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

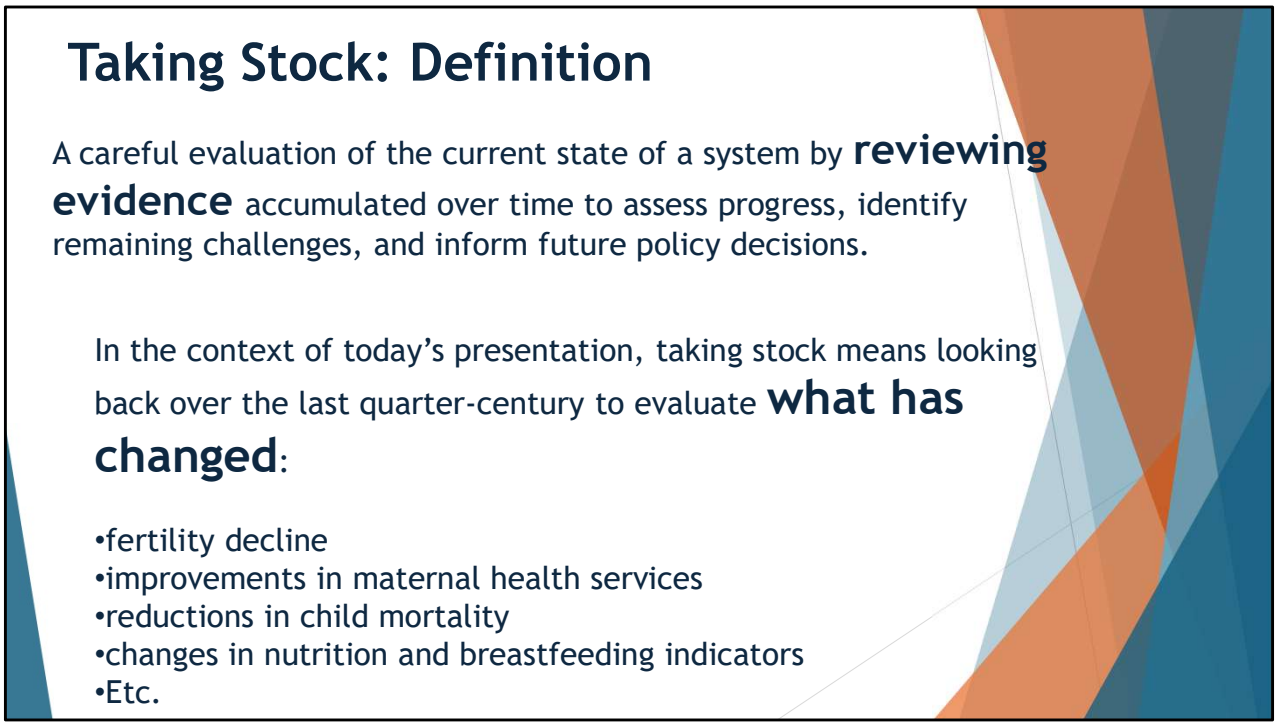
2. Looking Ahead (to 2050)
To identify:
Where progress is **likely to continue**
Where it may **slow or stall**
And where **targeted interventions** could accelerate gains

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



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.

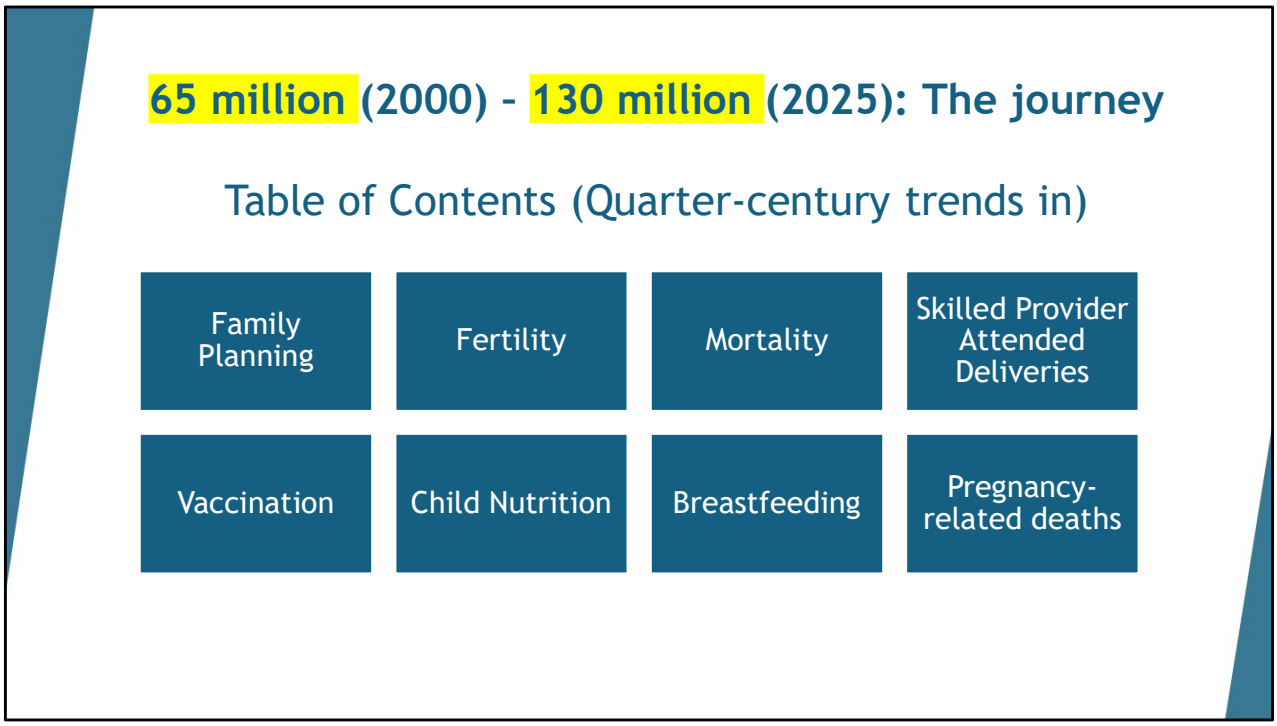
Background

Background..Contd.

Ethiopia's population increased to approximately 77 million by the 2007 national census and to more than 100 million by the mid-2010s. 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.



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**.

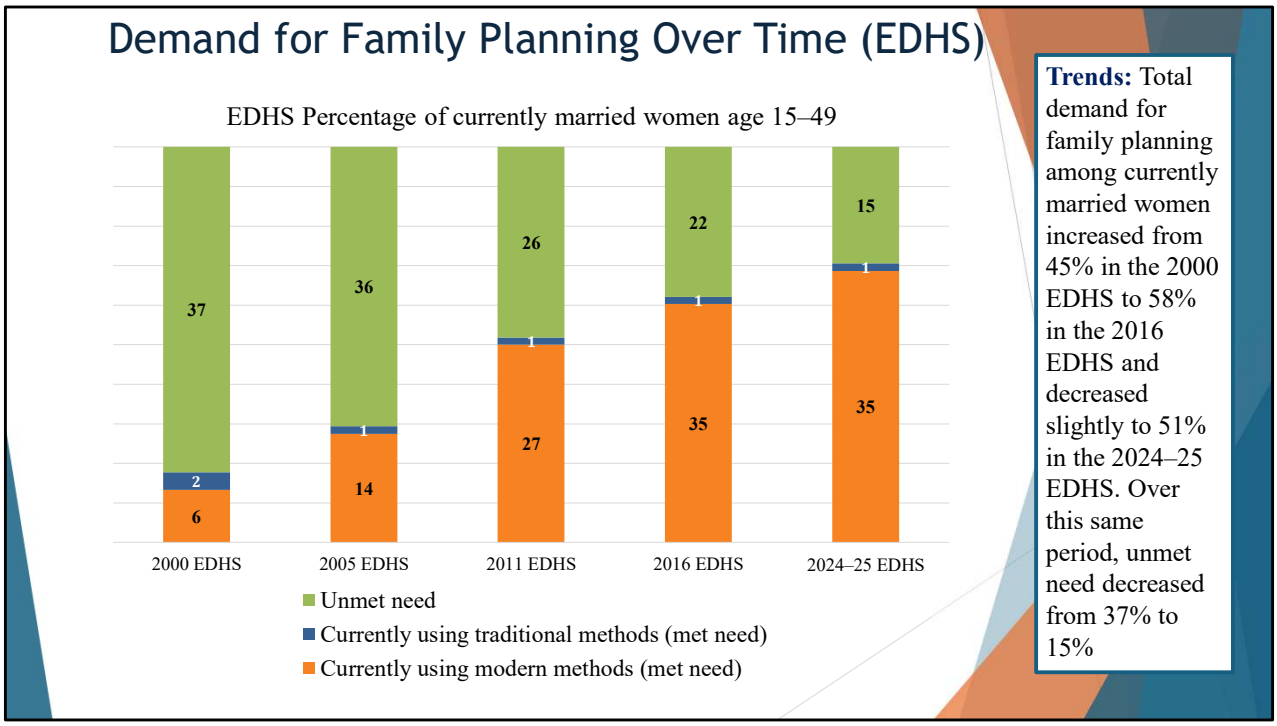
Domain 4. Maternal outcomes
Pregnancy-related mortality
This represents one of the most important indicators of **health system effectiveness**.

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



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:

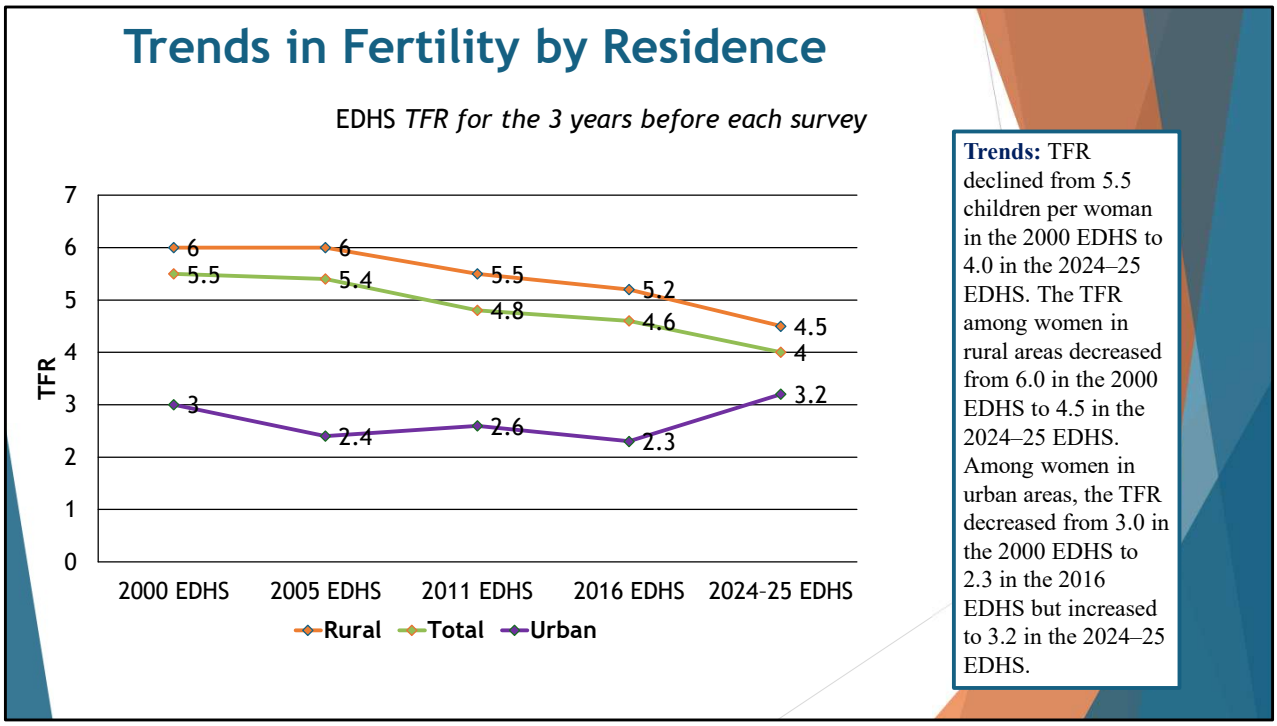
- Reaching **remaining unmet need (15%)**
- Expanding **method choice**
- Strengthening **adolescent reproductive health services**

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.

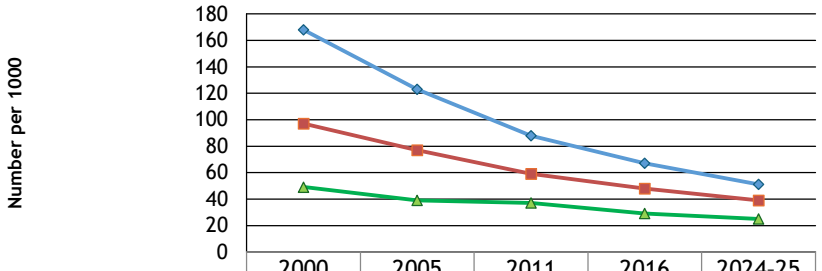
Policy Takeaways — Fertility Dynamics
1. Accelerate fertility decline through targeted family planning
Focus on **high-fertility rural regions** where the majority of births occur.

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



	2000 EDHS	2005 EDHS	2011 EDHS	2016 EDHS	2024-25 EDHS
Under-5 mortality	168	123	88	67	51
Infant mortality	97	77	59	48	39
Neonatal mortality	49	39	37	29	25

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 166 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

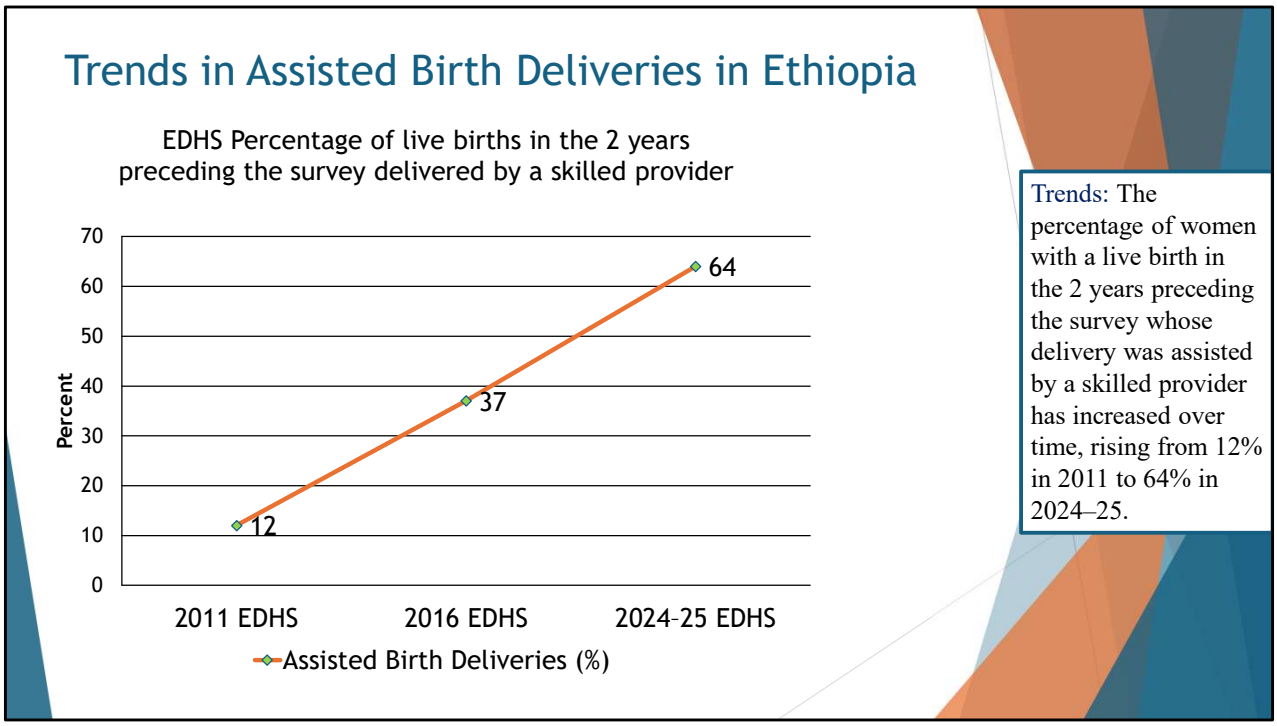
Shift in mortality composition
Over time, Ethiopia has transitioned from:
High mortality across all childhood stages
to:
Concentration of mortality in the neonatal period
This means:
Future reductions in under-five mortality will depend increasingly on **neonatal survival improvements**

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



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

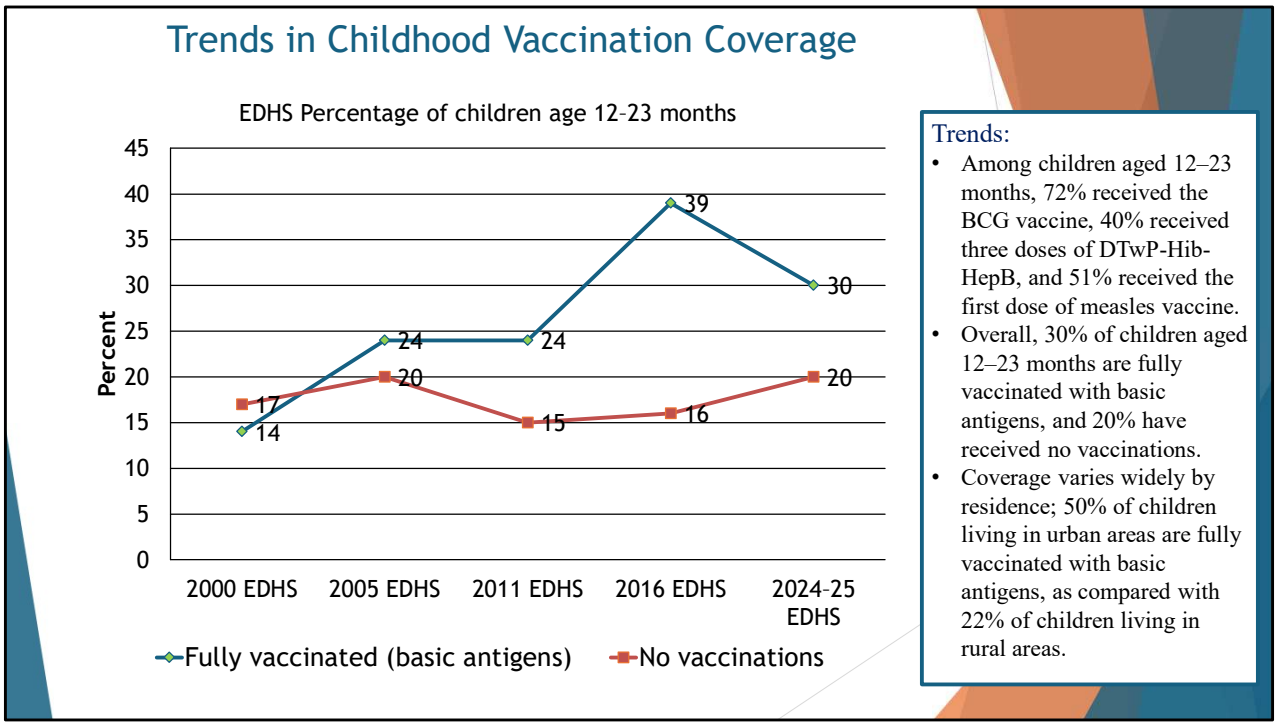
What it all means

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

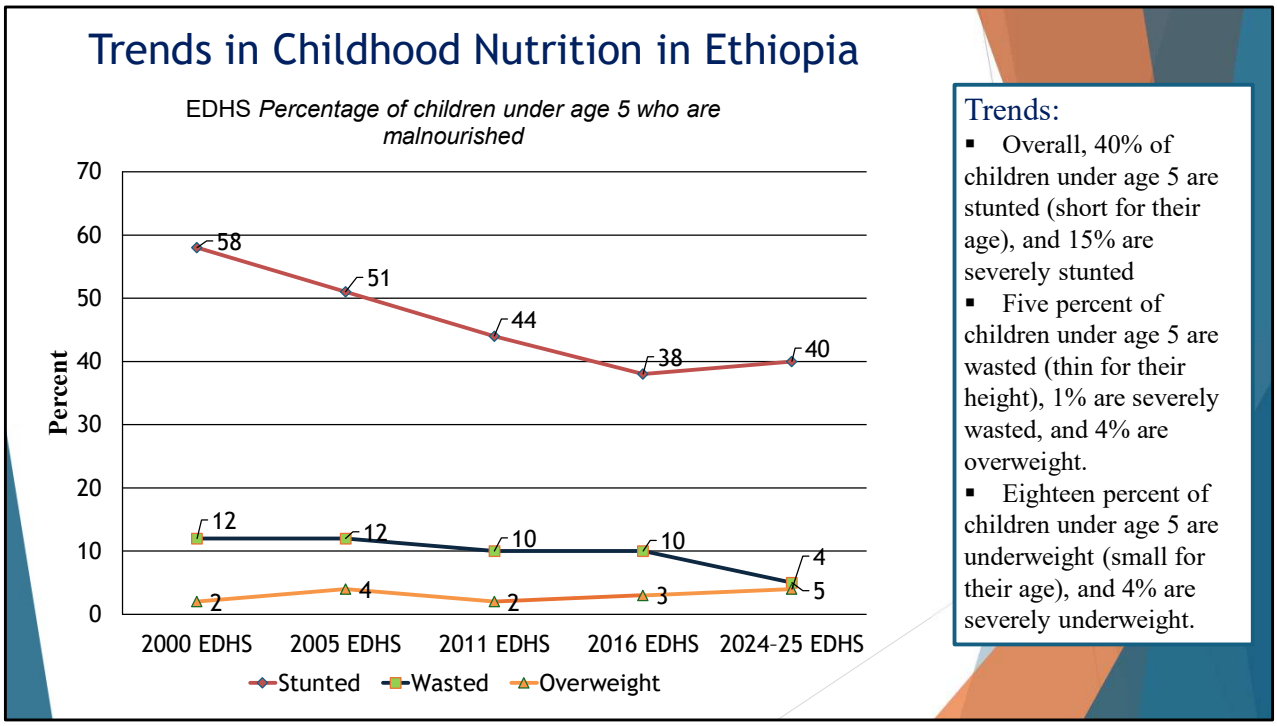
Expansion → Plateau → Equity challenge
While early gains contributed significantly to reductions in child mortality, the current challenge is:
Reaching the unreached
Sustaining and improving coverage in a more complex environment

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



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

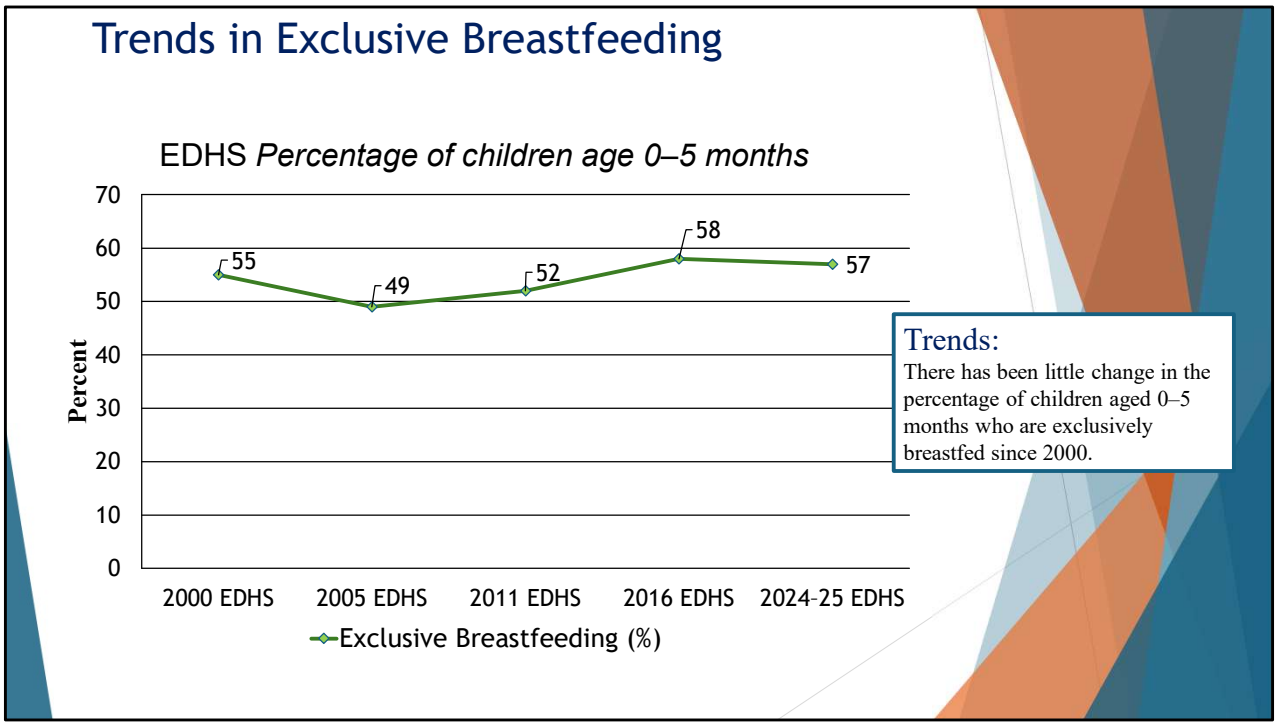
Low but increasing overweight
Overweight increased from **2% to 4%**.
While still low, this indicates the early stages of a **nutrition transition**, where:
Undernutrition and overnutrition coexist
This dual burden is becoming more common in developing countries undergoing economic and dietary change.

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

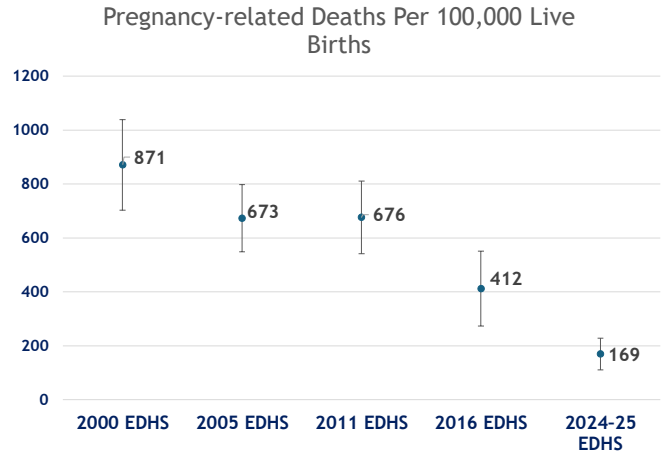
Looking Ahead to 2050 (Breastfeeding Outlook)
Exclusive breastfeeding represents one of the **clearest opportunities for accelerated progress**.

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)



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

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.

Survey	Point Estimate	Lower CI	Upper CI
2000 EDHS	871	703	1039
2005 EDHS	673	548	789
2011 EDHS	676	541	810
2016 EDHS	412	273	551
2024-25 EDHS	169	110	227

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**.

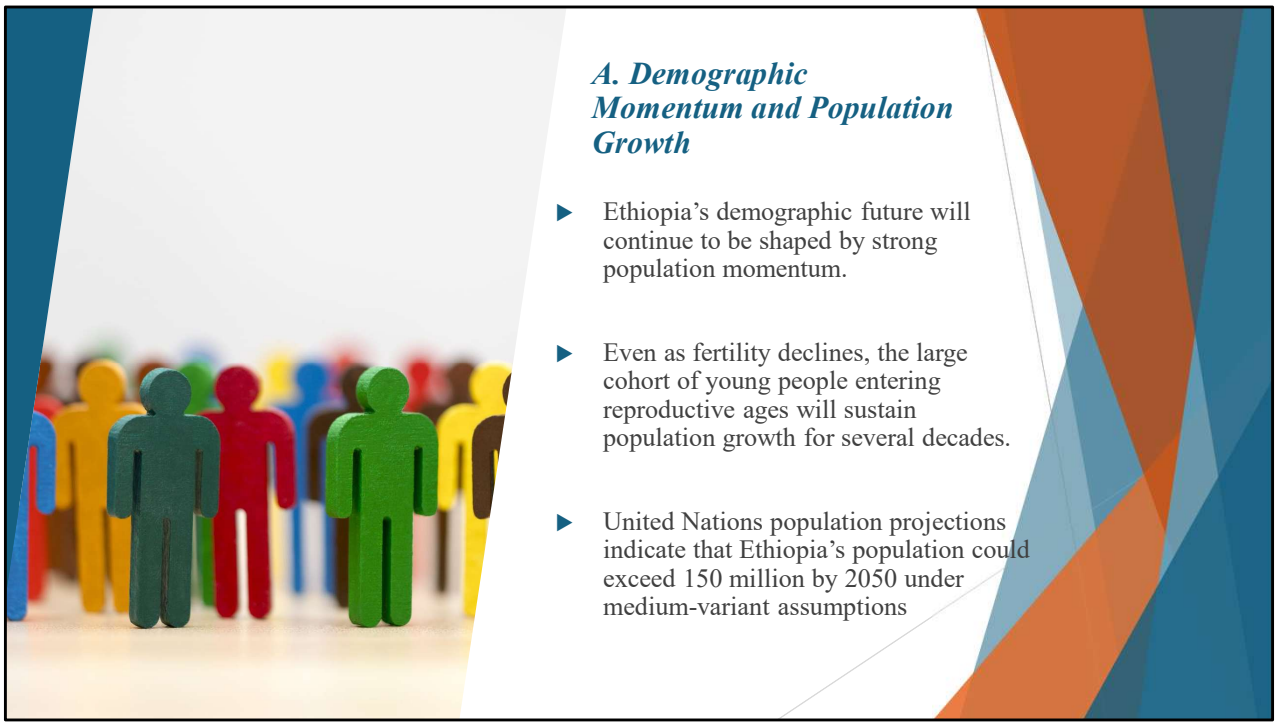
What it all means
Ethiopia has transitioned from:
Extremely high maternal mortality
→ to
substantially reduced—but still elevated—risk
At **169 per 100,000**, maternal mortality remains higher than:
Global targets
Middle-income country benchmarks
This means:
Major progress has been achieved
But **significant 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



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

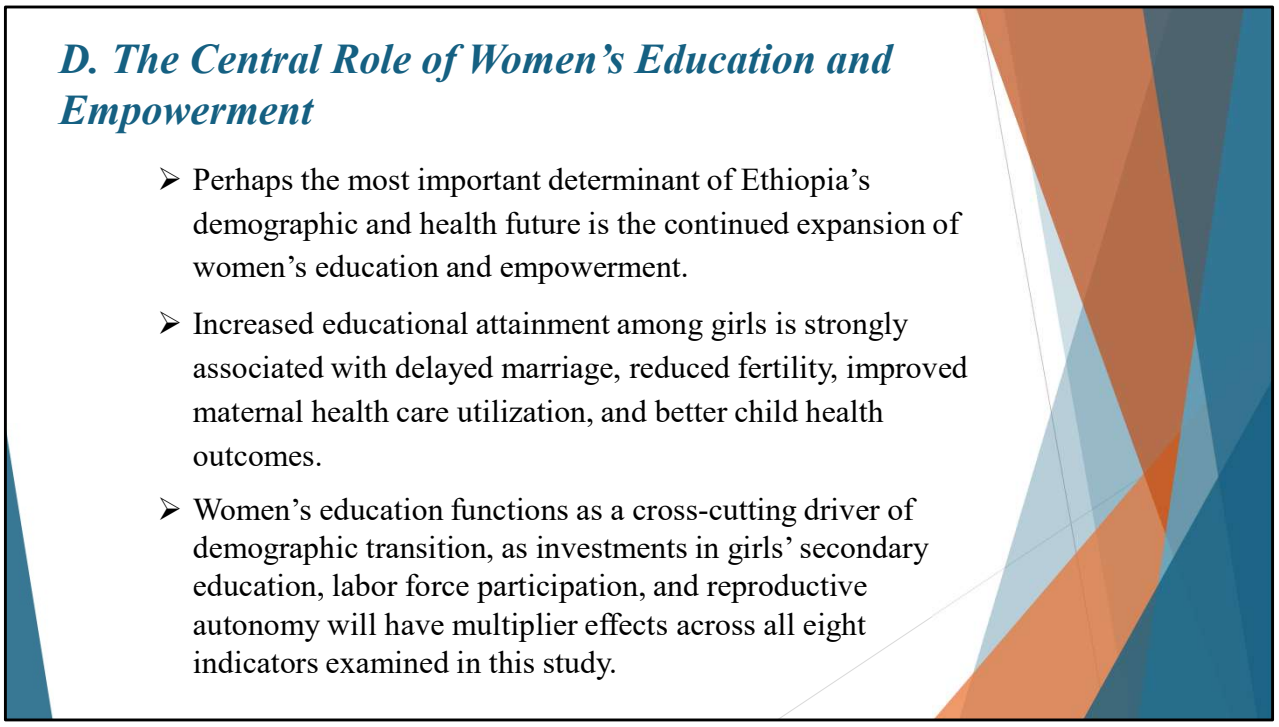
- Looking ahead, Ethiopia's fertility trajectory will be central to its demographic future.
- Continued expansion of modern contraceptive use and reductions in unmet need for family planning are expected to further lower total fertility rates.
- Regional disparities in contraceptive access and persistent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



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

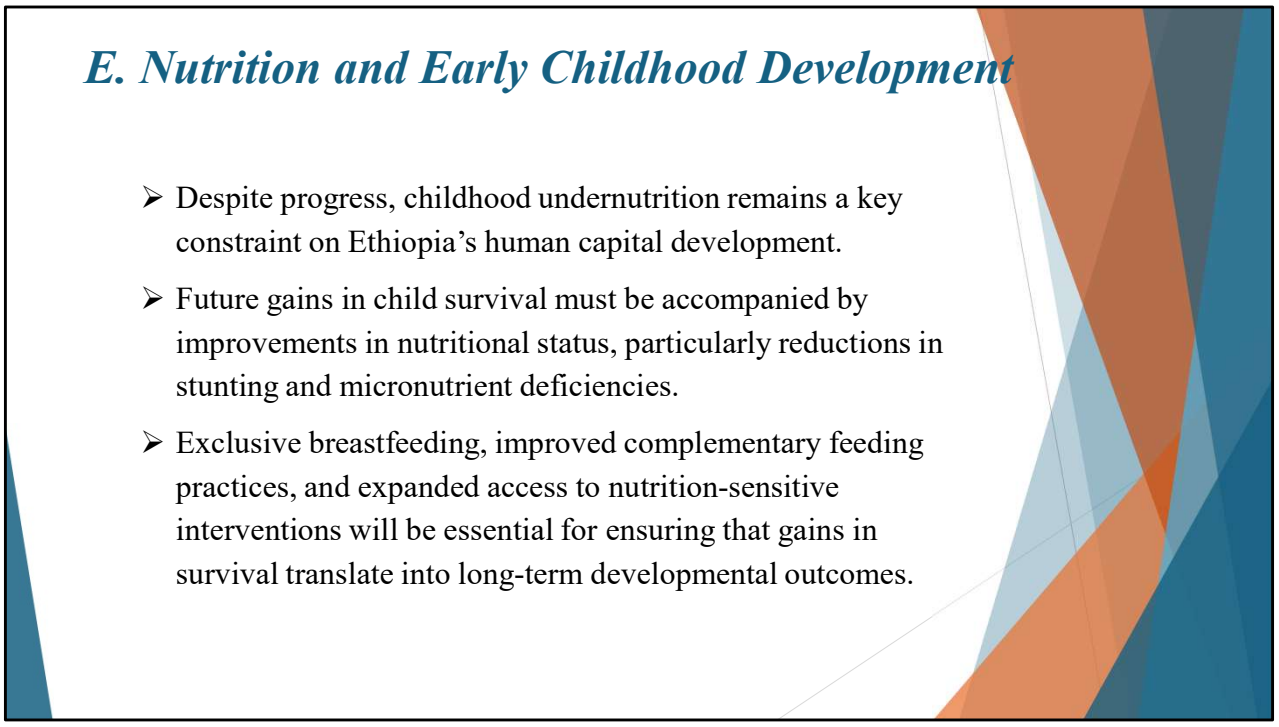
Economic participation strengthens autonomy and decision-making

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:

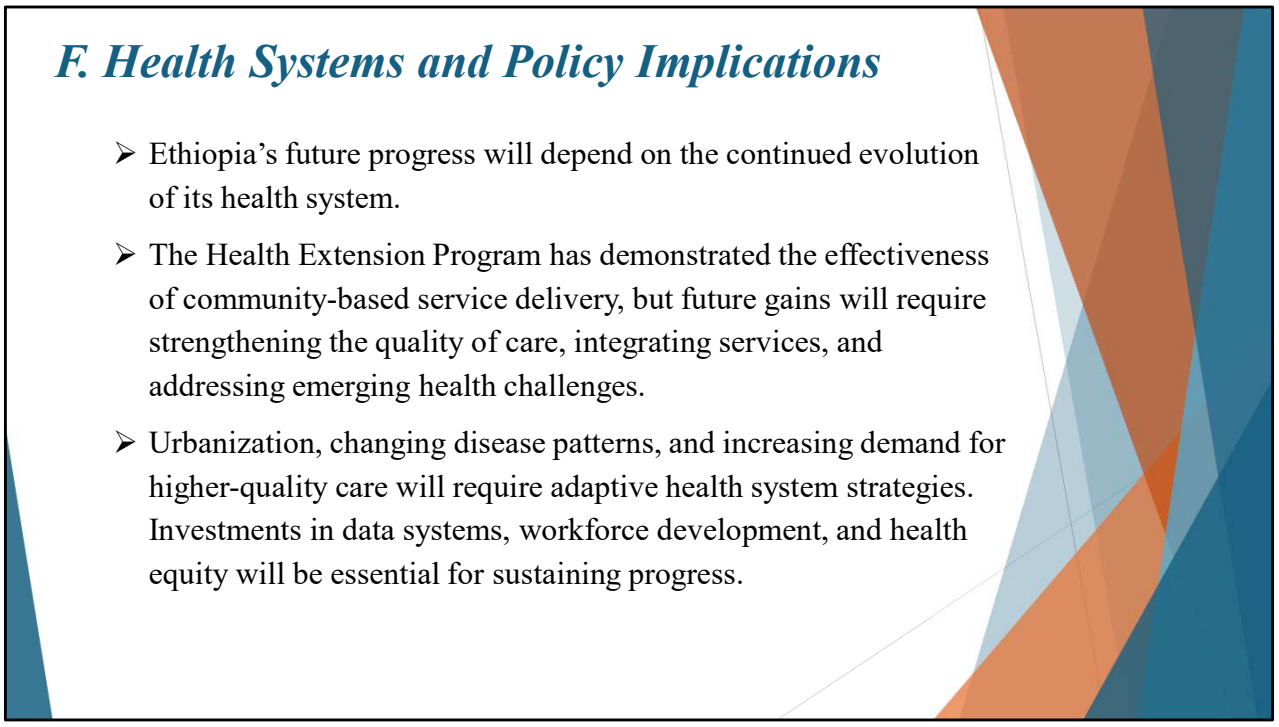
Investments in women's education produce simultaneous gains in fertility, maternal health, and child survival.



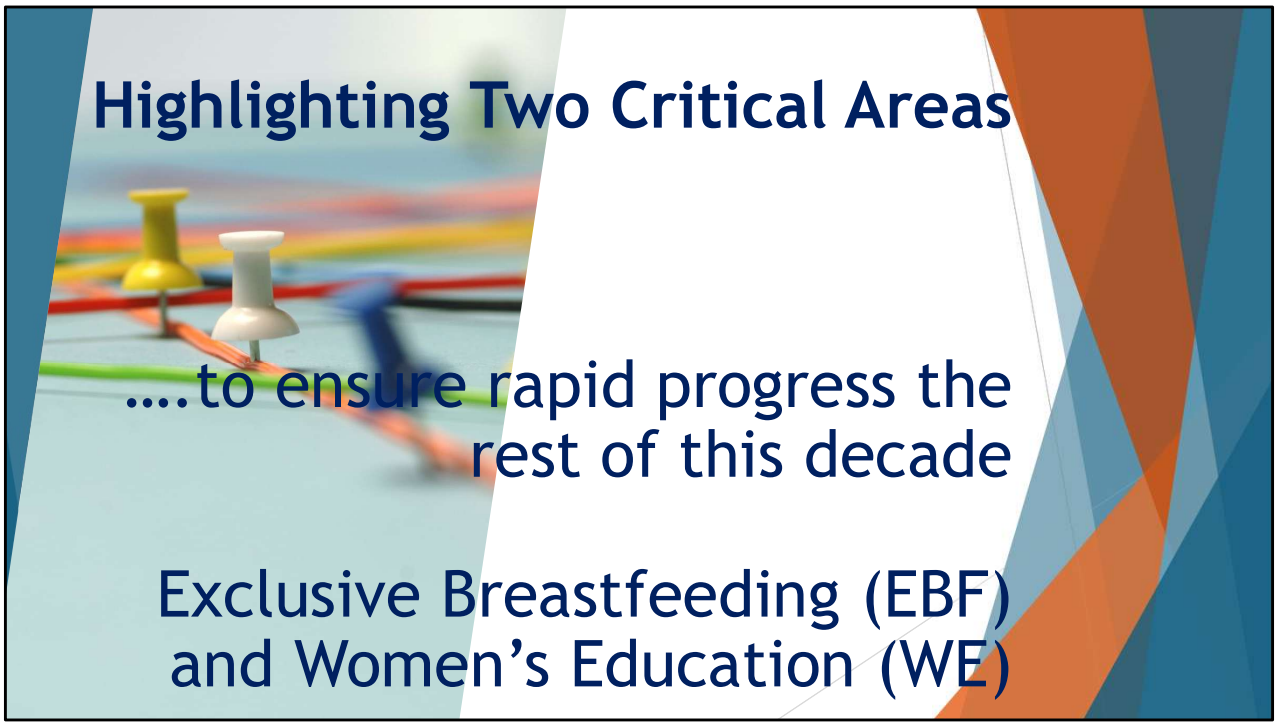
Ethiopia has reduced child mortality significantly, but **nutrition remains a binding constraint** on long-term development.
Key forward-looking issues:
Stunting remains high in several regions
Gains in survival must translate into **healthy growth and cognitive development**
Exclusive breastfeeding 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**.



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**



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

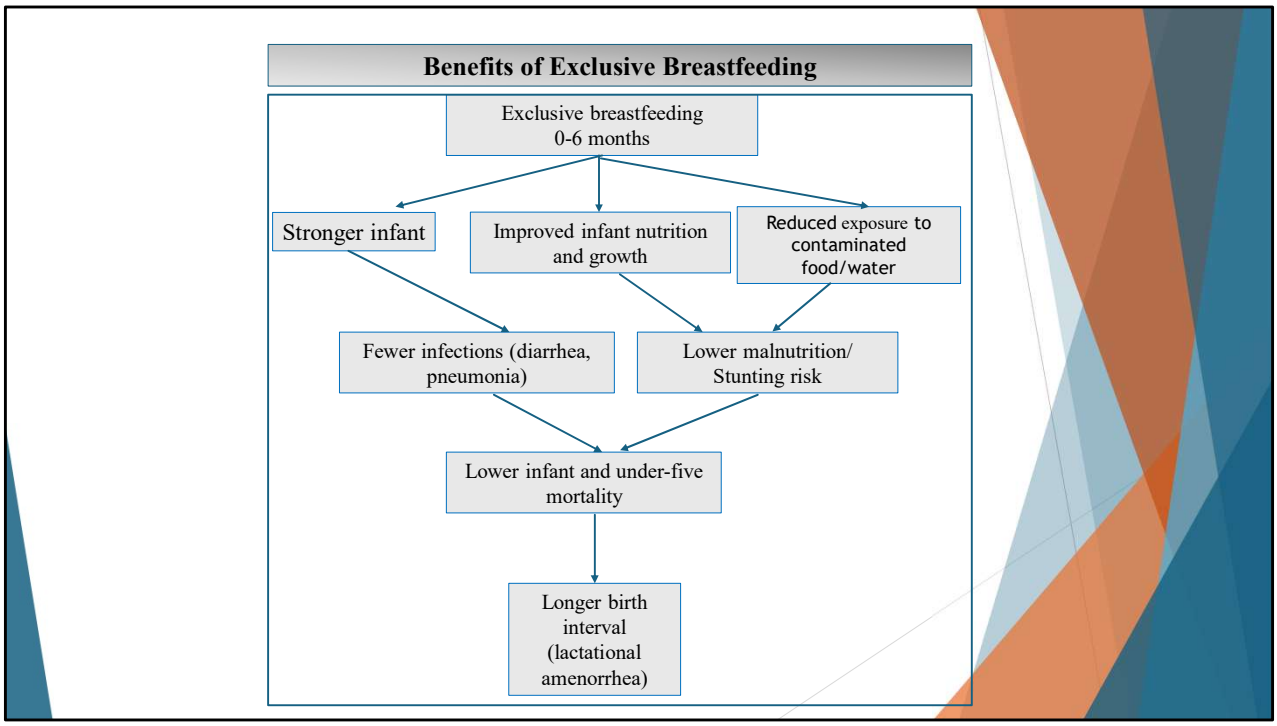
Women's Education & Empowerment (WE)
Progress made—but:
- Gaps remain in **secondary education completion**
- Persistent disparities in **rural areas**
- Unequal **economic participation**

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**

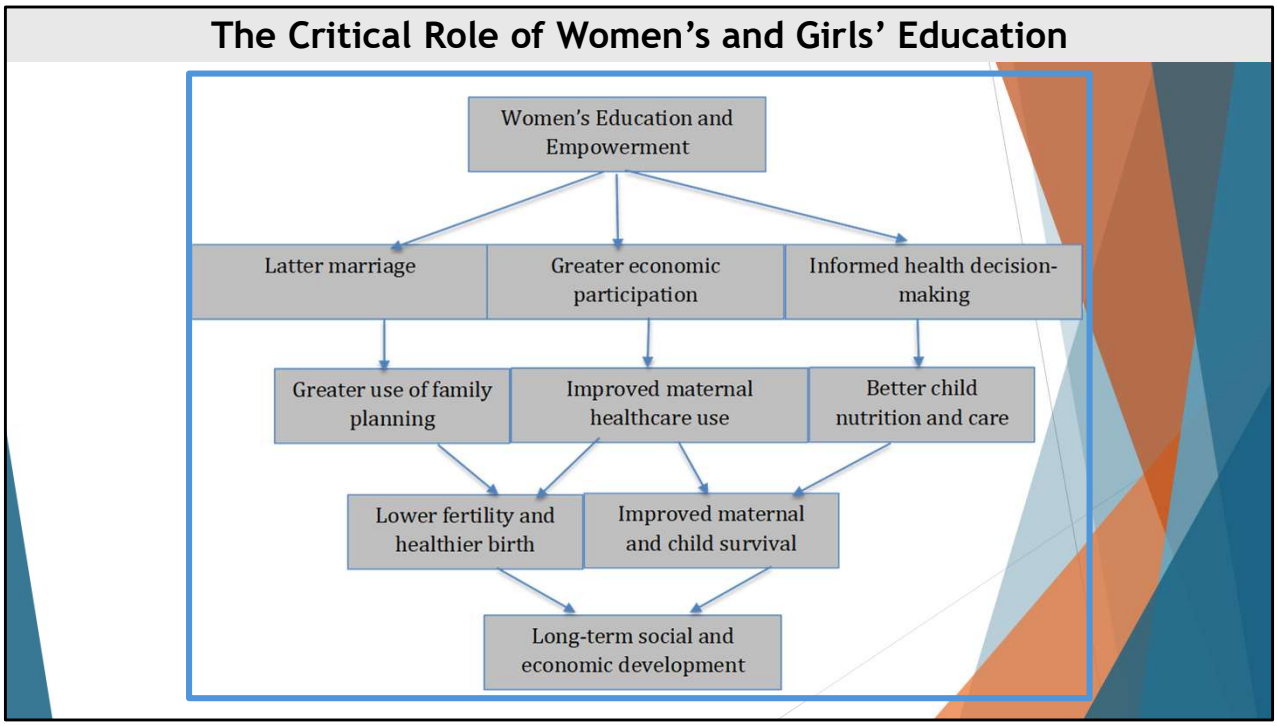
Improve long-term **human capital outcomes**

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

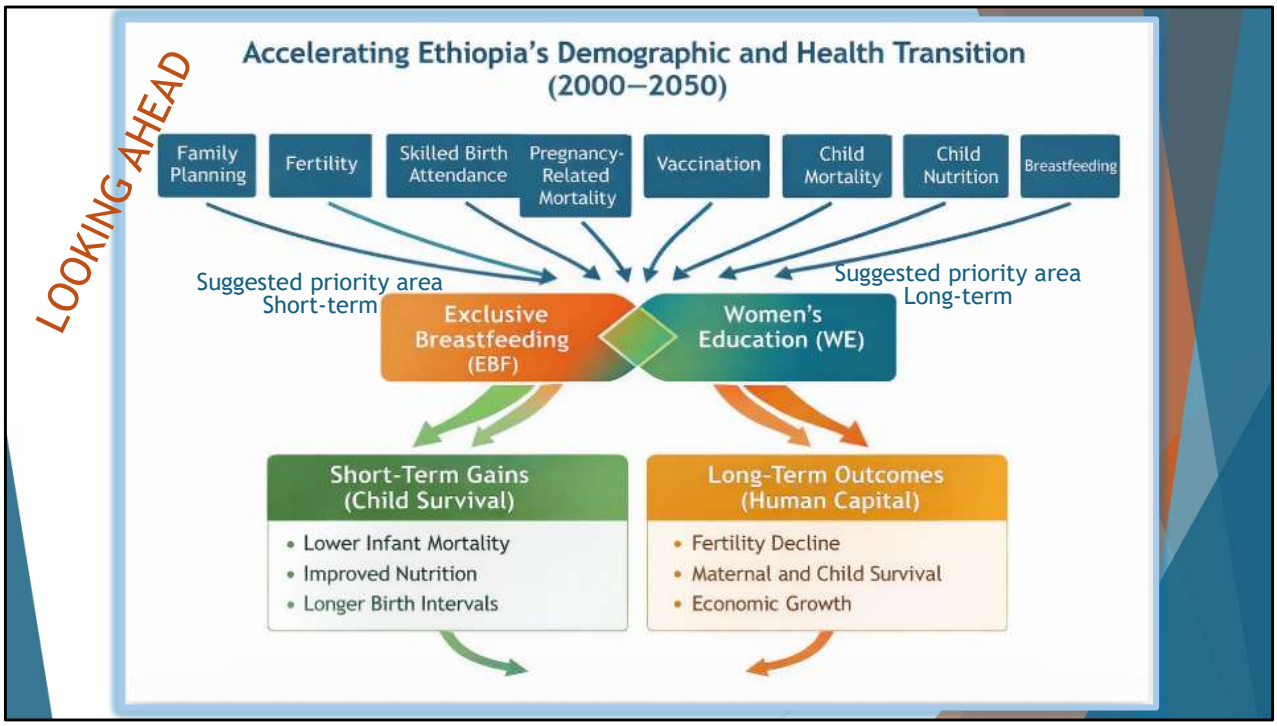
Looking ahead (to 2050):
Expanding girls' secondary education and women's empowerment will:
Accelerate **fertility decline**
Improve **maternal and child health outcomes**

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.

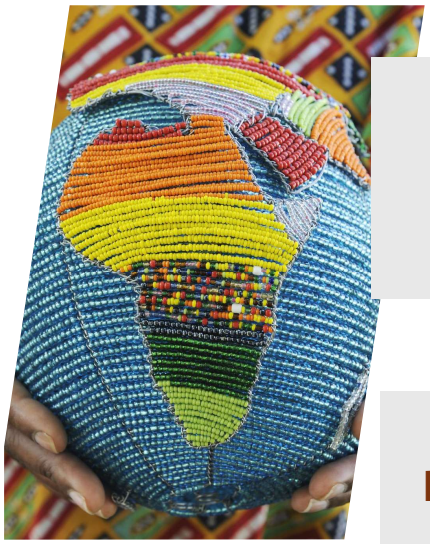
EBF (Exclusive Breastfeeding) = *high-impact, near-term accelerator*
WE (Women's Education & Empowerment) = *high-impact, structural accelerator*

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.

ETHIOPIAN DEMOGRAPHY AND HEALTH DASHBOARD

https://ethiodemography.maps.arcgis.com/apps/dashboards/e485f88663af4304992f9980324bd69a

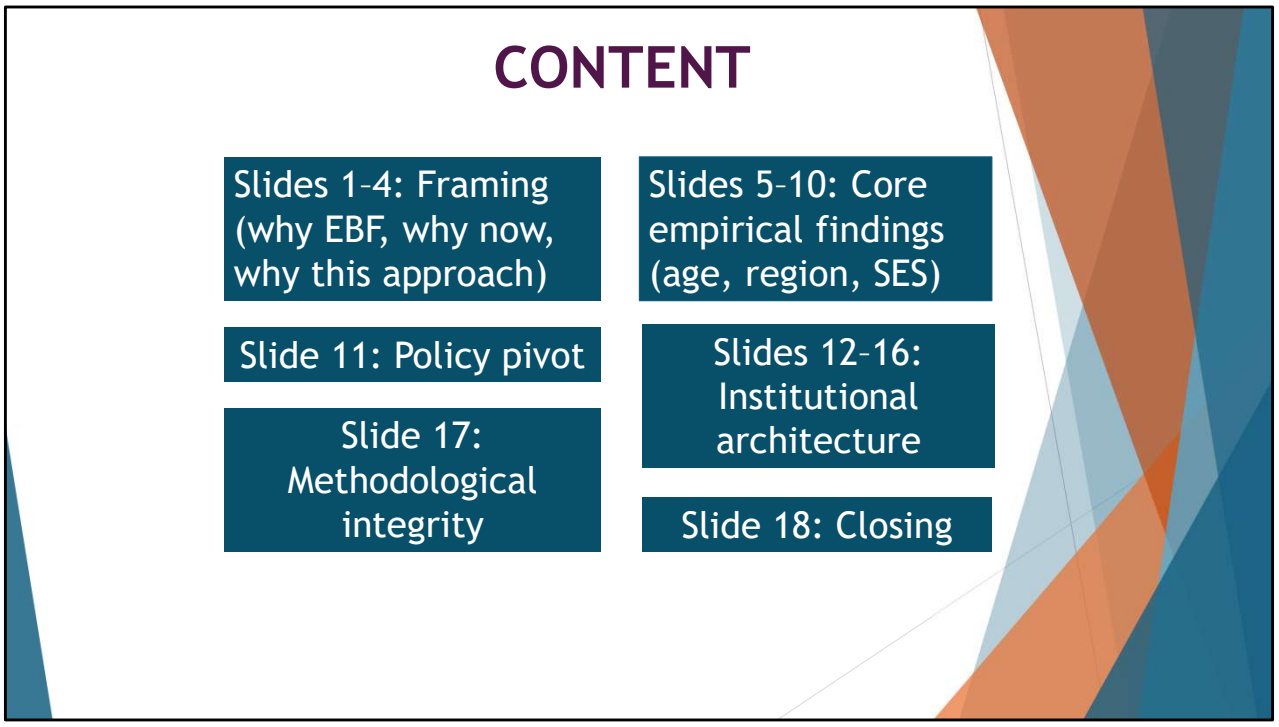


A Deep Dive Exclusive Breastfeeding

AYNALEM ADUGNA, PHD

Research Scientist, State of California

May 2026



This presentation begins with a broad retrospective of Ethiopia's quarter-century of demographic and health change, then narrows to a focused deep dive on exclusive breastfeeding (EBF)

EBF is singled out because of its persistent stagnation despite strong progress in other domains.

The presentation establishes why EBF matters

It does so by outlining its substantial benefits for infant survival, nutrition, and development, as well as maternal health, and the corresponding risks when exclusivity is not maintained.

The analysis then reframes EBF as a behavioral system rather than a structural outcome, demonstrating that the commonly cited national average (~58%) obscures a steep age-driven decline.

From Broad Trends to Deep Dive
Trends in Exclusive Breastfeeding –EBF

- ❑ We started with 8 domains of demographic & health change (25 years)
- ❑ Identified EBF as a priority for deeper analysis
- ❑ Conducted in-depth analysis of EDHS 2016 (R-based workflow)

Why was EBF singled out?

EBF was singled out because of its relative stagnation over time.

Unlike other domains—such as child mortality, immunization, or aspects of maternal health—which showed **clear and sustained improvement**, EBF exhibited:

Limited upward movement over the quarter-century

A pattern of **plateauing rather than continuous progress**

This stagnation made EBF analytically important—not just as an outcome, but as a **potential constraint on further gains in child survival and nutrition**.

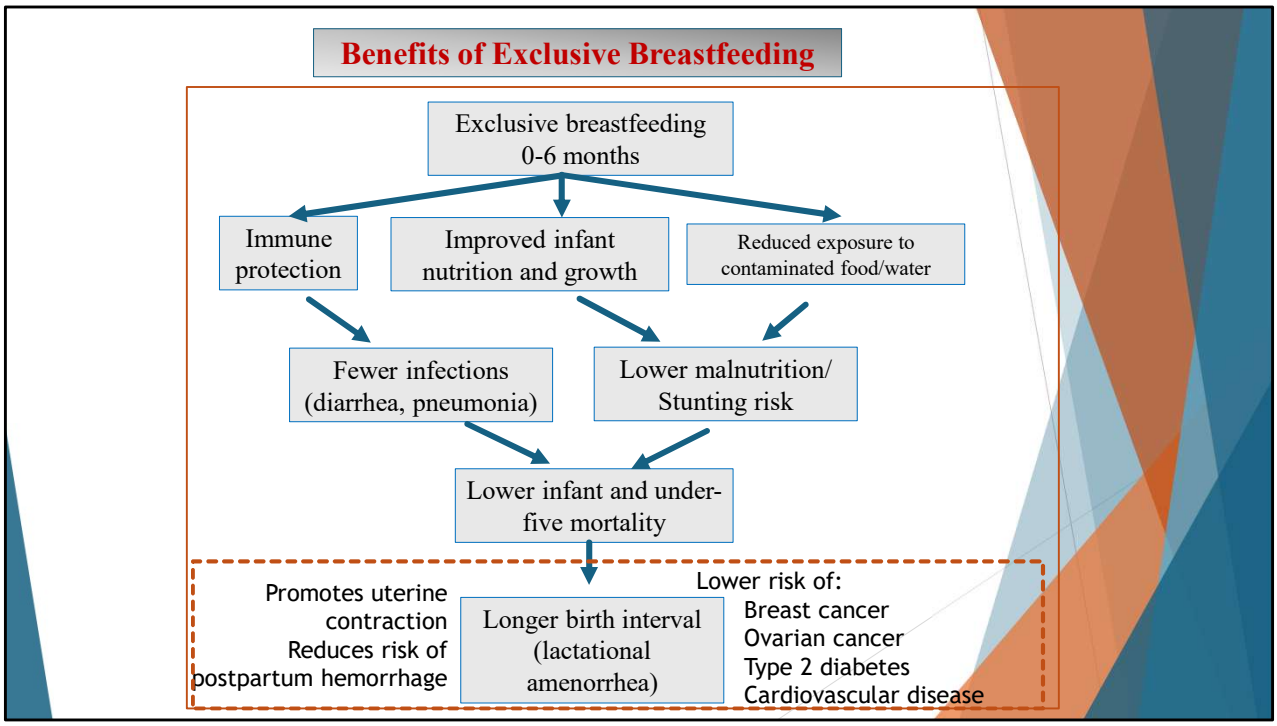
A closer look at the data then revealed something even more interesting.

Unlike more structural domains such as education or mortality decline, EBF displayed:

Strong short-term variation driven by infant age

Weak and non-linear socioeconomic gradients

And patterns consistent with a **time-sensitive, behaviorally driven process**



Before we move into the analysis, I would like to briefly ground our discussion in **why exclusive breastfeeding—EBF—matters so fundamentally**, both for infants and for mothers.

A. Benefits of Exclusive Breastfeeding

For the Infant

Exclusive breastfeeding during the first six months of life provides:

1. Optimal nutrition

Breast milk is uniquely tailored to the infant's needs

It contains the right balance of nutrients for growth and development

It adapts over time as the infant grows

2. Immune protection

Breast milk contains antibodies and bioactive compounds

It protects against:

- Diarrheal diseases
- Acute respiratory infections

These are leading causes of infant morbidity and mortality

3. Reduced risk of malnutrition

Helps prevent:

- Stunting
- Wasting
- Underweight

4. Long-term developmental benefits

Associated with improved:

- Cognitive development
- School performance

Reduced risk later in life of:

- Obesity
- Diabetes
- Chronic disease

For the Mother

Exclusive breastfeeding also confers important maternal benefits:

1. Postpartum recovery

Promotes uterine contraction

Reduces risk of postpartum hemorrhage

2. Birth spacing

Delays return of fertility through lactational amenorrhea

3. Reduced long-term disease risk

Lower risk of:

- Breast cancer
- Ovarian cancer

Emerging evidence for reduced risk of:

- Type 2 diabetes
- Cardiovascular disease

4. Psychosocial benefits

Strengthens mother–child bonding

Can support maternal well-being

B. Risks of Non-Exclusive Breastfeeding

For the Infant

When exclusive breastfeeding is not maintained:

1. Increased exposure to infection

Early introduction of:

- Water
- Other liquids
- Foods

Increases risk of contamination

Leads to higher rates of:

- Diarrhea
- Respiratory illness

2. Increased mortality risk

Non-exclusively breastfed infants are significantly more likely to die in the first months of life, especially in low-resource settings

3. Nutritional compromise

Breast milk is displaced by less optimal substitutes

Risk of undernutrition and impaired growth

For the Mother

The risks are less direct but still important:

1. Loss of protective health effects

Reduced duration of breastfeeding is associated with:

- Higher risk of breast and ovarian cancers
- Reduced metabolic protection

2. Shorter birth intervals

Earlier return to fertility

Potential implications for maternal and child health

Transition to the Analysis

So, when we talk about exclusive breastfeeding, we are not discussing a marginal behavior.

We are discussing one of the most powerful interventions for improving both **child survival and maternal health**.

And yet—despite its benefits—progress in Ethiopia has been **limited over time**.

That is what motivated this deep dive.

The question we will now turn to is:

If the benefits are so clear, why is exclusive breastfeeding not being sustained through the first six months—and what does the data tell us about how to change that?

Exclusive Breastfeeding (EBS) in Ethiopia

- An in-depth analysis appears to show that EBF in Ethiopia is a social-behavioral system, not a structural outcome

What "A behavioral system, not a structural outcome" means

1. What is a "structural outcome"?

A **structural outcome** is something primarily determined by **long-run, slowly changing conditions**, such as:

Education systems
Income/wealth
Infrastructure
Institutional access

Examples:

- Women's education levels
- Poverty rates
- Health service coverage

These outcomes:

- Change **gradually over years or decades**
- Show **clear, monotonic gradients** (e.g., higher education → better outcomes)
- Are relatively **stable across short time horizons**

2. What is a "behavioral system"?

A **behavioral system**, by contrast, is:

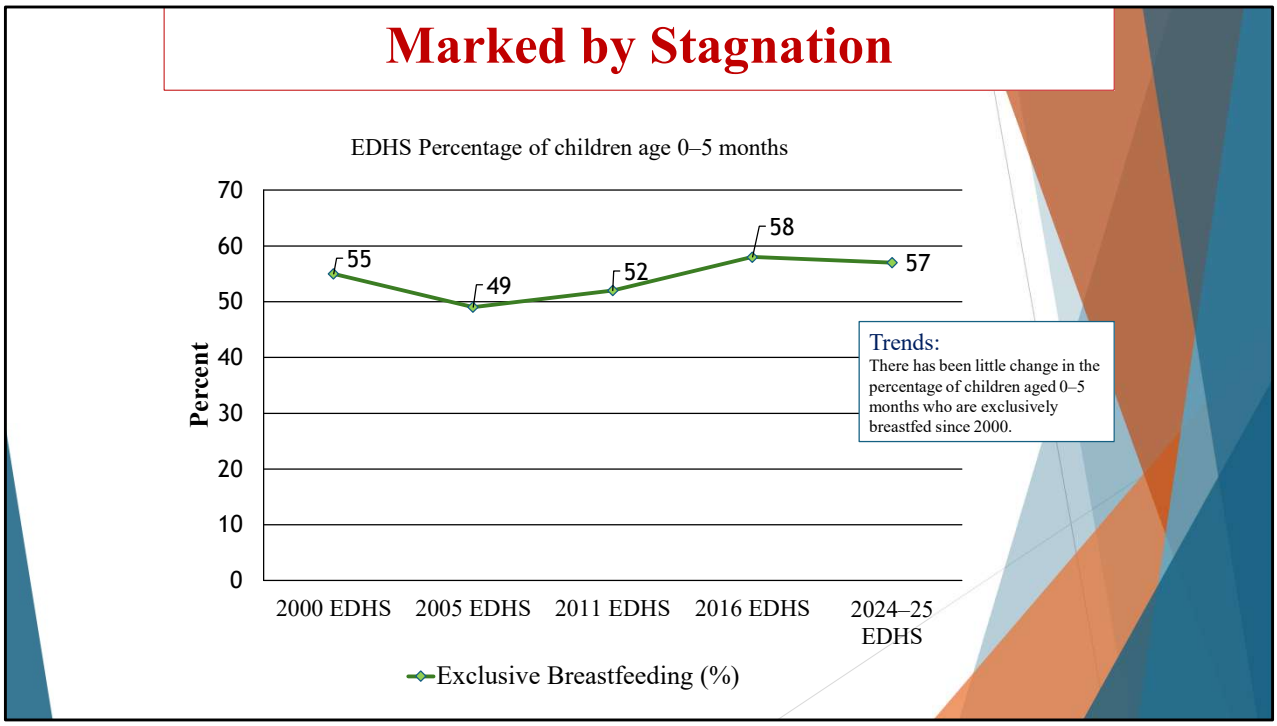
Time-sensitive (changes quickly)

Context-dependent (varies by local norms and situations)

Shaped by **daily decisions and constraints**

Influenced by **social interactions and perceptions**

It is not fixed—it **evolves over days, weeks, and months**.



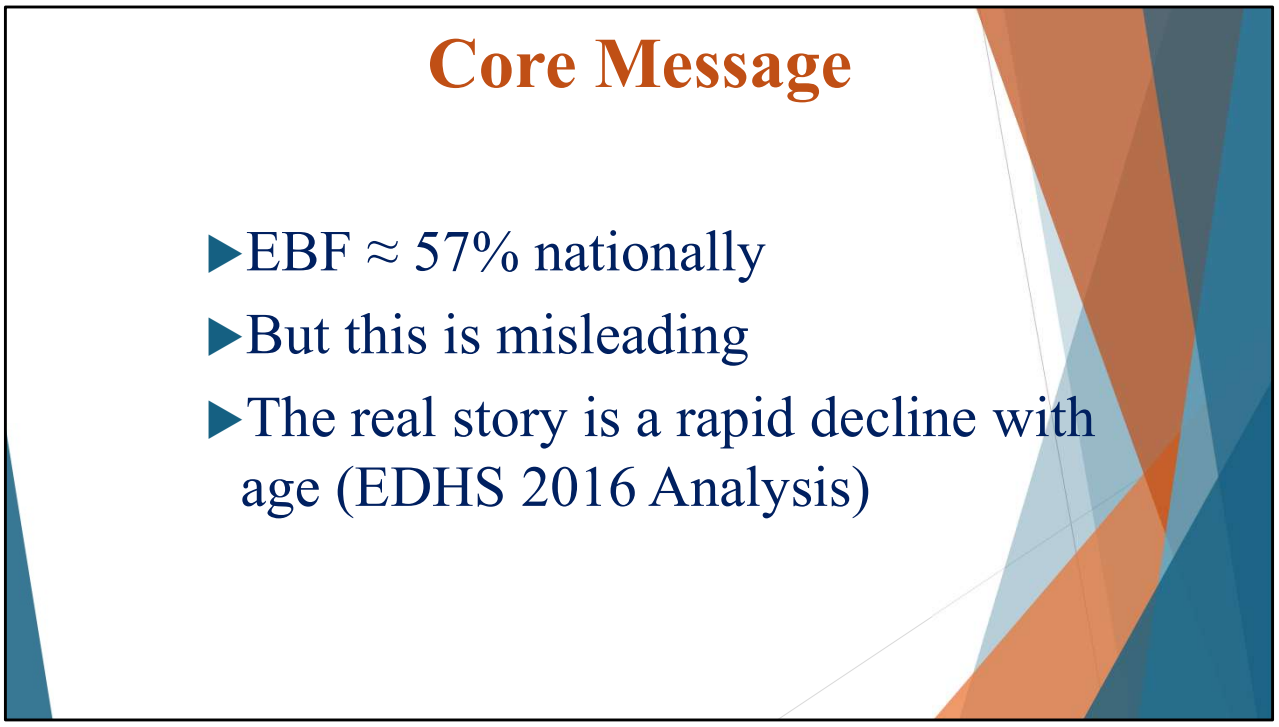
Three ways to sum up EBF in Ethiopia over the last 25 years:

1. **High-impact,**
2. **Low-cost,**
3. **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**.

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

Key Trend: Gap between current levels and global recommendations
WHO recommends EBF rates of **at least 70%**.
Ethiopia's current level is ~57%.



This slide presents what appears to be the **headline finding**:
that approximately **57 percent of infants under six months in Ethiopia are exclusively breastfed**.

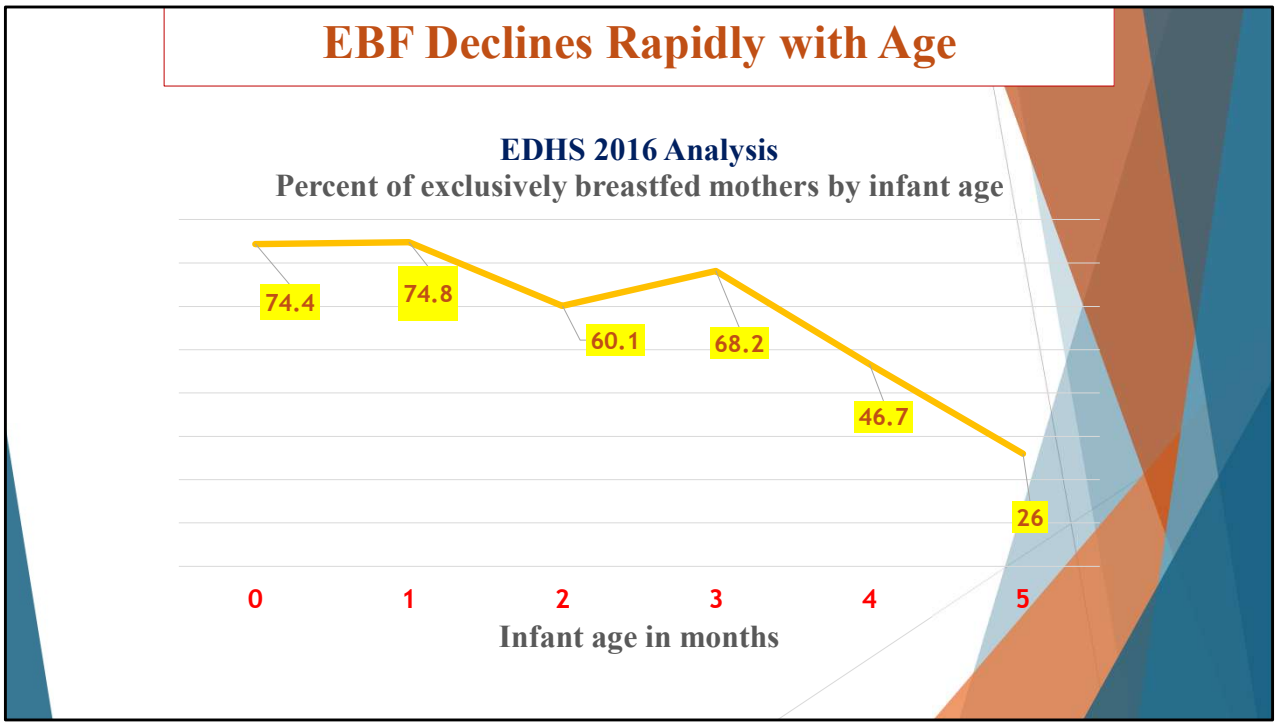
What the national figure does is:

- Combine infants who are **just born**, where EBF rates are very high
- With infants who are **approaching six months**, where EBF rates drop sharply
- So the average masks a **steep internal gradient**.

This is a classic case of what we might call **aggregation bias**

The summary statistic looks moderate and stable

But
The system is not stable at all; it exhibits a rapid drop-off.



This slide is the **analytical core of the entire presentation**.
What you see here is exclusive breastfeeding plotted by **infant age in completed months**, from birth through month five.
And the pattern is immediately clear—and quite striking.

- In the **first months of life**, EBF levels are very high—around **74 to 75 percent**
- By **month two**, we already begin to see a decline
- By **month four**, EBF has dropped to below 50 percent
- And by **month five**, it falls to approximately **26 percent**

So what appears, at the national level, as a **moderate 58 percent in 2016**, is actually the result of averaging:

- Very high adherence early on
- With very low adherence just a few months later

This is not a gradual decline—it is a **steep behavioral drop-off over a very short time window**.
Substantively, this is the most important finding in the analysis.
It tells us that:

- **Mothers overwhelmingly initiate exclusive breastfeeding**
- But **continuation becomes increasingly difficult as the infant ages**

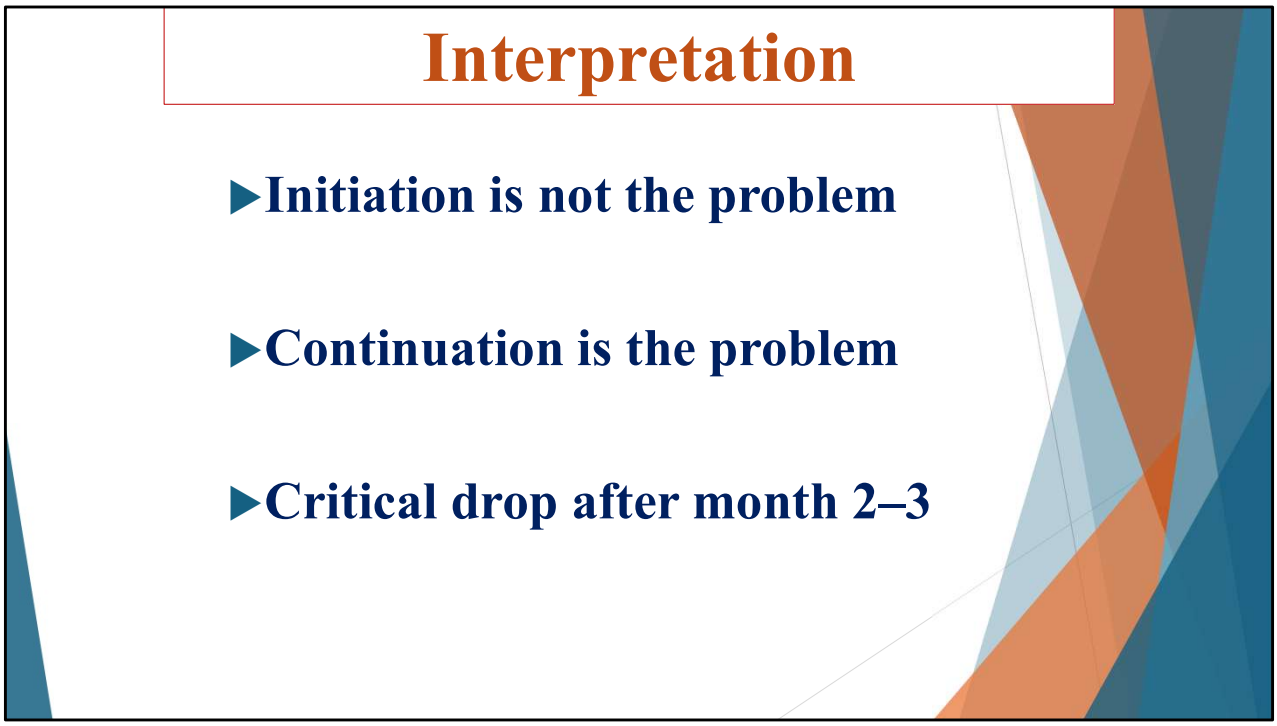
This fundamentally reframes the problem.

- The issue is not lack of awareness or failure to start breastfeeding.
- The issue is **attrition—loss of exclusivity over time**.

Now, it is also important to interpret this curve correctly.
This is not just a statistical pattern—it reflects a **behavioral trajectory shaped by real-world pressures**, including:
Perceptions that breast milk alone is no longer sufficient as the infant grows

- Early introduction of water or other liquids due to cultural norms
- Increasing maternal workload or return to employment
- Influence of family members or community practices around feeding

You may also notice a slight fluctuation around month three.
This should not be over-interpreted—it likely reflects **sampling variability**, not a true behavioral reversal.
The dominant pattern remains unequivocal:
Exclusive breastfeeding declines sharply with infant age
From a policy standpoint, this is where the implications become very concrete.
If we want to improve EBF outcomes, the priority is not:
Broad messaging about starting breastfeeding
But rather:
Targeted support to sustain exclusivity, especially between **months two and five**, where the drop-off is most pronounced
So, to summarize this slide in one sentence:
EBF in Ethiopia is not failing at the start—it is failing over time.
And that insight will help us reinterpret everything that follows, including regional variation and socioeconomic patterns.



Mothers are **starting breastfeeding appropriately**
Early postnatal practices are, in general, aligned with recommended guidance
So from a policy standpoint, this is important:

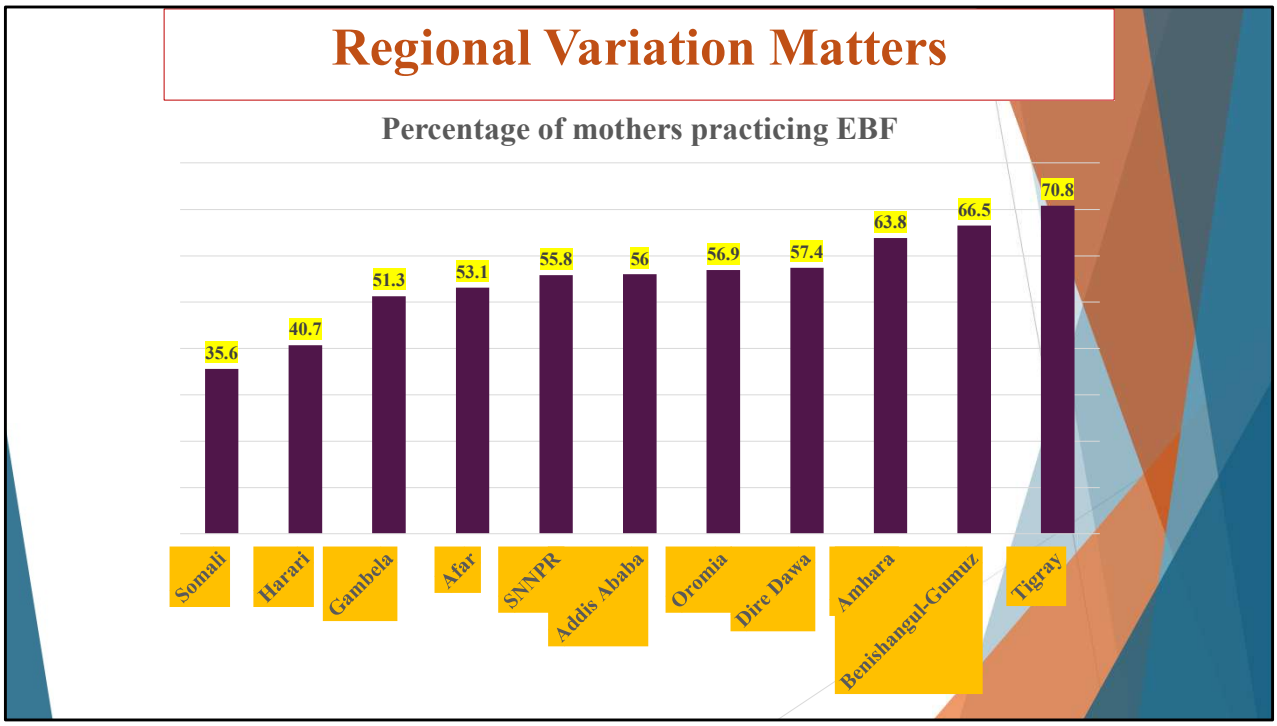
Between months two and five, several pressures begin to intensify:
Biological perceptions:
Mothers may perceive that breast milk alone is no longer sufficient as the child grows
Cultural practices:
Early introduction of water, herbal liquids, or other supplements may be encouraged
Household dynamics:
Advice from older family members—especially grandmothers—can influence feeding decisions
Economic and time constraints:
Mothers may return to work or face increasing workload demands, making exclusive breastfeeding more difficult
Service gaps:
Postnatal care and breastfeeding support often decline after the early weeks,

precisely when support is most needed
So what we are observing is not random decline—it is a **structured transition from a supported early phase to a less-supported later phase**.
This is why framing EBF as a **behavioral system** is so important.
Unlike structural indicators, where change is evolutionary:

Behavior

- Changes quickly
- Is sensitive to daily constraints
- Requires **continuous reinforcement**, not one-time intervention

Now, from a programmatic perspective, this leads to a very clear implication:
If interventions focus primarily on **initiation—such as facility delivery or early breastfeeding counseling—they will miss the point.**
Instead, the critical window for intervention is:
After the first month
Especially **months two through five**, where we see the steepest decline
So the policy pivot is:
From **"Start breastfeeding."**
→ to
"Help mothers continue exclusive breastfeeding under real-life conditions."
This reframing is essential because it shifts both:
Where we intervene, and
How do we design those interventions



This slide shifts the focus from time—infant age—to **place**, specifically regional variation in exclusive breastfeeding across Ethiopia.

What we see here is a **wide range of EBF prevalence across regions**:

At the higher end, regions such as **Tigray** and **Benishangul-Gumuz** show levels above **65–70 percent**

At the lower end, regions such as **Somali** and **Harari** fall closer to **35–40 percent**

And several large regions—**Oromia, SNNPR, Addis Ababa, Dire Dawa**—cluster around the national average

So the first takeaway is straightforward:

EBF is not evenly distributed across Ethiopia—regional context clearly matters.

However—and this is where the analysis becomes more nuanced—

the pattern does not follow a simple or intuitive geographic logic.

For example:

Urban vs. rural does not explain the variation:

- Addis Ababa, the most urbanized region, is not at the top
- Harari, also largely urban, is among the lowest

Pastoralist vs. non-pastoralist livelihoods do not explain it either:

- Afar shows moderate EBF levels

Somali, with a broadly similar livelihood structure, shows much lower levels

This tells us something very important:

There is no single structural or geographic axis that explains regional differences in EBF.

Instead, what we are likely observing is the result of **localized combinations of factors**, including:

- Cultural norms around infant feeding
- Community-level beliefs about breast milk sufficiency
- Access to and quality of maternal and child health services
- Strength of community support systems
- Local program implementation differences

In other words, **region is acting as a proxy for context**, not as a causal factor in itself.

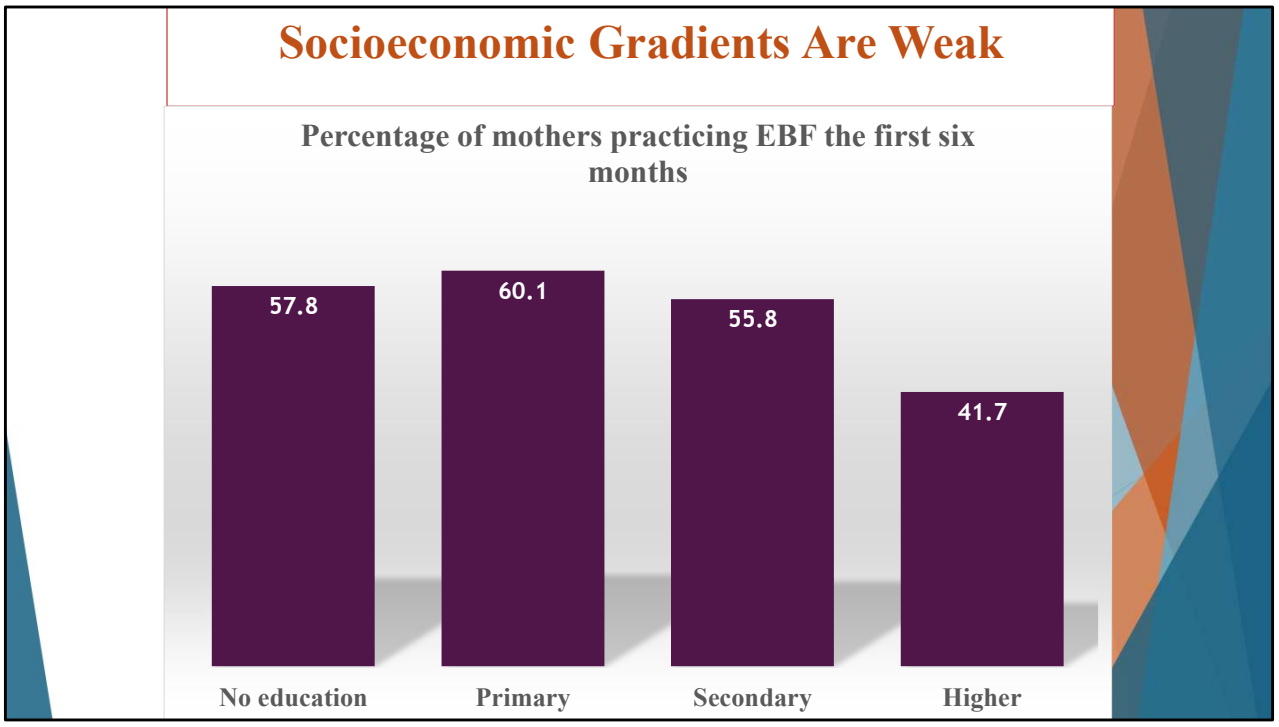
This has two important implications.

First, analytically:

We should be cautious about interpreting regional differences as inherently "better" or "worse" without understanding the underlying mechanisms

Second, from a policy perspective:

One-size-fits-all national strategies are unlikely to be effective.



This slide turns to a set of variables that are often assumed—almost by default—to be strong determinants of health behaviors:
maternal education and, by extension, socioeconomic status.
In many areas of public health, we expect to see a **clear, positive gradient**:
Higher education → better health behaviors
Lower education → poorer outcomes
But what we observe here for exclusive breastfeeding is quite different.
The pattern is **weak and non-linear**:
Mothers with **no education** and those with **primary education** show relatively similar—and even slightly higher—levels of EBF
As we move to **secondary education**, EBF does not increase—it declines slightly
And among mothers with **higher education**, EBF drops more noticeably
So instead of a steady upward gradient, what we see is:
A flattened—and even inverted—relationship
This is a critical finding, because it challenges a very common assumption:
That improving education alone will automatically improve breastfeeding outcomes.
Now, it is important to interpret this carefully.
This does **not** mean that education is unimportant.

Rather, it means that **education operates through competing pathways**.
On the one hand, higher education is associated with:

- Better access to health information
- Greater exposure to recommended practices
- Increased interaction with health services

These would tend to **support EBF**.
But on the other hand, higher education is also associated with:

- Greater likelihood of **formal employment**
- **Time constraints** and earlier return to work
- Urban lifestyles where alternatives to breastfeeding are more accessible

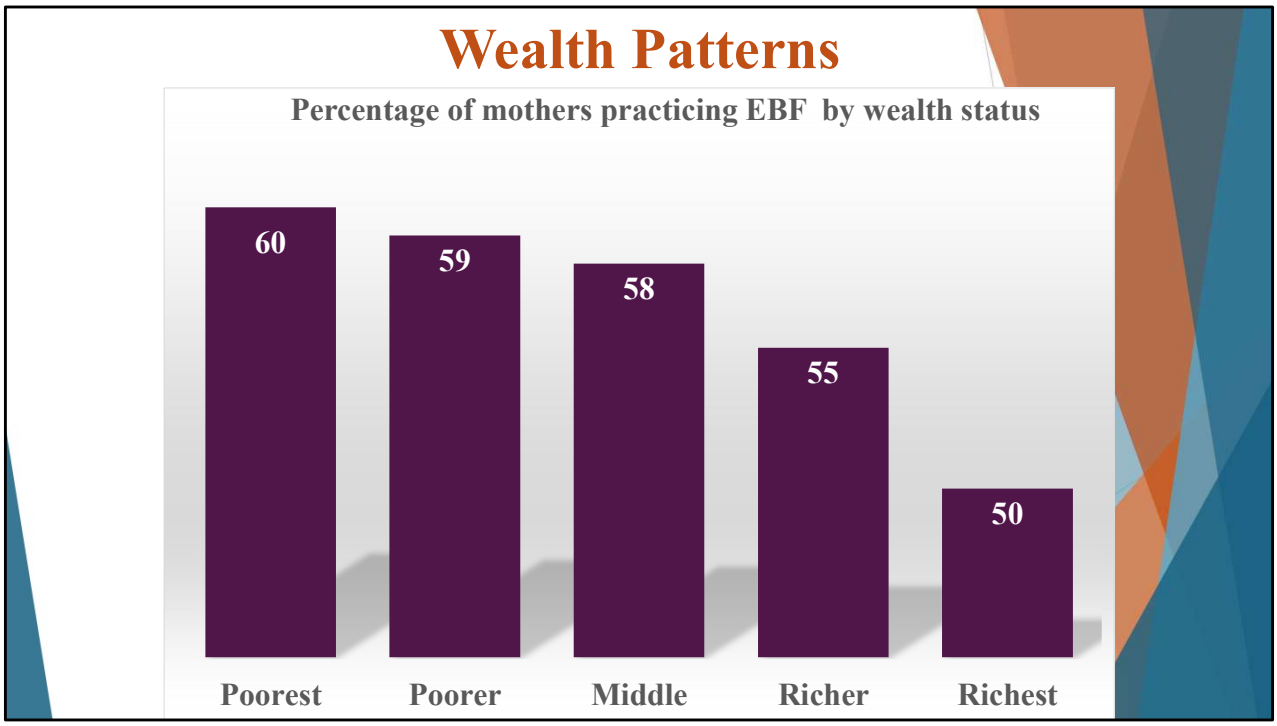
These factors tend to **undermine sustained exclusive breastfeeding**.
So what we are observing is the **net effect of opposing forces**, which results in:
A weak and non-linear overall pattern
This reinforces a central argument of the presentation:
EBF is not primarily structured by long-run socioeconomic position in the way many other health outcomes are.
Instead, it is shaped more strongly by:

- **Time dynamics (infant age)**
- **Contextual and behavioral factors**

From a policy perspective, this has important implications.
If we assume that:
Education alone will drive improvements in EBF
We risk missing the actual constraints that mothers face.
Instead, interventions need to address:

- **Practical feasibility**
- **Workplace conditions**
- **Time and support systems**

So to summarize this slide:
Socioeconomic gradients in EBF are **present but weak**
The relationship is **non-linear and sometimes counterintuitive**
And this further supports the conclusion that:
EBF is a behavioral system, not a structurally determined outcome



This slide extends the socioeconomic analysis by focusing specifically on **household wealth**.
Here again, if we were dealing with a typical health outcome, we would expect to see a **clear positive gradient**:
Higher wealth → better outcomes
Lower wealth → worse outcomes
But the pattern for exclusive breastfeeding is, once again, **surprisingly modest and somewhat counterintuitive**.
What we observe is:
EBF levels are **highest among the poorest households**, at around 60 percent
There is a **gradual decline** as we move up the wealth distribution
By the richest quintile, EBF falls to roughly **50 percent**
So the gradient exists—but it is:
Shallow, and in the opposite direction of what we might expect
Now, this does not mean that wealth negatively "causes" lower breastfeeding.
Rather, it reflects the **different environments and choices available across wealth levels**.
Let's unpack the mechanisms.
Among poorer households:

- Breastfeeding is often the **default and necessary option**
- Limited access to alternatives such as formula or other foods
- Stronger reliance on traditional infant feeding practices

These conditions tend to **support continued exclusive breastfeeding**, even in the absence of formal knowledge or services.

Among wealthier households:

- Greater access to **breastmilk substitutes and complementary foods**
- Higher likelihood of **urban residence and formal employment**
- Increased exposure to **marketing and social norms** that may favor early supplementation

These factors can **erode exclusivity over time**, even when knowledge levels are higher.

So, similar to education, wealth operates through **competing pathways**:

Enabling access and information on one side

Introducing constraints and alternatives on the other

The net result is:

A weak, slightly negative gradient

Why this matters analytically

Taken together with the education findings, this reinforces a key conclusion:

Socioeconomic status does not strongly structure EBF outcomes in Ethiopia.

This is very different from outcomes like:

- Child mortality
- Nutritional status
- Educational attainment

Where wealth and education typically show **strong, monotonic gradients**.

Policy implications

This has direct implications for how we design interventions.

If we assume:

"Target the poorest" → we improve EBF

We may miss the fact that:

Drop-off is occurring across all groups, including the better-off

And that:

The mechanisms differ:

Among poorer groups → structural constraints

Among richer groups → substitution, time pressure, and lifestyle factors

So effective policy needs to be:

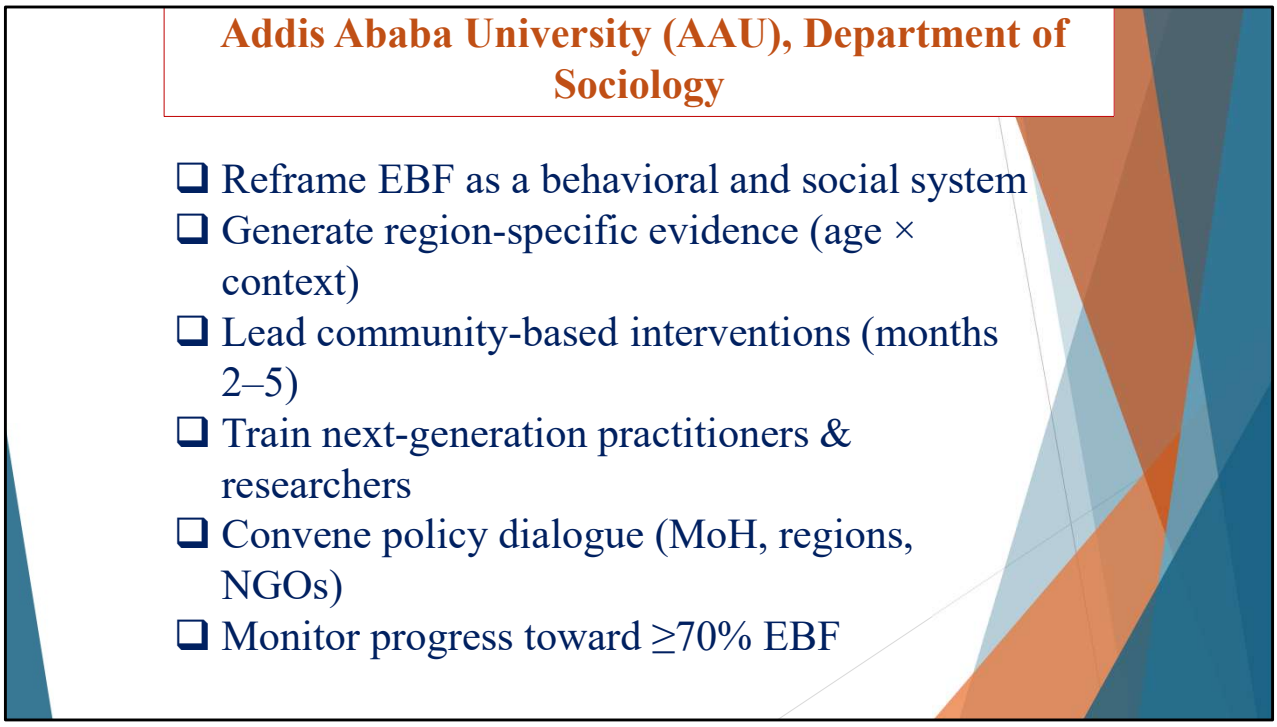
Differentiated, not uniform

Support for **continuation under workload constraints**

Regulation or guidance around **early introduction of substitutes**
Tailored messaging that addresses **different behavioral drivers across groups**

Bottom line for this slide
Wealth gradients exist but are **weak and slightly negative**
Higher wealth does not translate into better EBF outcomes
And this further strengthens the overarching conclusion:
Exclusive breastfeeding is shaped more by behavioral and contextual factors than by socioeconomic position alone

Institutional Ownership/Leadership



The starting point is alignment with the central finding of this analysis:
EBF is a behavioral and social system, not simply a clinical or informational issue.
That positioning places Sociology in a natural leadership role.

1. Reframing EBF as a Social System
The Department of Sociology can lead a national reframing of EBF:
Move the discourse from **individual choice** to **socially embedded behavior**
Examine how norms, household dynamics, gender roles, and informal advice networks shape feeding decisions
Identify how these factors change between **month 1 and months 2–5**, where the drop-off occurs
This reframing is essential for designing interventions that are **realistic and culturally grounded**.

2. Generating Region-Specific Evidence
A major contribution AAU Sociology can make is to deepen the analysis beyond

national averages:
Produce **region × age profiles of EBF**
Distinguish clearly between:

- **Initiation problems** (low at month 0–1)
- **Continuation problems** (steep decline after month 2)

Conduct **qualitative and mixed-method studies** in low-performing regions such as Somali and Harari to understand:

- Beliefs about breast milk sufficiency
- Norms around early supplementation
- Decision-making within households

This evidence base becomes the foundation for **precision policy**, not generic messaging.

3. Leading Community-Based Interventions (Months 2–5)
Given that the problem is a continuation, AAU Sociology can pilot and evaluate interventions focused on the **critical window (months 2–5)**:
Community dialogue models involving:

- Mothers
- Fathers
- Grandmothers and elder women

Behavioral reinforcement strategies:

- Peer support groups
- Home-based counseling
- Norm-shifting communication

Testing different models across regions to determine:

- What works
- For whom
- Under what conditions

The goal is to move from **theory to → tested intervention packages**.

4. Training the Next Generation
AAU's long-term influence comes through **training**:
Integrate EBF as a case study in:

- Social determinants of health
- Behavioral science
- Public health sociology

Train students in:

- DHS data analysis
- Mixed-methods research
- Program evaluation

Develop a cohort of graduates who understand:
How to translate data into actionable, context-sensitive interventions

5. Convening Policy Dialogue
AAU Sociology can act as a **neutral convening platform**:
Bring together:
- Ministry of Health
- Regional health bureaus
- NGOs and development partners

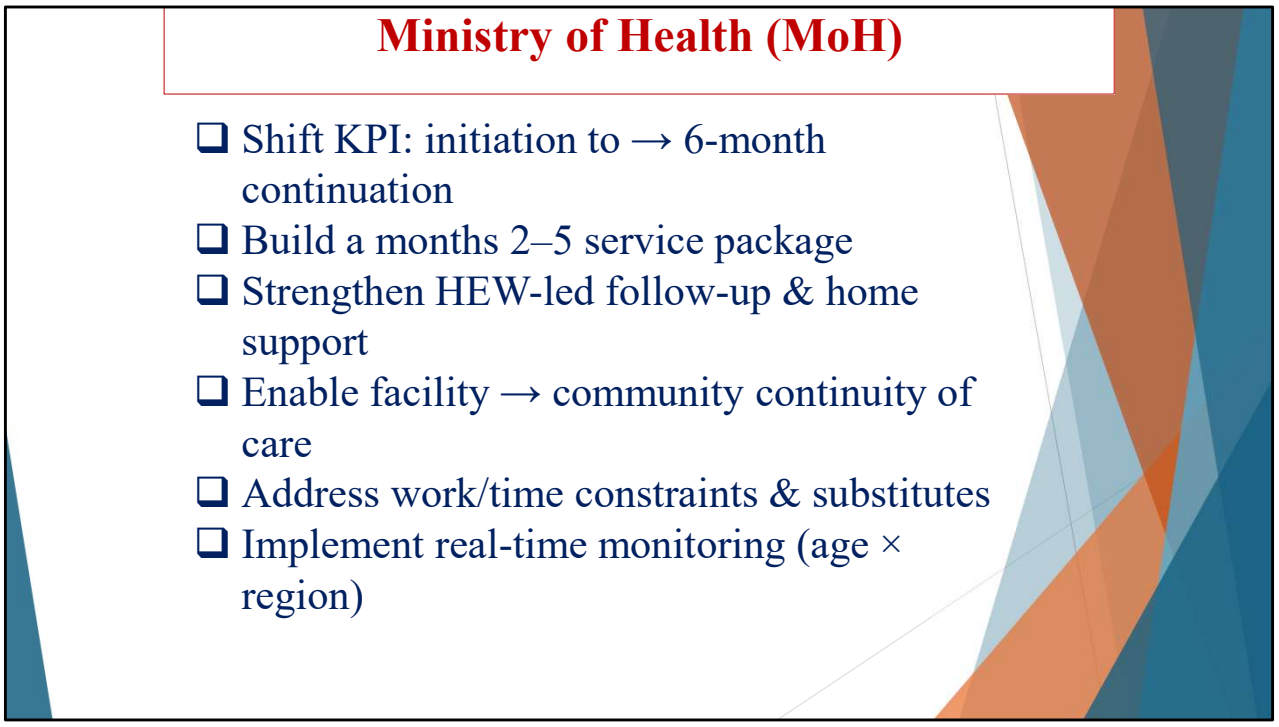
Facilitate translation of research into:
- Policy guidance
- Program design
- Implementation strategies

This helps bridge the persistent gap between **evidence and practice**.

6. Monitoring Progress Toward ≥70% EBF
Finally, AAU Sociology can support a national target:
Raising EBF to 70 percent or higher
This involves:
Establishing **monitoring frameworks**
Tracking:
- Age-specific EBF trends
- Regional performance

Providing an independent evaluation of program impact

In closing, AAU Sociology's role is not just to study breastfeeding—but to understand and reshape the social systems that determine whether exclusive breastfeeding is sustained.



The central directive is a programmatic pivot:
Reorient EBF policy from initiation metrics to sustained exclusivity through six months.

1. Shift the key performance indicator - KPI: From Initiation to Continuation
Current systems often emphasize:
Early initiation within 1 hour
Counseling at delivery
These remain important—but they are **insufficient**.
The MoH should adopt a **primary performance indicator** of:
EBF at 4–5 months and at 6 months, not just at birth or early weeks
This single shift will realign:
Supervision
Reporting
Incentives
Program focus
toward **where the losses actually occur**.

2. Build a "Months 2–5" Service Package
The data point to a clear intervention window.
MoH can formalize a **standardized continuation package**, including:
Scheduled **postnatal contacts at 1, 2, 3, and 4 months**
Focused counseling on:
- **Perceived milk insufficiency**
- Managing infant growth without supplementation

Practical guidance for:
- Feeding during maternal workload
- Expressing and storing breast milk (where feasible)

The key is **structured, repeated contact**, not one-time advice.

3. Strengthen Health Extension Worker (HEW) Follow-up
Ethiopia's **Health Extension Program** is a major asset.
The MoH can leverage it by:
Prioritizing **home-based follow-up visits in months 2–5**
Using HEWs to:
- Identify early signs of drop-off
- Provide corrective counseling
- Engage family members influencing feeding decisions

This shifts support **from facilities to households**, where behavior is actually determined.

4. Ensure Facility → Community Continuity of Care
One major gap is the drop in support after the immediate postnatal period.
MoH can institutionalize **handoffs**:
From **facility delivery** → to **HEW follow-up lists**
Ensure every newborn is **tracked and revisited** beyond the first weeks
This creates a **continuous care pathway**, rather than a front-loaded system.

5. Address Work, Time, and Substitution Pressures
Continuation fails not only because of knowledge gaps, but because of **practical constraints**.
MoH, in coordination with other sectors, can:
Promote **breastfeeding-friendly workplace practices**
Provide guidance on:
- Feeding schedules under workload constraints

Strengthen regulation and messaging around:

early introduction of water and breastmilk substitutes

The goal is to **make continued EBF feasible**, not just recommended.

6. Implement Real-Time Monitoring (Age × Region)

Monitoring systems should move beyond a single national average.
MoH should track:
EBF by infant age (0–5 months)
EBF by region
This allows:
Early identification of **where drop-off is occurring**
Targeted program adjustments
Accountability at regional and district levels

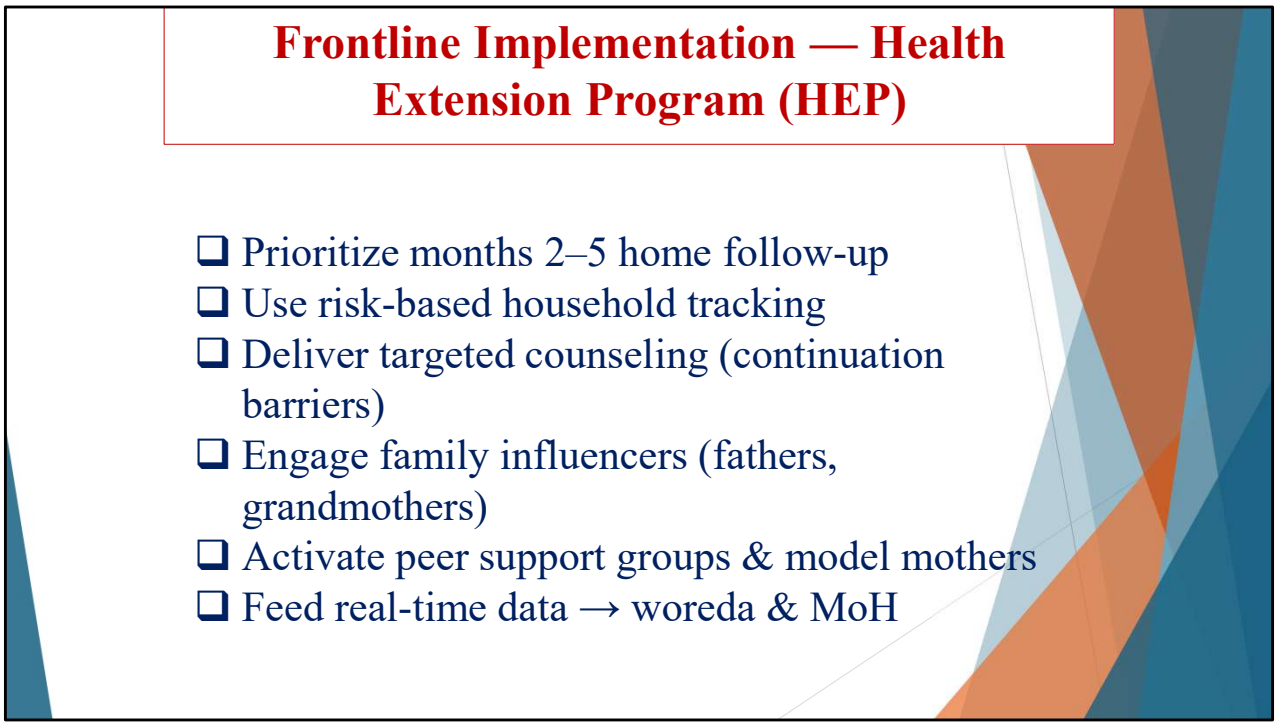
Closing Line for the Slide
The Ministry's role is to convert a high-initiation system into a high-continuation system—by building sustained support into routine service delivery.

When you're ready, we can develop the third institutional slide—ideally the **frontline system (Health Extension Program) or community platform**, to complete the ecosystem:
Academia (AAU) → MoH (delivery) → Community/HEW (implementation).
What does KPI stand for in "Shift KPI: initiation → 6-month continuation "
KPI stands for **Key Performance Indicator**.
In this context, it refers to the **specific metric the Ministry of Health uses to track program success**.
So when the slide says:
"Shift KPI: initiation → 6-month continuation"
it means:
Current focus (typical KPI):
% of infants who **start** breastfeeding (e.g., early initiation)
Proposed focus (new KPI):
% of infants who are **still exclusively breastfed at 4–5 months or at 6 months**

Why this matters
A KPI is not just a measurement—it **drives behavior in the system**:
What gets **measured** gets **managed**

What gets **reported** gets **prioritized**
What gets **rewarded** gets **done**
So shifting the KPI:
Moves attention from **starting breastfeeding**
To **sustaining exclusive breastfeeding over time**

Plain-language alternative (if you prefer for the slide)
If "KPI" feels too technical for your audience, you could say:
"Shift program focus: from starting breastfeeding → to sustaining it through six months"
or
"Measure success by continuation, not just initiation"



This slide focuses on the **Health Extension Program as the frontline delivery platform**—the point where policy becomes **actual behavior change**.
If the Ministry sets direction, the Health Extension Program ensures that:
Mothers receive sustained, practical support in the settings where feeding decisions are made—at home and within the community.

1. Prioritize Months 2–5 Through Home Follow-Up
The evidence is clear: the sharpest decline in exclusive breastfeeding occurs between **months two and five**.
So, the Health Extension Program should:
Move beyond early postnatal visits
Institutionalize **scheduled home visits during months 2, 3, 4, and 5**
This is the **critical window** where continuation either holds—or breaks down.
The emphasis shifts from:
“Did breastfeeding start?”
to
“Is exclusive breastfeeding still being maintained?”

2. Implement Risk-Based Household Tracking

Not all households face the same risks of early drop-off.

Health Extension Workers (HEWs) can use simple criteria to identify:

Mothers returning to work early

Households where:

- Water or other liquids are introduced early
- Family members influence feeding decisions

Infants showing signs of:

- Growth concerns
- Feeding difficulties

These households can be flagged for:

More frequent follow-up and targeted support

This ensures efficient use of limited frontline capacity.

3. Deliver Targeted Counseling on Continuation Barriers

At this stage, counseling must go beyond general messages.

HEWs should focus on **specific, common barriers**, including:

Perceived milk insufficiency ("the baby is still hungry")

Managing breastfeeding alongside **maternal workload**

Addressing beliefs around:

- Water supplementation
- Early complementary feeding

The goal is:

Problem-solving, not just messaging

Each visit should help mothers **navigate real-life constraints**.

4. Engage Family Influencers

Breastfeeding decisions are rarely made by the mother alone.

Key influencers include:

Grandmothers and elder women

Fathers

Other household members

HEWs should:

Include these individuals in counseling sessions

Address their concerns directly

Align household support with recommended practices

This is essential because:

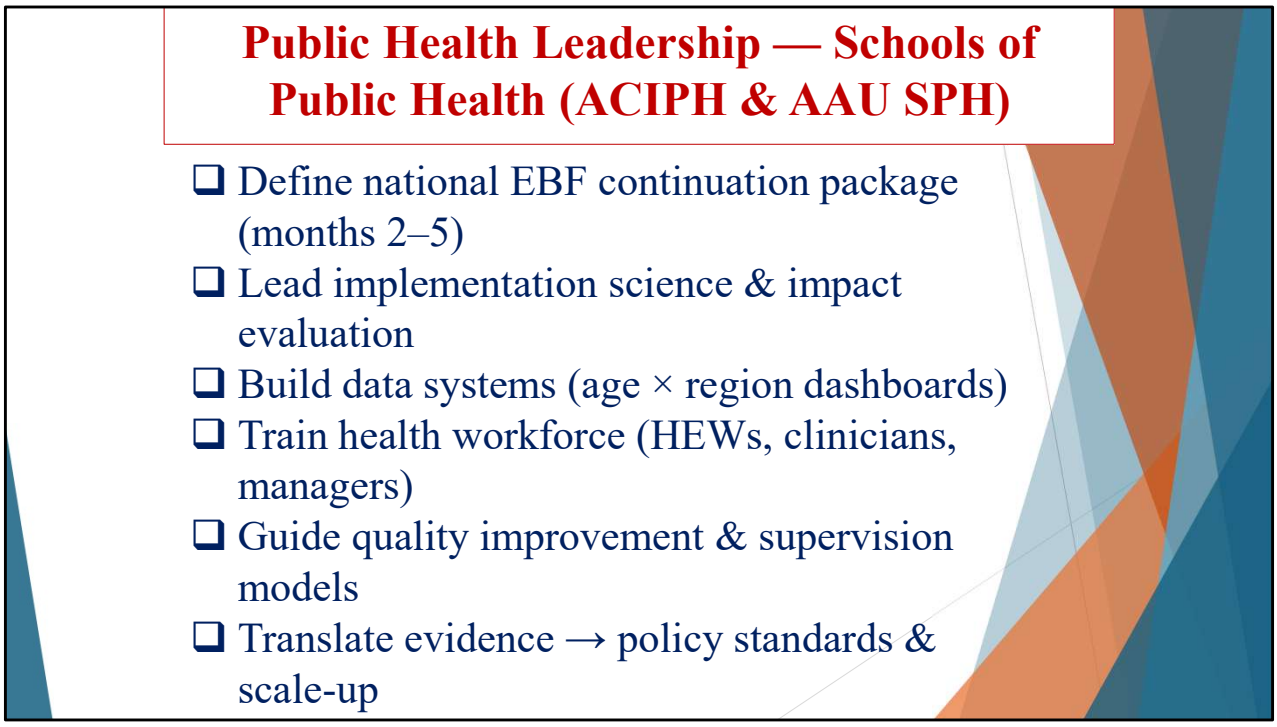
Norms and advice within the household can either reinforce or undermine exclusive breastfeeding.

5. Activate Peer Support and Model Mothers
Community-based reinforcement is critical.
The program can leverage:
Mother-to-mother support groups
Model mothers who successfully maintain EBF
These platforms:
Normalize sustained breastfeeding
Provide practical, experience-based advice
Reduce isolation and uncertainty among new mothers
This shifts support from **one-to-one counseling → to community reinforcement**.

6. Feed Real-Time Data Back into the System
Finally, the Health Extension Program plays a key role in **data generation and feedback**.
HEWs can:
Track EBF status by infant age during visits
Report simple indicators:
- EBF at 2 months
- EBF at 4–5 months

This information can be aggregated at:
Woreda level
Regional level
National level
Creating a **real-time picture of continuation performance**, not just national averages.

In closing, the Health Extension Program's role is to make exclusive breastfeeding sustainable—by supporting mothers where behavior is shaped: in households, over time, and within communities.



This slide positions the two schools of public health— the Addis Continental Institute of Public Health and the Addis Ababa University School of Public Health—as the **bridge between evidence and national scale**.
If Sociology helps us understand behavior, and the Ministry and Health Extension Program deliver services, then the Schools of Public Health ensure that:
What is delivered actually works—reliably, efficiently, and at scale.

The two institutions will:

1. Define the National "Continuation Package" (Months 2–5)
The first role is to **formalize what the system should deliver** during the critical drop-off period.
This includes designing a standardized, evidence-based package:
Timing and content of **follow-up contacts (1–5 months)**
Structured counseling protocols addressing:
- Perceived milk insufficiency
- Early supplementation pressures

Practical guidance for:
- Breastfeeding under workload constraints

Household engagement

The goal is to move from:

General recommendations to→ **Operational protocols that can be implemented nationwide**

2. Lead Implementation Science and Impact Evaluation

The two institutions are uniquely positioned to answer:

What works, for whom, and under what conditions?

They can:

Design and test **pilot interventions** across diverse regions

Compare different delivery models:

HEW-led home visits

Group-based counseling

Facility-linked follow-up systems

Use rigorous methods:

Quasi-experimental designs

Randomized trials where feasible

This ensures that scale-up is based on:

Evidence of effectiveness—not assumptions

3. Build Data Systems (Age × Region Monitoring)

A major gap identified in this analysis is the reliance on **aggregate indicators**.

Schools of Public Health can support the MoH in developing:

Routine monitoring systems that track:

EBF by infant age (0–5 months)

EBF by region and woreda

Simple dashboards that allow:

Early detection of drop-off

Targeted response

This transforms monitoring from:

Static reporting to → **Dynamic program management**

4. Train the Health Workforce

Sustained improvement requires **capacity building at multiple levels**:

Health Extension Workers (HEWs):

Practical counseling skills

Identifying and addressing continuation barriers

Facility staff:

Continuity of care from delivery to community follow-up

Program managers:

- Using data for decision-making
- Supervising continuation-focused programs

Training should emphasize:

Behavioral problem-solving, not just technical knowledge

5. Guide Quality Improvement and Supervision

Schools of Public Health can design and institutionalize:

Quality improvement (QI) cycles:

- Identify drop-off points
- Test small changes
- Scale what works

Supportive supervision tools that focus on:

- Continuation metrics
- Counseling quality
- Follow-up coverage

This ensures that programs **improve continuously**, not just operate.

6. Translate Evidence into Policy and Scale-Up

Finally, these institutions play a critical translation role:

Convert research findings into:

- **National guidelines**
- Training curricula
- Standard operating procedures

Support the Ministry in:

- Scaling proven interventions
- Avoiding ineffective approaches

In this sense, they ensure that:

Innovation becomes institutionalized practice

In closing, the two Schools of Public Health ensure that Ethiopia not only promotes exclusive breastfeeding but also systematically learns how to sustain it and then scales what works.