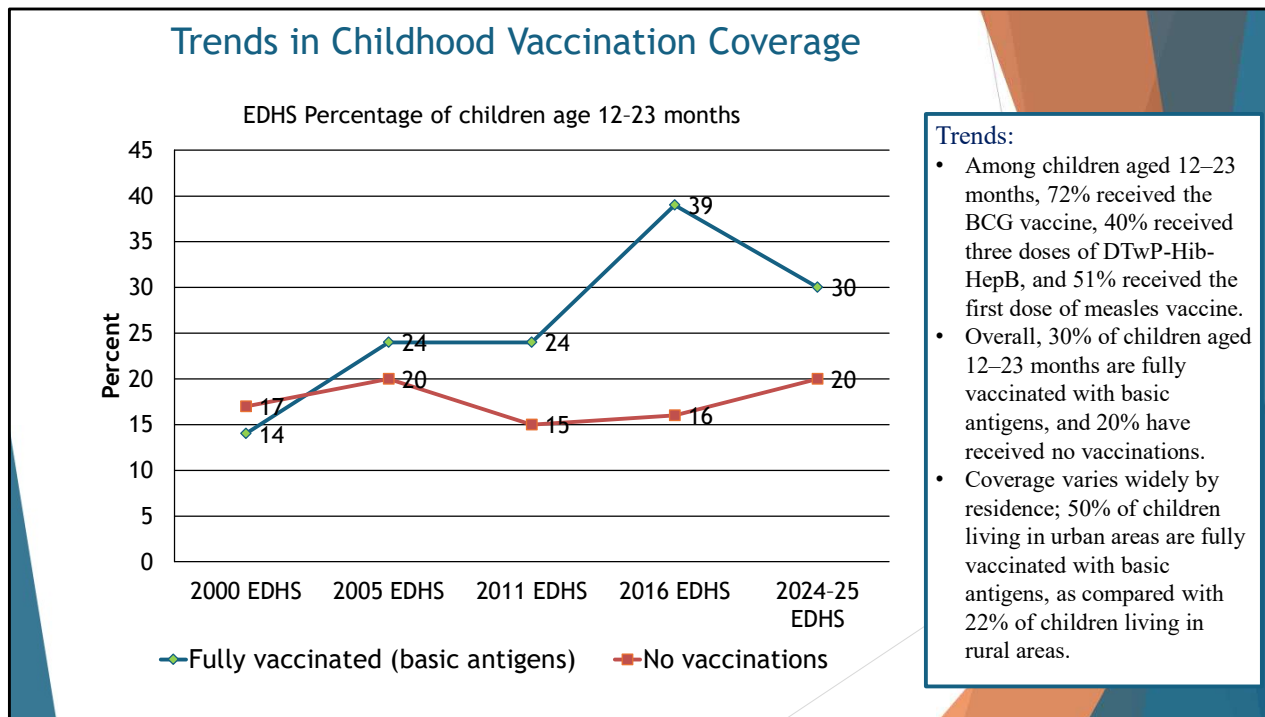
Trained staff

7. Align maternal health with broader system strengthening

Maternal care improvements depend on overall **health system performance**.



VACCINATION



This slide presents trends in **childhood vaccination coverage among children aged 12–23 months**, focusing on:

Fully vaccinated (basic antigens)

No vaccinations (zero-dose children)

Vaccination is one of the most effective interventions for reducing **child mortality**, particularly from infectious diseases.

Trend 1: Moderate increase in full vaccination coverage

The proportion of children fully vaccinated increased from **14% in 2000** to a peak of **39% in 2016**, but declined to **30% in 2024–25**.

This pattern reflects:

Strong expansion phase (2000–2016)

Followed by a **decline or plateau phase (2016–2025)**

This suggests that Ethiopia achieved early gains but is now facing **coverage sustainability challenges**.

Trend 2: Persistent burden of zero-dose children

The proportion of children receiving **no vaccinations**:

Increased from **17% in 2000** to **20% in 2024–25**

This is a critical concern because zero-dose children:
Are the **most vulnerable to preventable diseases**
Reflect **system failure to reach certain populations**
These children are often concentrated among:
Rural populations
Hard-to-reach communities
Lower socioeconomic groups

Trend 3: Coverage peaked and then declined

The peak in 2016 (39%) followed by a decline suggests:
Early success driven by:

Expanded immunization programs

Support from **global partners (e.g., Gavi)**

Recent stagnation or decline possibly due to:

System capacity constraints

Supply chain disruptions

Competing health priorities

Service interruptions

Trend 4: Significant inequities by residence

This slide highlights a major disparity:

Urban: ~50% fully vaccinated

Rural: ~22% fully vaccinated

This indicates that:

National averages mask **deep structural inequalities**

Vaccination coverage is strongly influenced by:

Access to health services

Infrastructure

Education and awareness

What it all means

Expansion → Plateau → Equity challenge

While early gains contributed significantly to reductions in child mortality, the current challenge is:

Reaching the unreached

Sustaining and improving coverage in a more complex environment

Looking Ahead to 2050

Vaccination coverage is expected to improve, but progress will depend on system strengthening.

Possible trajectory:

Full vaccination coverage could reach **60–80% by 2050**

Zero-dose children could be significantly reduced—but only with targeted strategies

Future success will depend on:

Reaching zero-dose populations

Strengthening **routine immunization systems**

Improving **supply chain reliability**

Expanding **community outreach**

Integrating immunization with **primary health care**

Without targeted efforts, inequities may persist even as overall coverage improves.

Policy Takeaways — Childhood Vaccination

1. Prioritize zero-dose children

Focus on children who receive **no vaccines at all**—the highest-risk group.

2. Shift from expansion to targeted outreach

Use **data-driven strategies** to identify and reach underserved populations.

3. Strengthen routine immunization systems

Move beyond campaigns to **consistent, reliable service delivery**.

4. Address rural–urban disparities

Expand services in **rural and hard-to-reach areas**.

5. Improve supply chain and logistics systems

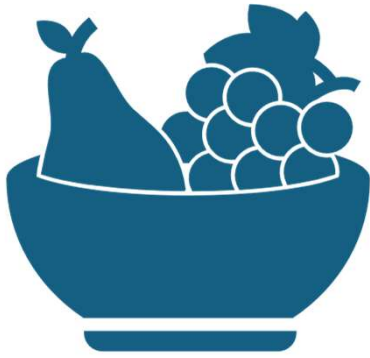
Ensure consistent availability of vaccines at all levels.

6. Integrate immunization with primary health care

Leverage the **Health Extension Program** for outreach and follow-up.

7. Maintain partnerships with global health programs

Sustain collaboration with organizations such as **Gavi and WHO**.

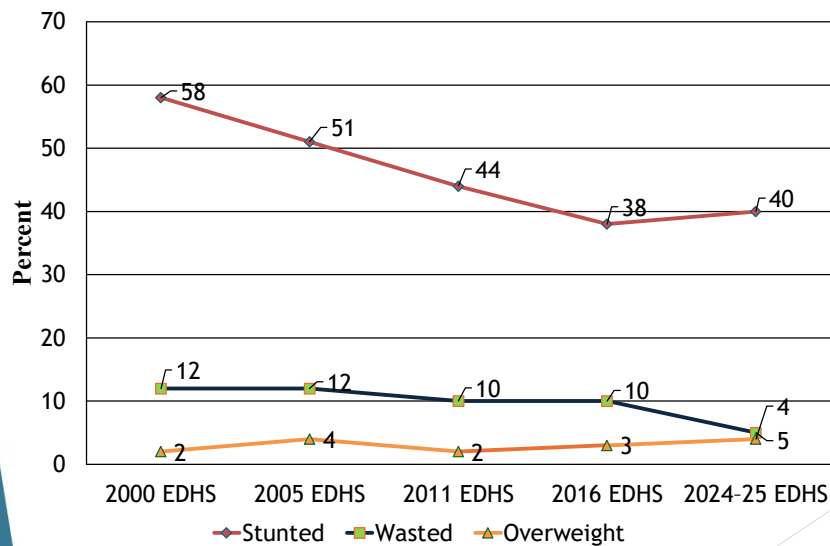


CHILD NUTRITION

CHILD NUTRITION

Trends in Childhood Nutrition in Ethiopia

EDHS Percentage of children under age 5 who are malnourished



Trends:

- Overall, 40% of children under age 5 are stunted (short for their age), and 15% are severely stunted
- Five percent of children under age 5 are wasted (thin for their height), 1% are severely wasted, and 4% are overweight.
- Eighteen percent of children under age 5 are underweight (small for their age), and 4% are severely underweight.

This slide presents trends in **three key indicators of child nutritional status among children under age 5:**

Stunting (chronic malnutrition) → long-term growth failure

Wasting (acute malnutrition) → recent weight loss / short-term shock

Overweight → emerging nutrition transition

These indicators reflect both **health system performance** and broader **social determinants** such as food security, poverty, and maternal health.

Trend 4: Persistence of undernutrition despite progress

This slide highlights that:

40% stunted

18% underweight

5% wasted

This indicates that improvements in survival have **not fully translated into optimal growth and development.**

Trend 1: Significant but incomplete reduction in stunting

Stunting declined from **58% in 2000** to **40% in 2024–25.**

This is a substantial improvement, reflecting:
Better **child survival and feeding practices**
Expanded **health and nutrition programs**
Improvements in **maternal health and education**
However, **40% remains very high**, indicating that:
Chronic undernutrition is still widespread
Long-term child development is significantly affected

Trend 2: Gradual decline in wasting (acute malnutrition)

Wasting declined from **12% to 5%** over the same period.

This suggests improvements in:

Short-term food security

Disease management

Emergency and community nutrition programs

However, wasting remains sensitive to:

Shocks (drought, conflict, food insecurity)

Seasonal variation

Low but increasing overweight

Overweight increased from **2% to 4%**.

While still low, this indicates the early stages of a **nutrition transition**, where:

Undernutrition and overnutrition coexist

This dual burden is becoming more common in developing countries undergoing economic and dietary change.

What it all means

Ethiopia has made progress in reducing child malnutrition, but the country remains in a:

High-burden, slowly improving nutrition environment

Key insight:

The challenge has shifted from survival alone to **quality of survival—healthy growth and development**

Nutrition is now the **central constraint** linking:

Child mortality

Cognitive development

Future economic productivity

Looking Ahead to 2050 (Nutrition Outlook)

Future progress will depend on moving beyond health interventions alone.

Expected trajectory:

Stunting may decline further to **20–25% by 2050** if progress accelerates

Wasting could fall below **5% consistently**

Overweight may continue to rise without preventive action

Key drivers of future improvement:

Maternal nutrition and health

Infant and young child feeding practices (IYCF)

Exclusive breastfeeding expansion

Food system improvements and dietary diversity

Integration of **nutrition with WASH and health services**

Without integrated action, progress may **stall**, particularly in high-burden regions.

Policy Takeaways — Childhood Nutrition

1. Prioritize stunting reduction as a national priority

Chronic malnutrition has the **largest long-term impact on human capital**.

2. Integrate nutrition across sectors

Nutrition outcomes depend on:

Health

Agriculture

Water and sanitation

Education

3. Strengthen maternal and early-life interventions

Focus on:

Pregnancy nutrition

First 1,000 days of life

4. Scale up exclusive breastfeeding and IYCF practices

These are among the **highest-impact, low-cost interventions**.

5. Address food security and dietary diversity

Improve access to **nutrient-rich foods**, not just caloric intake.

6. Prepare for the dual burden of malnutrition

Address both:

Undernutrition

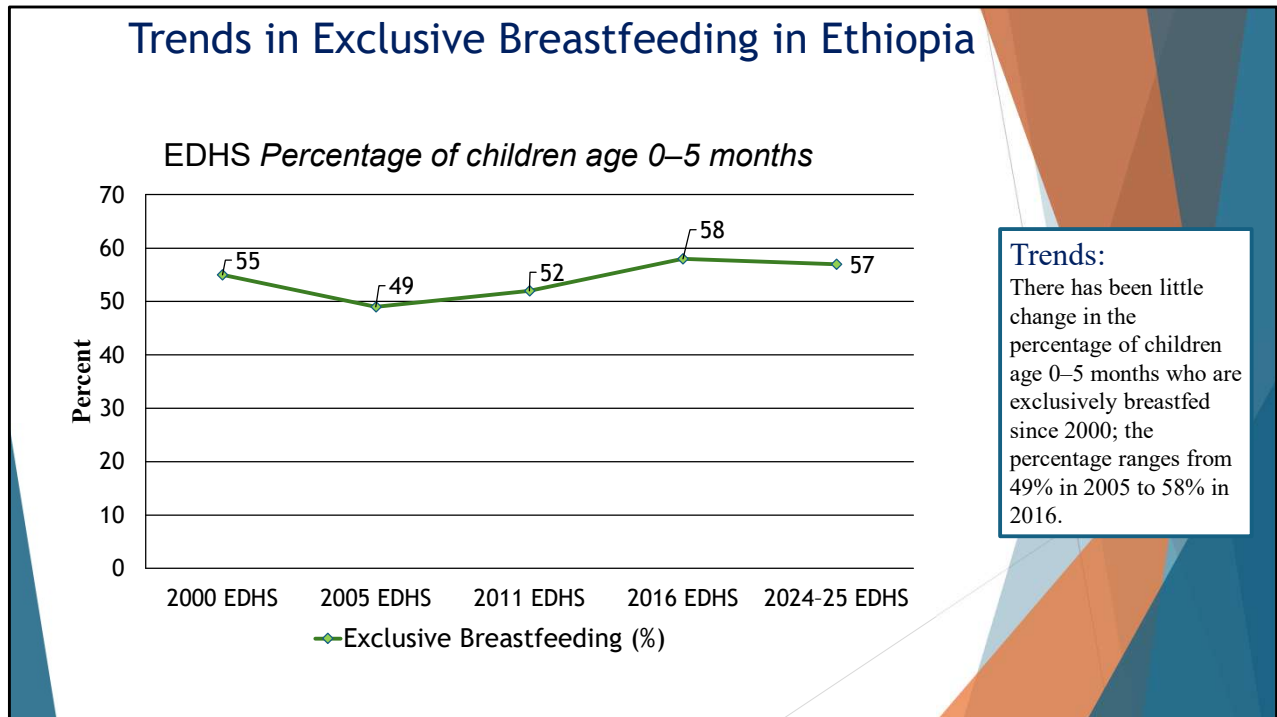
Emerging overweight and diet-related risks

7. Target high-burden populations and regions

Use **data-driven approaches** to reduce disparities.



▶ BREASTFEEDING



This slide presents trends in **exclusive breastfeeding (EBF)** among children aged **0–5 months** across five EDHS surveys.

Exclusive breastfeeding means:

Infants receive **only breast milk**

No water, other liquids, or foods

It is one of the **most effective, low-cost public health interventions** for improving child survival and development.

Key Trend 1:

Exclusive breastfeeding rates have remained relatively stable. No sustained upward trend over 25 years

Despite overall improvements in other child health indicators, EBF has **plateaued around 50–60%**.

Key Trend 2: Missed opportunity for high-impact gains

Unlike other indicators (e.g., mortality, skilled birth attendance), exclusive breastfeeding has **not experienced transformational improvement**.

This is important because EBF directly affects:

Infant immunity

Infection risk (diarrhea, pneumonia)

Nutritional status

Early growth and development

The plateau suggests:

Behavioral and cultural barriers

Gaps in **counseling and support**

Limited system emphasis relative to other interventions

Key Trend 3: EBF as a cross-cutting determinant

Exclusive breastfeeding is uniquely positioned because it influences **multiple domains simultaneously**:

Reduces **child mortality**

Improves **nutrition outcomes**

Supports **birth spacing** (via lactational amenorrhea)

Enhances **cognitive development**

This makes it one of the **highest-return interventions** in public health.

Key Trend 4: Gap between current levels and global recommendations

WHO recommends EBF rates of **at least 70%**.

Ethiopia's current level (~57%) indicates:

Progress, but

Significant room for improvement

This gap represents a **missed opportunity for accelerating gains in multiple indicators**.

Ethiopia has achieved major gains in:

Child survival

Maternal health

Immunization

But exclusive breastfeeding represents a **“stalled indicator”**:

A high-impact intervention that has not kept pace with broader system improvements

This highlights the need to address:

Behavioral determinants

Health system counseling practices

Social and workplace constraints

Looking Ahead to 2050 (Breastfeeding Outlook)

Exclusive breastfeeding represents one of the **clearest opportunities for accelerated progress**.

If EBF increases from ~57% to **70% or higher**, Ethiopia could achieve:

Further reductions in **infant mortality**

Lower rates of **diarrheal and respiratory disease**

Improvements in **nutrition and growth**

Better **cognitive and developmental outcomes**

Future progress will depend on:

Strengthening **facility-based counseling at birth**

Expanding **community-based education**

Supporting mothers through **postnatal care systems**

Addressing **social and workplace barriers**

Unlike many interventions, EBF improvements are:

Low-cost, high-impact, and immediately scalable

Policy Takeaways — Exclusive Breastfeeding

1. Elevate EBF as a national priority

Treat breastfeeding as a **core public health intervention**, not a secondary behavior.

2. Strengthen counseling at birth and postnatal care

Ensure every mother receives **practical, hands-on breastfeeding support**.

3. Integrate EBF into maternal and child health services

Link breastfeeding promotion with:

Antenatal care

Delivery care

Postnatal visits

4. Expand community-based education and support

Leverage the **Health Extension Program** to reinforce practices at the household level.

5. Address social and structural barriers

Consider policies that support:

Maternity leave

Workplace accommodations

6. Target early initiation and continuity

Focus on:

Immediate breastfeeding after birth

Sustained EBF for 6 months

7. Use EBF as a multiplier intervention

Recognize its role in improving:

Nutrition

Immunity

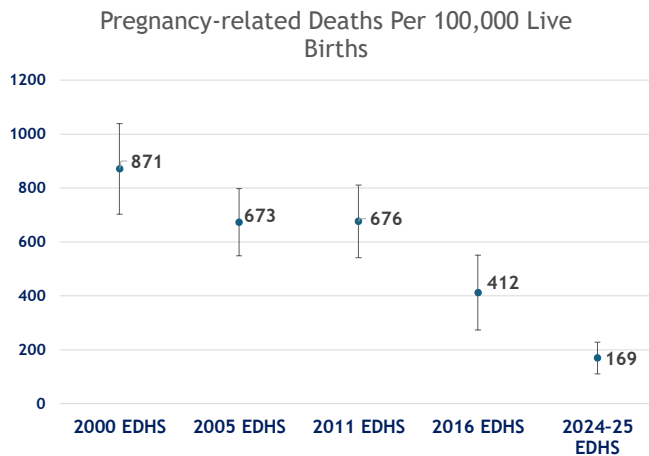
Birth spacing

Survival



PREGNANCY- ▶ RELATED DEATHS

Trends in Pregnancy-Related Mortality Ratio (PRMR)



There has been a steady decline in the PRMR over the seven-year period preceding the surveys: from 871 deaths per 100,000 live births in the 2000 EDHS to 676 in the 2011 EDHS, to 169 in the 2024–25 EDHS.

The estimated pregnancy-related mortality ratio (PRMR) for the 7-year period preceding the 2024–25 EDHS is 169 deaths per 100,000 live births; that is, for every 1,000 births in Ethiopia, about two women die during pregnancy or within 2 months of the end of a pregnancy from any cause, including accidents or violence

Survey	Point Estimate	Lower CI	Upper CI
2000 EDHS	871	703	1031
2005 EDHS	673	548	798
2011 EDHS	676	541	811
2016 EDHS	412	273	551
2024-25 EDHS	169	110	228

This slide presents trends in the **Pregnancy-Related Mortality Ratio (PRMR)**—the number of deaths associated with pregnancy per **100,000 live births**, based on EDHS estimates for the **seven years preceding each survey**.

Importantly, PRMR includes:

Deaths during pregnancy

Deaths during childbirth

Deaths within **two months postpartum**

Deaths from **all causes** related to pregnancy (including indirect causes)

The chart also displays **confidence intervals**, reflecting the uncertainty inherent in maternal mortality estimation.

Key Trend 1: Substantial long-term decline

PRMR declined from:

871 deaths per 100,000 live births (2000)

→ **169 deaths per 100,000 (2024–25)**

This represents an approximate **80% reduction** over 25 years—one of the most significant achievements in Ethiopia’s public health history.

Key Trend 2: Gradual decline followed by accelerated improvement

The trend shows two phases:

Phase 1 (2000–2011): Slow decline

871 → 673 → 676

Progress was **modest and uneven**

Phase 2 (2011–2025): Accelerated decline

676 → 412 → 169

Reflects **major system improvements**, including:

Expansion of **skilled birth attendance**

Improved **facility delivery**

Better **maternal health services**

Key Trend 3: Wide confidence intervals (measurement uncertainty)

The confidence intervals are relatively wide, especially in earlier surveys.

This reflects:

The **rarity of maternal deaths**

Reliance on **survey-based estimation methods**

However, despite this uncertainty, the **downward trend is clear and robust.**

Key Trend 3: Wide confidence intervals (measurement uncertainty)

The confidence intervals are relatively wide, especially in earlier surveys.

This reflects:

The **rarity of maternal deaths**

Reliance on **survey-based estimation methods**

However, despite this uncertainty, the **downward trend is clear and robust.**

What it all means

Ethiopia has transitioned from:

Extremely high maternal mortality

→ to

substantially reduced—but still elevated—risk

At **169 per 100,000**, maternal mortality remains higher than:

Global targets

Middle-income country benchmarks

This means:

Major progress has been achieved

But **significant work remains**

Looking Ahead to 2050 (Maternal Mortality Outlook)

If current trends continue, Ethiopia could:

Reduce PRMR to **below 100 per 100,000 by 2035–2040**

Approach **50–70 per 100,000 by 2050**

However, future reductions will be **harder to achieve** and will depend on:

Improving **quality of care**, not just access

Expanding **emergency obstetric and newborn care (EmONC)**
Strengthening **referral systems and transport**
Addressing **indirect causes of maternal death**
Reducing **regional and socioeconomic disparities**

Policy Takeaways — Maternal Mortality (PRMR)

1. Shift from access to quality of care

Ensure that facility deliveries result in **safe outcomes**, not just increased coverage.

2. Strengthen emergency obstetric care systems

Invest in:

Comprehensive EmONC

Referral systems

Transport networks

3. Address indirect causes of maternal death

Include:

Anemia

Infections

Chronic conditions

4. Improve continuity of care

Link:

Antenatal care

Delivery care

Postnatal care

5. Target high-risk populations and regions

Focus on:

Rural areas

Underserved communities

6. Strengthen data and maternal death surveillance

Improve:

Measurement accuracy

Real-time monitoring

7. Integrate maternal health with broader system strengthening

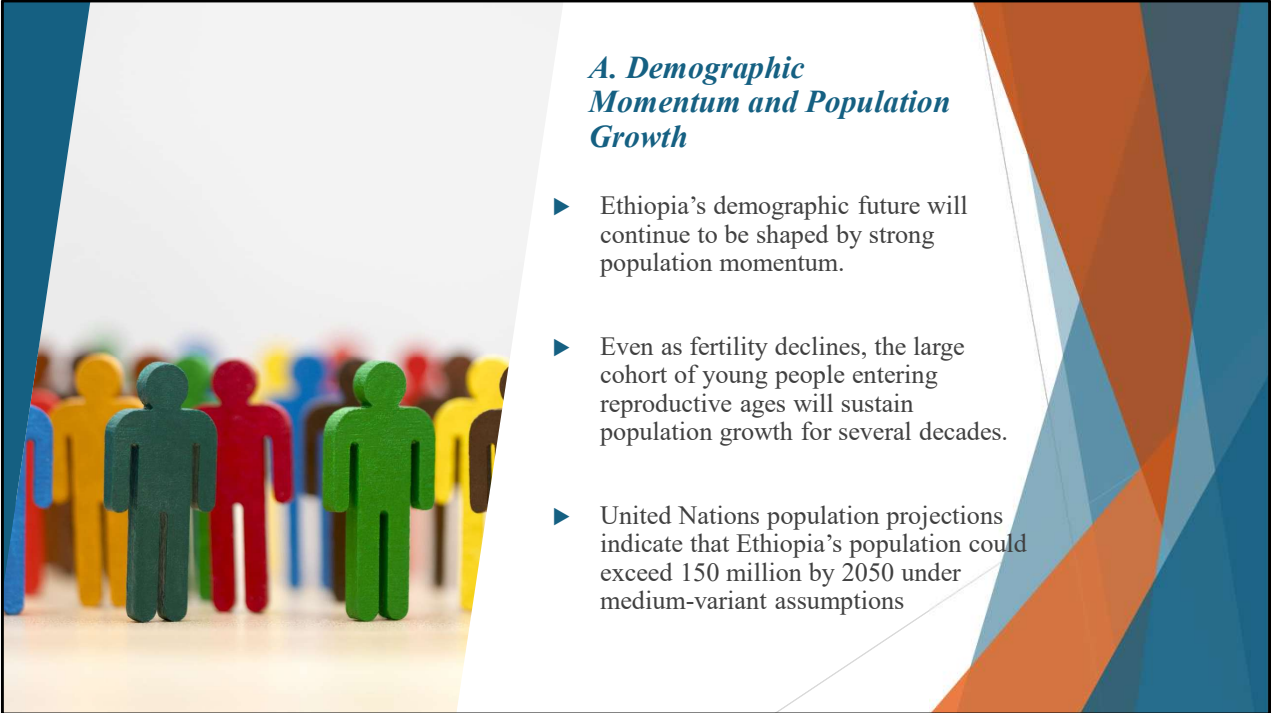
Maternal outcomes reflect overall **health system performance**.



Prospects to 2050

- A. Demographic Momentum and Population Growth*
- B. Fertility Transition and Reproductive Health*
- C. Maternal and Child Health: Toward Convergence*
- D. The Central Role of Women's Education and Empowerment*
- E. Nutrition and Early Childhood Development*
- F. Health Systems and Policy Implications*

Prospects to 2050



A. Demographic Momentum and Population Growth

- ▶ Ethiopia’s demographic future will continue to be shaped by strong population momentum.
- ▶ Even as fertility declines, the large cohort of young people entering reproductive ages will sustain population growth for several decades.
- ▶ United Nations population projections indicate that Ethiopia’s population could exceed 150 million by 2050 under medium-variant assumptions

Ethiopia’s demographic future will be shaped primarily by **population momentum**. Even with declining fertility, the large cohort of young people—born during earlier high-fertility periods—is now entering reproductive ages. This means population growth will continue for several decades even if each woman has fewer children on average.

According to **United Nations medium-variant projections**, Ethiopia’s population is expected to rise from roughly 128–130 million today to **about 150–160 million by 2050**. This trajectory reflects two simultaneous forces: (1) declining mortality—especially among children—and (2) still-elevated fertility relative to replacement level.

For planning purposes, this implies:

Sustained demand for maternal and child health services

Continued pressure on **urban systems** (housing, sanitation, health facilities)

A growing **youth population**—both a demographic dividend opportunity and a service-delivery challenge

The key policy implication is that **health system expansion must outpace population growth** to maintain and improve gains in coverage and outcomes.

B. Fertility Transition and Reproductive Health

- Looking ahead, Ethiopia's fertility trajectory will be central to its demographic future.
- Continued expansion of modern contraceptive use and reductions in unmet need for family planning are expected to further lower total fertility rates.
- Regional disparities in contraceptive access and persistent sociocultural barriers may slow progress in some areas.

Ethiopia is clearly in the **mid-phase of the fertility transition**. Fertility has declined substantially since 2000, but remains above replacement level, with strong **urban–rural and regional variation**.

Looking ahead to 2050:

Continued expansion of **modern contraceptive use** will be central

Reductions in **unmet need**—especially among adolescents and rural women—will drive further decline

Age at first marriage and first birth will be critical levers

Comparative DHS experience (Kenya, Rwanda) shows that fertility decline accelerates when three conditions align:

Reliable method mix and supply chains

Female secondary education

Norm change around ideal family size

For Ethiopia, the likely pattern is:

Near-replacement fertility in urban areas

Moderate-to-high fertility persisting in some rural regions

Policy priority: **targeted, equity-focused family planning strategies**, not one-size-fits-all expansion.

C. Maternal and Child Health: Toward Convergence

- Ethiopia is likely to see continued improvements in maternal and child health outcomes, particularly if current trends in service utilization are sustained.
- Further reductions in child mortality will depend on closing gaps in immunization coverage, improving neonatal care, and addressing persistent nutritional challenges.
- Achieving levels observed in middle-income countries will require improvements in the quality of care, referral systems, and health system capacity.

Ethiopia has achieved **large gains** in child survival and maternal service utilization since 2000. The next phase is **convergence**—closing the gap with middle-income benchmarks.

Child health outlook:

Continued decline in **under-five mortality**, but at a slower pace (as levels get lower)

Increasing importance of **neonatal survival**, which now constitutes a larger share of under-five deaths

Maternal health outlook:

Further increases in **skilled birth attendance and facility delivery**

Needed shift from **coverage** → **quality of care**

Key constraints going forward:

Quality gaps (not just access)

Referral systems and **emergency obstetric care capacity**

Persistent **geographic inequities**

Policy implication: the system must evolve from **expansion to performance optimization**—quality, continuity, and integration of care.

D. The Central Role of Women's Education and Empowerment

- Perhaps the most important determinant of Ethiopia's demographic and health future is the continued expansion of women's education and empowerment.
- Increased educational attainment among girls is strongly associated with delayed marriage, reduced fertility, improved maternal health care utilization, and better child health outcomes.
- Women's education functions as a cross-cutting driver of demographic transition, as investments in girls' secondary education, labor force participation, and reproductive autonomy will have multiplier effects across all eight indicators examined in this study.

Women's Education and Empowerment—the **"WE" framework**—is the **single most powerful cross-cutting determinant** of Ethiopia's future demographic and health outcomes.

Evidence across DHS countries shows that increases in girls' education are associated with:

Lower fertility

Delayed marriage and first birth

Higher **contraceptive use**

Greater **use of maternal health services**

Improved **child survival and nutrition**

Looking to 2050:

Expansion of **secondary education for girls** is decisive

Economic participation strengthens autonomy and decision-making

WE acts as a **multiplier across all eight indicators**

This is not just a social policy—it is a **core health strategy**.

Key message for policymakers:

Investments in women's education produce simultaneous gains in fertility, maternal health, and child survival.

E. Nutrition and Early Childhood Development

- Despite progress, childhood undernutrition remains a key constraint on Ethiopia's human capital development.
- Future gains in child survival must be accompanied by improvements in nutritional status, particularly reductions in stunting and micronutrient deficiencies.
- Exclusive breastfeeding, improved complementary feeding practices, and expanded access to nutrition-sensitive interventions will be essential for ensuring that gains in survival translate into long-term developmental outcomes.

Ethiopia has reduced child mortality significantly, but **nutrition remains a binding constraint** on long-term development.

Key forward-looking issues:

Stunting remains high in several regions

Gains in survival must translate into **healthy growth and cognitive development**

Exclusive breastfeeding is a major opportunity:

Current levels (~50%) have **stagnated**

Increasing toward **70%** could:

- Reduce infections (diarrhea, pneumonia)

- Improve early nutrition

- Lower infant mortality

- Support birth spacing

Complementary priorities:

Improved **infant and young child feeding (IYCF)**

Micronutrient interventions

Integration with **WASH (water, sanitation, hygiene)**

Policy implication:

The next phase is not just saving lives—it is **building human capital**.

F. Health Systems and Policy Implications

- Ethiopia's future progress will depend on the continued evolution of its health system.
- The Health Extension Program has demonstrated the effectiveness of community-based service delivery, but future gains will require strengthening the quality of care, integrating services, and addressing emerging health challenges.
- Urbanization, changing disease patterns, and increasing demand for higher-quality care will require adaptive health system strategies. Investments in data systems, workforce development, and health equity will be essential for sustaining progress.

Slide F — Health Systems, Urbanization, and Policy Outlook

Notes:

Ethiopia's Health Extension Program has been central to past success. The next phase requires **system evolution**.

Key trends to 2050:

Rapid urbanization → new service delivery models needed

Epidemiologic transition → dual burden (infectious + non-communicable diseases)

Rising expectations for **quality of care**

System priorities:

Strengthen **primary health care + referral systems**

Invest in **health workforce capacity**

Expand **data systems and analytics** (DHS, administrative, real-time data)

Focus on **equity—last-mile populations**

Strategic shift:

From **coverage expansion** → **system performance and resilience**

Highlighting Two Critical Areas

....to ensure rapid progress the rest of this decade

Exclusive Breastfeeding (EBF)
and Women's Education (WE)

Justification for EBF and WE

1. Cross-Domain Influence (System-Wide Reach)

What this means

These interventions influence **multiple indicators simultaneously**, rather than acting within a single program silo.

Exclusive Breastfeeding (EBF)

EBF operates through **biological, behavioral, and environmental pathways**:

Child mortality → reduces infections (diarrhea, pneumonia)

Child nutrition → improves early growth and reduces stunting risk

Fertility → increases birth spacing (lactational amenorrhea)

Health system engagement → strengthens postnatal care contact

👉 One behavior → impacts **at least 3–4 of the eight topic areas directly**

Women's Education & Empowerment (WE)

WE operates through **social, economic, and decision-making pathways**:

Family planning → higher contraceptive use

Fertility → delayed marriage, fewer children

Maternal health → increased skilled birth attendance

Child health → improved care-seeking and feeding practices

Vaccination → higher uptake and completion rates

👉 One structural factor → influences **nearly all eight topic areas indirectly**

Key takeaway

Most interventions improve one outcome at a time. These two improve multiple outcomes simultaneously, which makes them disproportionately powerful.

2. High Return on Investment (Impact Relative to Cost)

What this means

These interventions produce **large health and development gains per unit of investment**, compared to more resource-intensive strategies.

Exclusive Breastfeeding (EBF)

Requires **minimal infrastructure**

Delivered through:

- Counseling at birth

- Community health workers

No need for:

- Complex supply chains

- Expensive technology

Returns include:

- Reduced healthcare costs (fewer infections)

- Improved cognitive development

- Reduced mortality

👉 One of the **lowest-cost, highest-impact interventions globally**

Women's Education & Empowerment (WE)

Higher upfront investment, but **multi-sector returns:**

Health returns:

- Lower maternal mortality

- Lower child mortality

Demographic returns:

- Reduced fertility

- Improved dependency ratios

Economic returns:

- Increased workforce participation

Higher household income

Intergenerational gains in education and health

👉 One of the **highest long-term returns in development economics**

Key takeaway

These are not just effective interventions—they are efficient ones. They deliver more impact per investment than most alternatives.

3. Under-Realized Potential

What this means

These areas have already shown **positive impact**, but are **not yet maximized**, meaning additional gains are achievable without starting from scratch.

Exclusive Breastfeeding (EBF)

Stagnated at **~50–60% over 25 years**

Global recommendation: **≥70%**

This gap represents:

Unrealized, immediately actionable gains

No need for new systems—just **better use of existing ones**

Why under-realized?

Limited counseling quality

Cultural practices

Weak postnatal follow-up

Workplace constraints

Women's Education & Empowerment (WE)

Progress made—but:

Gaps remain in **secondary education completion**

Persistent disparities in **rural areas**

Unequal **economic participation**

This means:

The system has begun to benefit from WE

But has **not yet captured its full effect**

Key insight

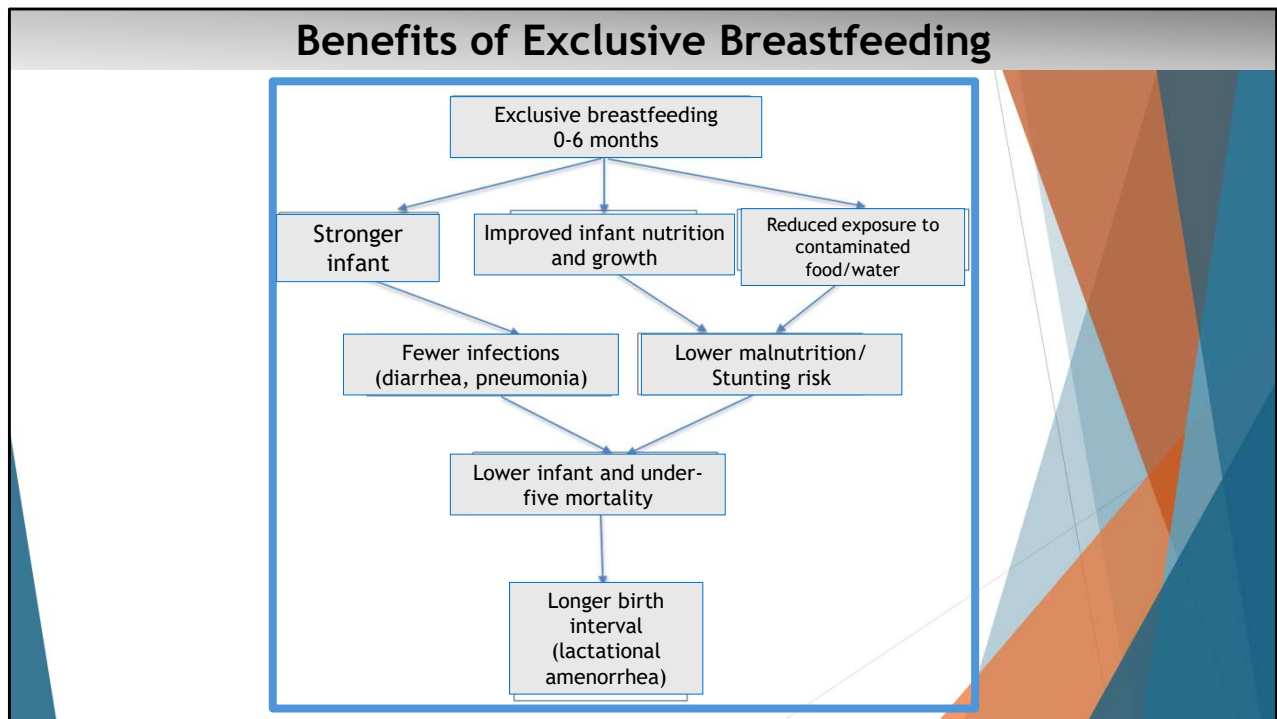
These are not new ideas—they are partially implemented solutions with room for significant expansion.

Key takeaway

The advantage here is that we are not starting from zero. These are areas where progress is already visible—but not yet maximized.

Integrated Summary

These two areas were selected because they sit at the intersection of three powerful characteristics: they influence multiple outcomes at once, they deliver high returns relative to cost, and they remain underutilized despite their proven impact.



A. Exclusive Breastfeeding (Critical Area 1)

Exclusive Breastfeeding as a System Multiplier

This slide highlights exclusive breastfeeding not as a single indicator, but as a **system-wide multiplier intervention**—one that simultaneously affects child survival, nutrition, and fertility.

Core message: High-impact, low-cost, underutilized

Exclusive breastfeeding is one of the **most powerful and cost-effective public health interventions**, yet it has **stagnated at around 50–60%** in Ethiopia over the past quarter century.

This stagnation represents a **missed opportunity** to accelerate progress across multiple domains.

Pathway explanation (a walk through of the diagram):

Exclusive breastfeeding (0–6 months) operates through three primary

mechanisms:

1. Biological protection

Strengthens the infant immune system

→ Reduces infections such as **diarrhea and pneumonia**

2. Nutritional sufficiency

Provides optimal nutrition for early growth

→ Reduces **malnutrition and stunting risk**

3. Environmental protection

Reduces exposure to contaminated food and water

→ Particularly critical in low-resource settings

Downstream effects:

These pathways converge to produce:

Lower infant and under-five mortality

Improved **growth and development**

Enhanced **cognitive outcomes**

In addition:

Exclusive breastfeeding contributes to **longer birth intervals** through lactational amenorrhea

→ Directly linking to **fertility reduction**

Strategic insight (key message for policymakers):

Exclusive breastfeeding is the only intervention in this framework that simultaneously influences:

Child mortality

Nutrition

Fertility

This makes it uniquely powerful.

Looking ahead (to 2030–2050):

Increasing EBF from ~57% to **70%+** could:

Accelerate reductions in **infant mortality**

Reduce **stunting prevalence**

Contribute to **fertility decline**

Improve long-term **human capital outcomes**

And importantly:

It requires **minimal infrastructure investment compared to other interventions**

Policy emphasis (what must change):

Shift from **awareness** → **practical support**

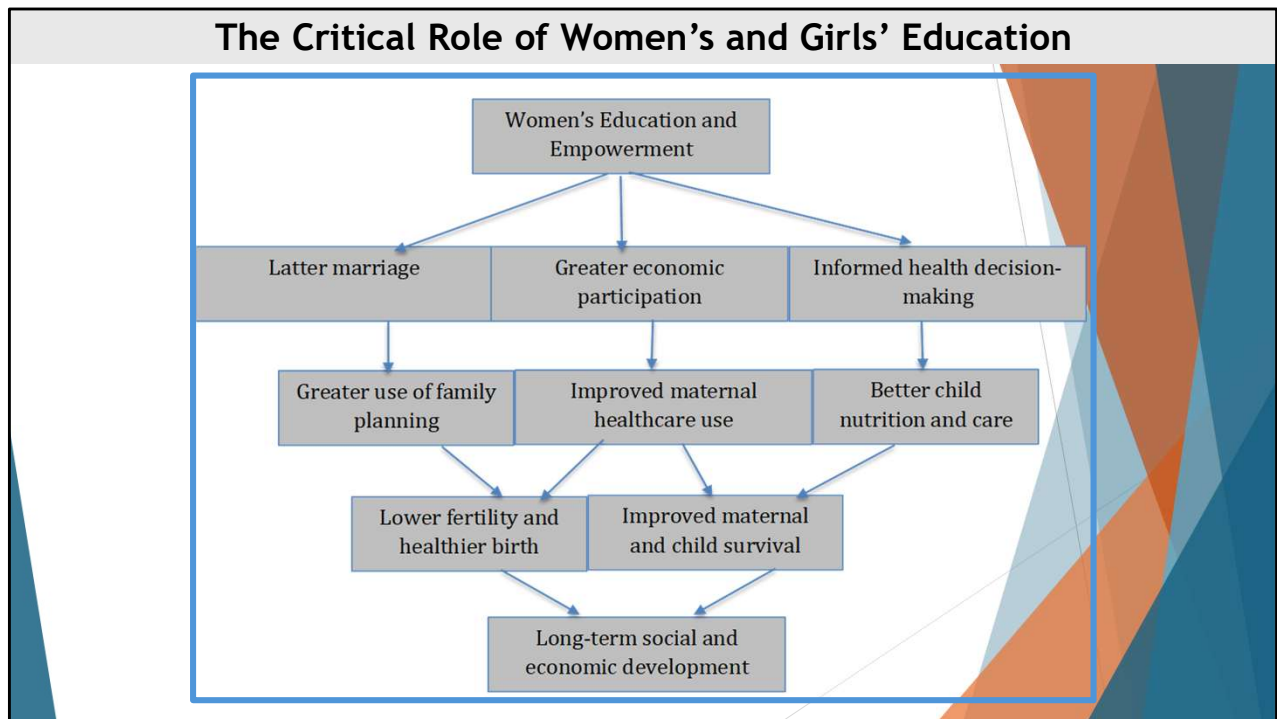
Strengthen **facility-based counseling at birth**

Expand **postnatal follow-up**

Address **social and workplace constraints**

In Sum

If Ethiopia is looking for one intervention that delivers immediate, cross-sector impact at scale, exclusive breastfeeding is it.



B. Women's Education and Empowerment (Critical Area 2)

Women's Education as the Foundation of Demographic Transition

Opening framing:

This slide presents women's education and empowerment not simply as a social goal, but as the **central driver of Ethiopia's demographic and health transformation**.

Core message: The "WE" multiplier effect

Women's Education and Empowerment (WE) is the **single most powerful structural determinant** across all eight topic areas analyzed in the study. Unlike sector-specific interventions, WE produces **system-wide, sustained change**.

Pathway explanation (a walk-through of the diagram):

Women's education and empowerment influence outcomes through three primary pathways:

1. Delayed marriage and childbearing

Leads to:

- Later age at first birth
- Reduced lifetime fertility

2. Economic participation

Increases:

- Household income
- Resource allocation toward health and nutrition

3. Informed decision-making

Improves:

- Health-seeking behavior
- Use of maternal and child health services

Intermediate outcomes:

These pathways lead to:

- Greater **use of family planning**
- Increased **maternal healthcare utilization**
- Improved **child nutrition and care**

Final outcomes (system-wide impact):

These effects converge to produce:

- Lower fertility**
- Improved maternal survival**
- Improved child survival**
- Enhanced **long-term economic development**

Strategic insight (key message for policymakers):

If exclusive breastfeeding is the most powerful short-term intervention, women's education is the most powerful long-term intervention.

It shapes:

- Demand for services
- Utilization of services
- Outcomes across generations

Looking ahead (to 2050):

Expanding girls' secondary education and women's empowerment will:

- Accelerate **fertility decline**
- Improve **maternal and child health outcomes**

Strengthen **economic development trajectories**

Reduce **intergenerational poverty**

Countries that have advanced rapidly in demographic transition (e.g., Kenya, Egypt) show strong alignment between **female education gains and fertility decline**.

Policy emphasis (what must change):

Prioritize **girls' secondary education completion**

Promote **economic opportunities for women**

Integrate WE into:

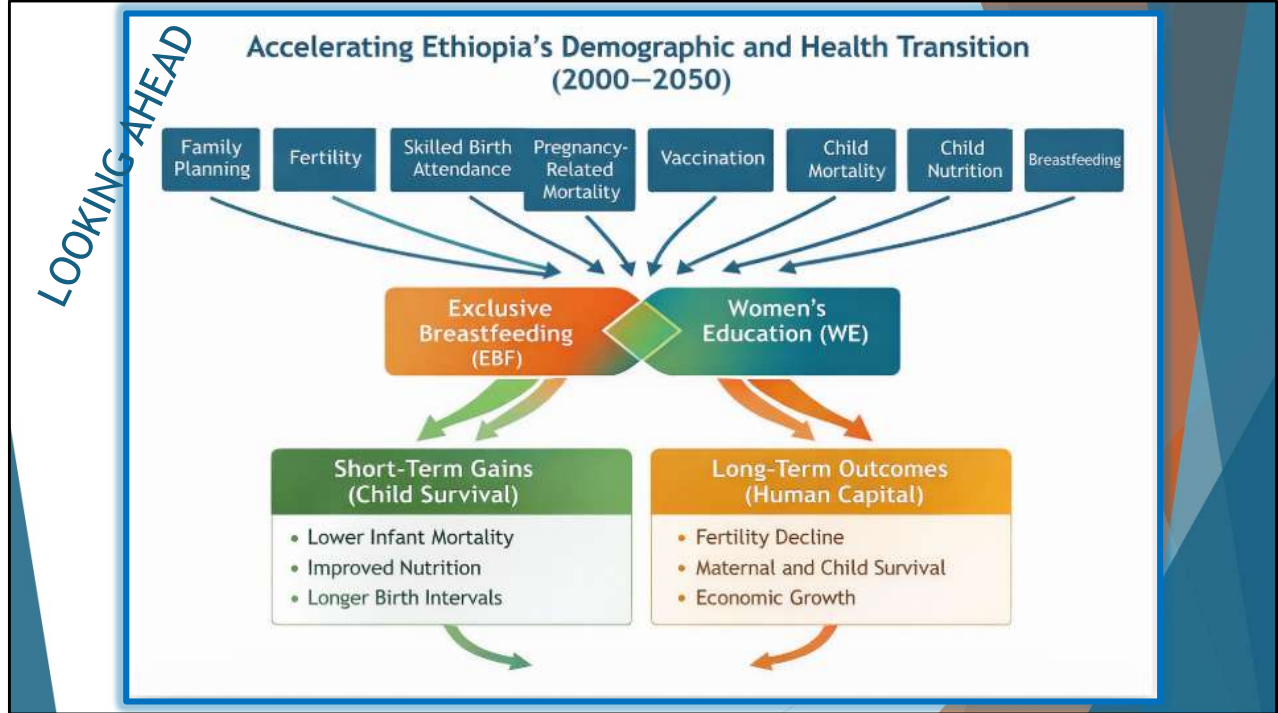
- Health policy

- Development planning

- Demographic strategy

In Sum

Ethiopia's long-term demographic future will not be determined in clinics—it will be determined in classrooms.



This diagram is a **closing synthesis**:

The **top** = the 8 topic areas analyzed

The **middle** = how they interact (system)

The **bottom arrows** = two topic areas selected as best candidates for acceleration

The **end points** = Ethiopia's future trajectory

The eight topic areas we analyzed remain the foundation of Ethiopia's progress. What this slide highlights is that some areas—like breastfeeding and women's education—have the potential to **accelerate progress across several of those domains at once**.

At the bottom of this diagram, you see two arrows. These do not represent the only drivers of change. Rather, they highlight two areas where targeted action can **accelerate progress across multiple domains simultaneously**.

Two high-leverage acceleration pathways within a broader system of drivers—not the only drivers of change.

EBF (Exclusive Breastfeeding) = *high-impact, near-term accelerator*
WE (Women's Education & Empowerment) = *high-impact, structural accelerator*

The arrows point to:

Accelerated improvement across the system

Faster reductions in child mortality

Faster improvements in nutrition

Faster declines in fertility

Faster improvements in maternal outcomes

Overall, the arrows point to accelerated progress—not because these are the only drivers, but because they are areas where gains can be multiplied across the system.

THE END