YOUTH REPRODUCTIVE HEALTH IN ETHIOPIA

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Pav Govindasamy, Ph.D.
ORC Macro
Calverton, Maryland, USA

Aklilu Kidanu, Ph.D.
Hailom Bantayerga, Ph.D.
Miz-Hasab Research Center
Addis Ababa, Ethiopia

November 2002

ORC Macro

MEASURE DHS+

Miz-Hasab
Research Center

This report is based on an in-depth analysis of the 2000 Ethiopia Demographic and Health Survey (DHS). Funding for this study comes from the David and Lucile Packard Foundation.

The authors wish to thank Dr. Girma Wolde Michael of Zone 5 Health Office in Addis Ababa, Ethiopia, for help with the literature review; Dr. Kristin Nelson Mmari of the Division of General Pediatrics and Adolescent Health, University of Minnesota, for review of this report; Albert Themme of ORC Macro and Kefene Asfaw of the Central Statistical Authority of Ethiopia, for data processing help; Noah Bartlett and Katherine Senzee of ORC Macro for word processing assistance and creativity in the design and layout of the report; and Dr. Sidney Moore of ORC Macro for editing the report.

Additional information on this report and the 2000 Ethiopia DHS survey may be obtained from ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 (telephone: 301-572-0200; fax: 301-572-0999; email: reports@macroint.com; internet: www.measuredhs.com).

Suggested citation:

Govindasamy, Pav, Aklilu Kidanu and Hailom Banteyerga. 2002. *Youth Reproductive Health in Ethiopia*. Calverton, Maryland: ORC Macro.

Cover photos: Hailom Banteyerga

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FOREWORD

Young people constitute one-third of the total population in Ethiopia. Their number is expected to grow from 20.3 million in 2000 to 25 million in 2010. The reproductive health problems of young people in Ethiopia are multifaceted and interrelated. Childbearing begins at an early age: 45 percent of the total births in the country occur among adolescent girls and young women. Sexual violence and commercial sex work have become common phenomena among young girls. As a result, they have become primary victims of the HIV/AIDS crisis that has spread throughout the country. In general, young people are at high risk for reproductive health problems. The situation is aggravated by the overall poor socioeconomic environment and harmful traditional practices. Because of the complex nature of the problems, youth reproductive health strategies demand a multisectoral and integrated approach.

Young people have limited access to reproductive health services that focus on the special needs of adolescents. Inadequate knowledge about adolescent sexual behavior, cultural influences, and the limited capacity of implementers hinder the provision of reproductive health education and services to young people. It is therefore essential to have data on the extent of adolescent sexual activity and contraceptive use, pregnancy rates, and other reproductive health issues in order to have a clear understanding of the situation.

The David and Lucile Packard Foundation sponsored a national conference on adolescent reproductive health (ARH) services in November 2000. The aim of this conference was to have a common understanding of the ARH issues in Ethiopia and to identify priorities and areas of focus for action. Since then, the Foundation has allocated a significant proportion of its funds for improving the reproductive health situation of adolescents in the country. Today, with the support of the Foundation, more than half a million young Ethiopians have access to appropriate reproductive health information and services throughout the country; over 80 youth clubs address the reproductive health needs of youths; Marie Stopes International and the Family Guidance Association of Ethiopia provide youth-friendly services in 11 youth-friendly clinics and educational centers. Save the Children USA operates a school-based reproductive health program in all the 27 government high schools of Addis Ababa. Because of its success, the program has become a model for the government's effort to introduce family life education programs in the country's school system.

Our support for the youth is not limited to reproductive health only. In the towns of Jimma and Kombolcha, we helped establish youth vocational and employment creation centers through OIC International; Lem Ethiopia provides integrated environment protection and reproductive health education in 10 high schools and the surrounding communities of Oromia and Amhara regions. We hope to establish a pilot Youth Development Fund in the next few months.

It is within this context that the Foundation has funded this in-depth analysis of the 2000 Ethiopia Demographic and Health Survey (DHS) data relating to adolescents and young adults. The objective of this analysis is to develop a comprehensive report on the fertility, family planning, and health behavior of adolescent and young adults in Ethiopia. We believe that this study will provide valuable information on what kinds of services are needed and where, so that appropriate programs can be developed to respond to these needs.

We are happy that the report of the analysis is now ready. We would like to extend our gratitude to ORC Macro and the Miz-Hasab Research Center for the quality and timeliness of the report.

Sahlu Haile
Senior Program Advisor, Population

SUMMARY OF FINDINGS

This report is based on an in-depth analysis of 6,570 women and 1,008 men age 15-24 interviewed in the 2000 Ethiopia Demographic and Health Survey (DHS). These youth are a subgroup of a nationally representative sample of 15,367 women age 15-49 and 2,607 men age 15-59 interviewed between February and May 2000.

Ethiopian youth are confronted with many challenges. The majority live in rural areas. Their level of education is generally low and a substantial proportion of school-age youth are employed in low-paying jobs. Young women are less educated than men and less likely to be employed. Young women and men in Ethiopia have very limited exposure to the mass media.

Sexual Experience and Exposure

Early initiation of sex poses health risks for both young women and men. Sexual experience begins early in Ethiopian society. One in two young women are sexually experienced, that is, they have had sex at some time compared with one in three young men. The median age at which women age 25-49 first had sexual intercourse is 16. Three in ten women in this age group have had sex by age 15, two in three by age 18, and more than 80 percent by age 20. On the other hand, men initiate sex an average of four years later than women. Although young women initiate sex at an earlier age than young men, sexual experience for most women is in the context of marriage, in contrast to men who initiate sex before marriage. More than two-thirds of young women are sexually active, that is, they have had sex in the month preceding the interview, compared with two-fifths of young men.

The practice of female genital cutting (FGC) is widespread in the country and more than seven in ten young women have been circumcised. Although there has been a decline in FGC over the years, with the percentage of women circumcised declining with age, there continues to be widespread support for this harmful practice.

Knowledge and Use of Family Planning

A sizeable proportion of young Ethiopians know about family planning, with knowledge of modern methods of family planning substantially higher than knowledge of traditional methods among both women and men. However, most sexually experienced young women and men in Ethiopia do not use contraceptives. Men are more likely to report current use of a method than women. Unmarried sexually experienced young women and men report higher levels of contraceptive use than their married counterparts. Young adults have a clear preference for modern contraceptive methods.

Despite the shift toward use of contraception among the young, nearly one-third of women age 15-24 have an unmet need for family planning. Not surprisingly, a greater proportion of young women want to space rather than limit the number of children that they have. Health providers do not take adequate advantage of contact

with young nonusers to discuss family planning.

Fertility and Childbearing

Ethiopia is characterized by rapid population growth, a direct result of high fertility levels. As a result, most of the population is young—under 25 years of age. Childbearing begins at an early age. Among teenage women, 13 percent have given birth to at least one child, and among women in their early twenties, more than one-third have two or more children. Teenage pregnancy and childbearing increases from 1 percent among women age 15 to 40 percent among women age 19.

A sizeable proportion of births to young women are reported as unintended. More than half of all births to women under age 15, and more than one in three births to women age 15-19 and 20-24 are unintended at the time of birth. These results underscore the importance of addressing the unmet need for family planning of young adults, and providing them with access to basic reproductive health information that will enable them to take control of reproductive health decisions.

Maternal and Child Health

Young women are more vulnerable to pregnancy complications because of their physiological immaturity. In addition, their inexperience with childcare practices influences maternal and child health. The majority (> 70 percent) of young mothers in Ethiopia do not receive antenatal care during pregnancy. A small percentage (7 percent) receive delivery assistance from a health professional, but only 6 percent of births to young mothers take place in a health facility. Less than one in ten mothers receive a postnatal checkup from a medical professional in the first two days after delivery.

Ethiopia has some of the highest rates of infant and child mortality in the world. The data show that children born to mothers in their teens have a substantially greater risk of dying young. On the other hand, children born to young mothers are slightly better off in terms of nutritional status than children of older mothers.

Knowledge of HIV/AIDS

Ethiopia has one of the highest levels of HIV/AIDS prevalence in sub-Saharan Africa. DHS data show that most young Ethiopians have heard of AIDS, with men somewhat more likely than women to have heard of the infection. More than four in five young women and nine in ten young men age 15-24 know about AIDS. Community meetings are the most important source of information on HIV/AIDS. Although AIDS awareness is relatively high among youth in Ethiopia, nearly a third of young women and a sixth of young men do not know a specific way to avoid contracting the infection.

Young women are more vulnerable to HIV/AIDS infection than young men for a number of social, cultural, and biological reasons. Using condoms has proven effective in preventing the transmission of HIV/AIDS. However, less than 2 percent of women age 15-24 who were sexu-

ally active in the year before the survey, used a condom during their last sexual intercourse. Condom use among men is much higher: one in five sexually active men age 15-24 used a condom at last intercourse. Condom use is also higher with a noncohabiting partner than a cohabiting partner. Knowledge of and access to condoms is especially low among women age 15-19, young never-married women, women who are not sexually active, and uneducated women.

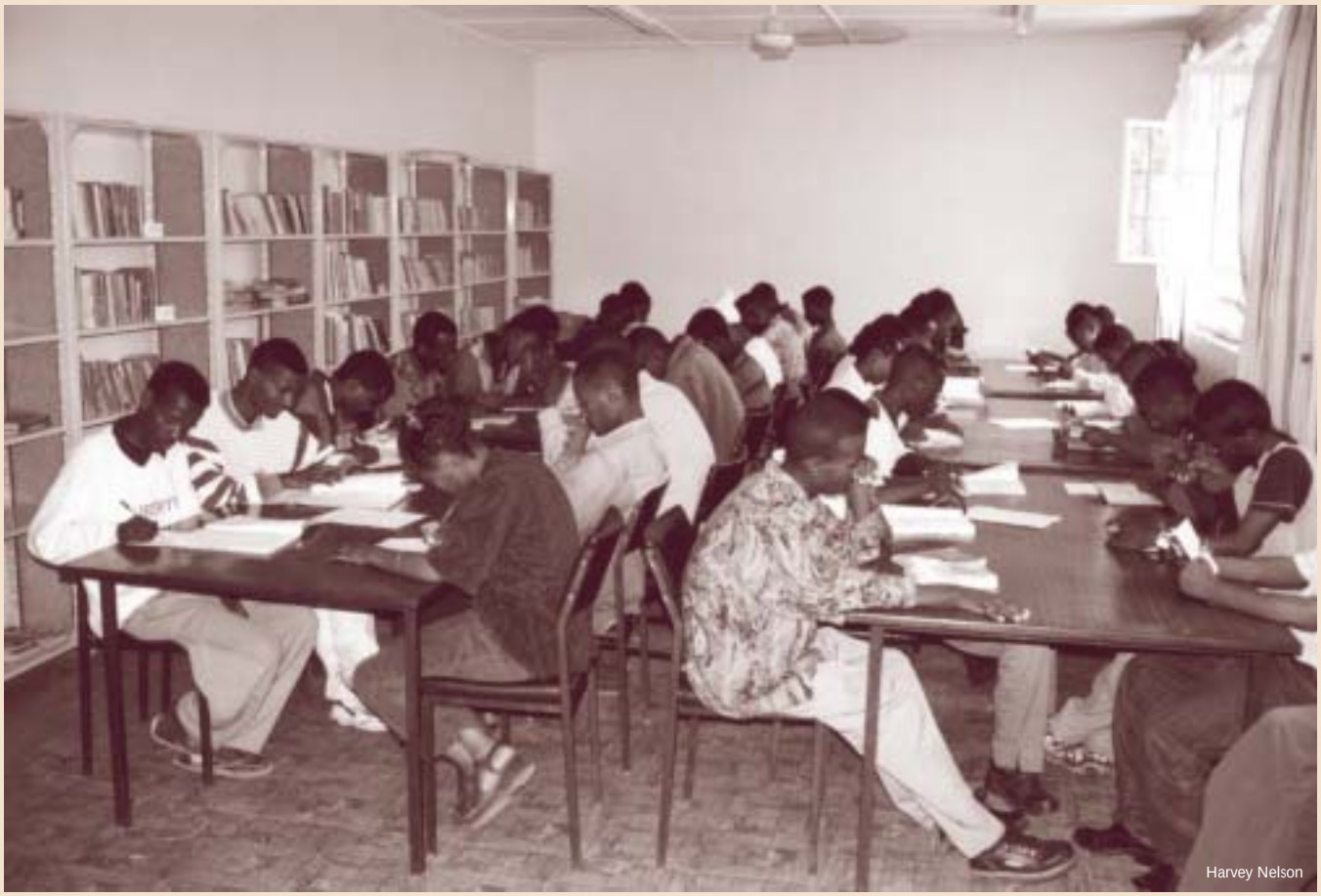
Two in three men age 15-24 who have heard of AIDS want to be tested for the infection. Men in their teens are only slightly less likely to want voluntary counseling and testing (VCT) than men in their early twenties. Sexually transmitted infections (STIs) are an additional risk to young Ethiopians. DHS data show that more than half of women age 15-19 and two in five women age 20-24 have no knowledge of STIs. At the same time, two-fifths of men age 15-19 and one-quarter of men in their early twenties (20-24) have no knowledge of STIs.

Programmatic Implications

Focused policies and programs employing a multisectoral approach are essential if the existing adverse situation faced by young adults is to be reversed. Health programs should be geared toward educating health care providers to be more sensitive to the special needs of youth. Targeted family planning services can prevent high-risk and unwanted pregnancies and reduce maternal and childhood morbidity and mortality. Increased access to information about family planning and improved contraceptive services for young women at risk could facilitate improvements in coverage, quality, and effectiveness of maternity care services.

Education programs should be relevant to the needs of today's youth. They must be well thought out and well designed to be effective in addressing the social, economic, and cultural problems of the targeted groups. Young Ethiopian women are especially at disadvantage. Education is essential to empower women with decisionmaking capability. Much improvement is needed in educating youth about HIV/AIDS and other STIs. Since community meetings are important forums for youth education, this avenue needs to be exploited to the fullest. Programs to address youth reproductive health need to provide alternatives for young people who drop out of school at an early age. Besides taking measures to encourage young people to stay in school until the completion of their studies, education should also emphasize vocational training.

Chapter 1
Youth Reproductive Health: An Overview



Introduction

Ethiopia is the third largest country in sub-Saharan Africa with a total area of 1,104,000 square kilometers. It is also one of the most populous countries in that region. Ethiopia has a population of 68 million, an annual growth rate of 3 percent, and a population density of 159 persons per square mile (PRB 2002).

The combination of rapid population growth and low per capita income (only US$660 in 2000) typify the country's extreme level of poverty (PRB, 2002). Forty-five percent of the population lives in poverty with 47 percent of the rural population and 33 percent of the urban population falling below the poverty line (MEDAC, 1999).

The country is characterized by an expanding, largely rural, youth population. It is estimated that young people age 10-24 constitute more than a third of the population, roughly 21 million (MOH, 2002a). The economic, political, and social situation in Ethiopia has seriously affected this group. Access to education and health services remains limited, particularly for young rural women and men, and unemployment is a problem, particularly among young people living in urban areas. According to the Ministry of Labor and Social Affairs (MOLSA), 87 percent of all registered job seekers are between the ages of 15 and 29 (MOLSA, 1997). Among registered job seekers only 5 percent reported

Adolescent, Youth, Young Adult?

This report focuses on women and men age 15-24. For the most part they have been referred to as young adults or youth. The term 'youth' or 'young adult' is often used to refer to women and men age 10-24, however, since the 2000 Ethiopia DHS did not collect information at the individual level from those age 10-14, this group has been left out of the analysis. The term 'adolescent' usually refers to women and men age 10-19. The onset of puberty generally marks the entry into the period of adolescence. While there is general agreement on the transition from childhood to adolescence, the question of when adolescence ends and adulthood begins is less clear. This is because the period of adolescence is culture specific and quite different between and within societies. In some cultures, the transition from adolescence to adulthood is very short. This is usually the case in most developing countries where school attendance among the young is relatively low and children leave school early to find some kind of employment to support the family and take on adult responsibilities. Moreover, in societies where young girls are married upon attaining puberty (often to preserve their chastity), and become mothers soon after, adolescence is practically nonexistent. An added burden in most poor societies is the low level of employment, and this has contributed to the extremely vulnerable situation of young adults.

that they were able to get jobs. Youth migrate from rural to urban areas looking for jobs. Young women are increasingly employed in menial jobs and may work as housemaids, cleaners, or commercial sex workers. Young men often end up as day laborers and become exposed to and engage in various types of risk behavior including unsafe sex and use of alcohol and drugs.

Problems Faced by Youth

Traditional practices and poor living conditions often lead young people to engage in sex at an early age. In a survey conducted among high school students in Addis Ababa, 38 percent reported that they were sexually active (Gebre, 1990). Of these sexually active students, 71 percent experienced first sex between the ages of 14 and 16. Similar situations have been observed in other Ethiopian cities: 58 percent of students from the Gondar Medical School (Kidan and Azeze, 1995), 55 percent of 18- and 19-year-old youth from Harar (Korra and Haile, 1999), and 32 percent of unmarried youth in Jimma were reported to be sexually active (FGAE, 1998).

Harmful traditional practices such as early marriage, female genital cutting (FGC), and marriage by abduction affect the health of young women. Early marriage is one of the cultural traditions that expose young women to reproductive health problems. The 1990 National Family and Fertility Survey revealed that 34 percent of women were married before age 15 (CSA, 1993). FGC is widely practiced in Ethiopia (NCPTE, 1998). Marriage by abduction is also widely practiced: at the national level, 69 percent of respondents reported knowing that marriage by abduction took place in their area (NCPTE, 1998).

Rape is a common occurrence among young women in both urban and rural areas. In a study conducted among adolescents from six peri-urban centers in Ethiopia, 9 percent of sexually active young women and 6 percent of sexually active young men reported having been raped; 74 percent of women reported sexual harassment (OSSA and DSW, 1999).

The reproductive health situation of youth is a major concern. The prevalence of sexually transmitted diseases (STDs) like HIV/AIDS is relatively high among young people in Ethiopia. According to the HIV sentinel surveillance of mothers seeking antenatal care, HIV/AIDS prevalence is 11 percent among women age 15-19 and 15 percent among those age 20-24 (MOH, 2000a).

The two major risk factors for the spread of STDs among youth in Ethiopia are the practice of having multiple sexual partners and the limited use of condoms (MOH, 1998; MOH, 2000a). A study conducted in high schools in Addis Ababa indicated that 54 percent of sexually active youth have experienced sex with more than one partner; 43 percent of sexually active students reported knowing

about condoms at the time of their first sexual experience, but only 18 percent said they had ever used condoms (Eshetu et al., 1997).

Unintended pregnancy is a serious problem among teenagers, especially since teenage pregnancy is associated with health risks to the mother during pregnancy and delivery. Several studies in Ethiopia have documented the prevalence of unintended pregnancies among young women. A household study of adolescents in Addis Ababa found that the median age at first pregnancy was 16 years with two in three women becoming mothers before the age of 20. Of the 957 female respondents, 50 percent had been pregnant in the past and 74 percent of these pregnancies resulted in abortions (Tadesse et al., 1996). In a survey of adolescents conducted in Awassa, Nazareth, and Addis Ababa, 64 percent of the respondents knew of a girl whose schooling was interrupted due to an unwanted pregnancy (Mekonnen and Alemu, 1995).

Abortion, which is illegal in Ethiopia, places many young women at risk, primarily because it is usually conducted under unsafe conditions. However, actual data on the prevalence of illegal abortion is difficult to collect. To date, the most comprehensive study on abortion in Ethiopia was conducted in 1993. The study collected data from 5 hospitals in Addis Ababa during a period of six months. Findings revealed that there were a total of 1,603 induced abortion cases, of which 15 percent occurred among women under the age of 15; 31 percent occurred among women age 16-20; and 62 percent occurred among women 16-25. Forty-five percent of the abortions were among single women, and 42 percent were among women with only a primary school education or less (Yoseph, 1993). A three-year retrospective study on abortion was conducted in Jimma Hospital (southwestern Ethiopia) between 1989 and 1992 (Abdella, 1996). During this period there were a total of 1,540 abortions. The mean age of patients was 24.4 years; the youngest patient was 13. Fifty-four percent of the cases were under age 25, with 23 percent age 13-19 and 31 percent age 20-24. Fifteen of the abortion-related deaths (54 percent) were to women under 25 years of age.

Lack of family support and limited educational opportunities have led many youth to turn to life on the streets. Currently, there are about 100,000 street children in the country, with 40,000 in Addis Ababa alone. The majority are boys between 14 and 17 (CYAO, 1995). Both boys and girls face a difficult and violent life. In-depth discussions with 32 of the young girls living on the streets indicated that 12 had been raped, 9 others were sexually attacked, 21 were beaten, all of them were robbed, and 7 had had at least one pregnancy. The major problems faced by the boys were frequent beatings and theft. Addiction was a problem among both groups, and included chewing *chat* (leaves from a locally grown plant), sniffing benzene, and consuming alcohol and hashish (the latter mostly among older teens) (MOLSA, 1993).

Many young women are forced to practice sex for money. It is difficult to estimate the number of commercial sex workers, but it is believed to be in the thousands. Most of the prostitutes are quite young. A study on child prostitution in Addis Ababa showed that most prostitutes are migrants (66 percent) and most are under 18 years of age; the mean age is 15 years (Baardson, 1993). Young prostitutes are exposed to many types of violence. A study, conducted in Addis Ababa among commercial sex workers age 9-18 years found that 82 percent of these girls had their first sexual contact before age 16, and 50 percent of these contacts had been coerced, including rape. Financial need was cited by 85 percent of respondents as the reason for resorting to prostitution (Fisseha, 1997). Another study estimated that 35,000 females (about 7 percent of all adult females) in Addis Ababa practice multipartner sexual contact (Mehret et al., 1990b). The consequences of childhood prostitution include health problems resulting from physical abuse, early and unwanted pregnancy, STDs, HIV/AIDS, and abortion, as well as psychological problems, low self-esteem, hopelessness, and stigma. A study of sex workers in urban areas found that 21 percent of 15- to 19-year-olds and 19 percent of 20- to 24-year-olds are infected with the HIV virus. This study also found that in Addis Ababa, sex workers age 15-24 had an HIV prevalence rate of 37 percent, the highest of any age group. According to Fisseha (1997), only 27 percent of commercial sex workers use condoms regularly.

Drug trafficking and drug abuse, although not a problem in the past, are becoming more common in Ethiopia. According to the MOH Department of Pharmacy report for 1993-94, of the 291 drug abusers and traffickers for which age was reported, 223 (77 percent) were age 15-25 (CYAO, 1995). The majority of these young people were students or unemployed youth. Chewing *chat* has become a major problem among youth. It is exacerbated by lack of employment opportunities and general feelings of hopelessness.

Addressing Youth Problems

Ethiopian youth face a multitude of problems caused by poverty, traditional beliefs, and misconceptions. As an age group, their material, social, health and reproductive needs have not been given the required attention. Government policies and programs so far have tried to address the needs of youth along with those of the general population. However, there is now greater recognition among government leaders that youth have special needs that require different policies and program efforts. The rest of this chapter explains what government and non-government organizations are doing to meet the health, education, employment, and reproductive health needs of Ethiopian youth.

Education Needs

The government education policy addresses the education needs of young people by making education purposeful and relevant to employment and the economic realities of the country (TGE, 1994b). It aims to make education accessible, relevant, and equitable. According to the Education Sector Strategy (TGE, 1994a) three major areas are emphasized:

- Curriculum change in line with the new educational objectives that make education more relevant to the demands of the community;
- Improvement in the quality of education throughout the system;
- Expansion of primary and vocational education to be more attuned to the actual situation in the country and demands of the economy, and to maintain some degree of equity and sustainability.

Efforts to make at least primary education accessible to all children by the year 2015 will have a considerable impact on the youth population. However, educational opportunities for adolescents are still limited. According to the Ministry of Education (MOE), the gross enrollment ratio (GER) for secondary schools is 13 percent, 15 percent for males and 11 percent for females (MOE, 2001).

The MOE began implementing the revised curriculum and syllabus for secondary education in 2001 to prepare most youth for vocational training. This was based on the belief that young people who finish high school should have marketable skills. Primary education was also integrated into community life, to prepare dropouts to carry out locally available work. It is believed that this will make education purposeful and relevant to the needs of the community.

To address the negative effects of unemployment on the life of young people, especially in the rural areas, the government is promoting expansion of the agricultural sector to increase the employment opportunities for rural youth and to minimize rural-urban migration (TGE, 1991).

A separate ministry, the Ministry of Youth and Sports, was set up in 2002 to address the needs of youth. The ministry has been working to organize the recreational needs of youth, especially sports. It is also in the process of organizing a national workshop to identify the needs and problems of youth with the aim of formulating a youth policy.

Health Needs

Access to basic health services is an important factor that affects the quality of life. About 49 percent of the population in Ethiopia is estimated to have access to health services (MOH, 2002a). The present health policy aims to make basic health services accessible to all by expanding health facilities, training more health professionals, and involving the private sector (TGE, 1993a). It also emphasizes the need to expand family health services through:

- Making maternal health care and referral facilities available for high-risk pregnancies;
- Promoting family planning for the optimal health of the mother, child and family;
- Teaching principles of appropriate maternal nutrition; promoting breastfeeding; and advocating home preparation of weaning foods, and the availability of weaning foods at affordable prices;
- Expanding and strengthening immunization services and optimizing access and early utilization of available health care facilities for the management of common childhood diseases, particularly diarrheal diseases and acute respiratory infections;
- Addressing the special health problems and related needs of adolescents;
- Encouraging paternal involvement in family health;
- Identifying and discouraging harmful traditional practices.

The Ministry of Health began working toward a policy to address adolescent reproductive health needs in 1996. It directed the formation of a national adolescent reproductive health steering committee, instituted training on adolescent reproductive health management for health care providers, developed and distributed IEC materials, and conducted and participated in ARH workshops. It has produced a report entitled *Five-Year Action Plan for Adolescent Reproductive Health in Ethiopia*. The document describes the reproductive health problems of youth and identifies HIV/AIDS infection, abortion and its health complications, early marriage and motherhood, and high-risk pregnancies as critical ARH issues. The following ARH strategies are outlined in the document:

- Promotion of a positive policy and program environment;
- Provision of knowledge and skills; and
- Provision of quality reproductive health services for adolescents/youth.

The government of Ethiopia is taking measures to curb the spread of HIV/AIDS. It has issued a policy on HIV/AIDS that focuses on youth (FDRE, 1998). The National AIDS Council was formed composed of members of ministries, NGOs, distinguished individuals and religious leaders, and chaired by the head of state. The council has been reviewing and providing directives on the steps that need to

be taken to control the spread of the HIV/AIDS epidemic. An HIV/AIDS secretariat has also been formed with branches at the wereda level. The HIV/AIDS secretariat in collaboration with NGOs and other organizations has implemented educational programs that include providing care and support for people living with HIV/AIDS (PLHA), forming and strengthening anti-HIV/AIDS clubs that work on HIV/AIDS education and prevention in kebeles, and supporting HIV/AIDS research. It aims to raise awareness about HIV/AIDS transmission and to promote prevention and care services for PLHA in the target communities. It focuses on youth as the most vulnerable group and the group most in need of protection against HIV/AIDS infection.

The National Population Policy was initiated by the government to address the problems associated with rapid population growth (TGE, 1993b). The policy focuses on expanding family planning services and improving the quality of life of the people. It aims to increase the minimum age at first marriage from 15 to 18. It also aims to expand family planning information by offering counseling services in schools, encouraging youth groups to actively participate in population activities, and promoting family education by including population topics in the curricula of high school students.

The other policy that has a far-reaching impact on young women is the Women's Policy issued in 1993 (TGE, 1993c). It aims to protect women from various types of oppression such as denying women access to health services, employment, and education; and to protect their right to own property and to participate in political activities. It also aims to protect women from harmful traditional practices such as FGC, rape, abduction, and forced early marriage. A department for women's affairs has been established in the office of the Prime Minister to address women's needs and rights. The Department has been effective in bringing the problems and agendas of women to the forefront. The Ethiopian Women's Lawyers Association (EWLA) was formed, and is now active in advocating women's cases by organizing workshops and seminars and by using the media to disseminate information on women issues.

Intervention Programs

Adolescent reproductive health is drawing attention from NGOs operating in Ethiopia and a number of intervention programs have been implemented:

- The David and Lucile Packard Foundation sponsored a National Workshop on Adolescent Reproductive Health in Bahir Dar in December 2000, and is supporting several ARH programs in the country. The workshop held at Bahir Dar involved youth in addition to government and non-government representatives and resource people. The workshop discussed problems faced by youth: unemployment; the absence of an open and frank dialogue between youth

and their family; the absence of effective counseling, education, and information services on the subject of reproductive health; increased use of drugs and *chat;* inadequate and poor media coverage of adolescent reproductive health issues; problems related to harmful cultural practices, particularly those coming from abroad such as drug use and pornography films; failure to recognize rural youth's sexual needs and reproductive health problems; the absence of continuous support to clubs created with the support of youth or donor agencies; failure to implement population, health, and educational policies (Kidanu and Fekade, 2001).

- In recognition of the problems faced by youth, the Ethiopia Public Health Association at its annual conference included a panel discussion on ARH issues.
- Save the Children (USA), after conducting a baseline survey on ARH, has started a program that focuses on providing information and contraceptives to ARH clubs.
- The Family Guidance Association of Ethiopia (FGAE) has established a comprehensive program that covers both in-school and out-of school youth. The program focuses on providing clinical services, counseling information and recreation activities.
- The Organization for Social Services for AIDS (OSSA) runs school-based reproductive health clubs emphasizing the prevention of HIV/AIDS.
- Marie Stopes International offers programs that address ARH issues by distributing contraceptive methods and educating youth about sexual behavior.
- The Good Samaritan has established a rape crisis center in Wereda 8 of Addis Ababa to combat the physical and psychological problems faced by rape victims.

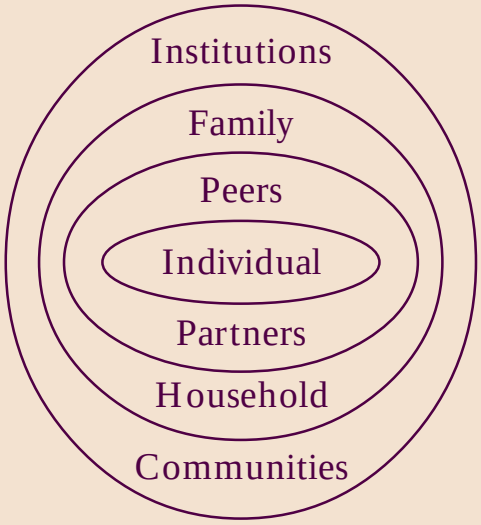
These are some attempts being made now to address youth ARH needs. The existing ARH programs, however, have some drawbacks:

- NGOs run their ARH programs using less qualified peer educators, peer promoters, peer service providers, and community-based reproductive health agents.
- Existing ARH programs suffer from a lack of clear policy guidelines; limited service coverage; widespread poverty and unemployment; limitation of resources; non-commitment from public offices; poor sustainability of donor funding; shortage of essential drugs and diagonistics; lack of appropriate IEC materials; negative attitudes of parents and communities; lack of facilities—office rooms, halls, recreation, etc; lack of coordination and duplication of programs (Wondayehu et al., 2000).

Wondayehu and others recommend that the existing ARH shortcomings could be tackled by expanding on services to include:

- Implementing a comprehensive ARH policy that involves both government and NGO stake-

Factors That Influence Youth Reproductive Health



Youth Decisionmaking and Reproductive Health Behaviors

Reproductive Health Outcomes:

- Fertility
- Abortion
- Morbidity
  - STI / HIV
  - RTI
  - Anemia
- Mortality
- Nutritional Status

Individual

- Age and Gender
- Place of residence
- Knowledge, attitudes and beliefs
- Religion
- Self Efficacy
- Skills:
  - motivation to do well in school
  - actively engaged in learning
- Alcohol and drug use
- Other related risky behavior
  - depression, stress
  - running away from home
- Sexual and physical abuse

Peers and Partners

- Perception of peer behaviors
  - perception that peers are sexually active
  - perception that peers are using alcohol or drugs
- Relationship with partner(s)
  - age and income differentials
- Exchange of money or goods for sex
  - sexual pressure
- Sense of commitment to partner

Family and Household

- Low educational and economic levels
- Family attitudes
  - devaluing education
  - supporting early marriage and childbearing
  - discouraging young people's access to information and services
- Harmonious relationship with family
  - quality interaction with family
  - family's values are communicated to youth
  - supervision by adult family members

Institutions

- Connectedness with religious organizations
- Connectedness with schools
  - availability of education
  - a safe school environment
  - academic performance and aspirations
- Availability of youth programs
  - leisure activities
  - counseling
  - sexual abuse services
- Relationship with other adults through community institutions

Communities

- Disorganization (high unemployment levels, poverty, low education levels, political instability, war, crime, high migration)
- Social norms
- Lack of opportunities
- Policy (legality of contraceptives, age of legal marriage, health and education services for youth)
- Policy (illegality of abortion, weak enforcement of rape laws)
- Mass Media (mass media that provides role models and examples of responsible behavior)
- Mass Media (pornography, sexually permissive and violent media)

Source: Adamchak et al., 2000

holders;

- Establishing a multi-sectoral ARH coordinating body that includes both public and private organizations;
- Revitalizing school health programs;
- Making services accessible to rural youth by instituting ARH activities in government health institutions; establishing more community-based reproductive health (CBRH) centers in smaller towns with outbreaks; collaborating with religious institutions for the promotion of RH awareness;
- Establishing youth centers in major towns;
- Allocating more resources for ARH by Government and NGOs;
- Building capacity in peer promoters including communication skills;
- Reviewing available RH/FP IEC materials and producing more IEC in local languages;
- Controlling the production of *chat* and cannabis, and banning consumption of addictive drugs and substances in schools, the work place and public places;
- Banning imports and shows of pornographic movies and pictures;
- Reviewing and liberalizing some of the laws and legislations including safe termination of unintended pregnancies.

The 2000 Ethiopia Demographic and Health Survey

The Demographic and Health Survey conducted in 2000 provides information useful for understanding the health and life situation of youth in Ethiopia. It is currently the most comprehensive source of data on youth in Ethiopia. The following chapters, which are based on the 2000 Ethiopia DHS data, present an in-depth analysis of the background characteristics of youth, their sexual experience and marital status, knowledge and use of contraception, fertility and childbearing behavior, and knowledge and attitude toward HIV/AIDS, with some suggestions on programmatic implications. It is hoped that this study will help in formulating a more comprehensive policy on youth reproductive health and contribute to the development of more effective programs to address the reproductive health problems faced by Ethiopian youth.

The 2000 Ethiopia DHS is the first comprehensive nationally representative population and health survey conducted in Ethiopia. The survey provides current and reliable data on fertility, family planning, child mortality, children's nutritional status, utilization of maternal and child health services, and knowledge of HIV/AIDS. This information is essential for informed policy decisions, planning, monitoring, and evaluation of programs on health in general and reproductive health in particular at both the national and regional levels. The Ethiopia DHS survey collected this information from a nationally representative sample of 15,367 women age 15-49 and 2,607 men age 15-59. Three types

of questionnaires were used: the Household Questionnaire; the Women's Questionnaire; and the Men's Questionnaire. The questionnaires were administered in the five main languages used in the country: Amarigna, Oromigna, Tigrigna, Somaligna and Afarigna. The survey was fielded between February and May 2000.

The Ethiopia DHS survey was carried out under the aegis of the Ministry of Health and was implemented by the Central Statistical Authority. ORC Macro provided technical assistance through its MEASURE *DHS*+ project. The survey was funded principally by the U. S. Agency for International Development (USAID) through a bilateral agreement with the Essential Services for Health in Ethiopia (ESHE) project. The United Nations Population Fund (UNFPA) provided additional funding.

The sample for the Ethiopia DHS survey is based on a two-stage, stratified, nationally representative sample of households. The 1994 Population and Housing Census provided population and housing information on the list of enumeration areas (EAs) in the country. At the first stage of sampling, 540 EAs—139 in urban areas and 401 in rural areas—were selected using systematic sampling with probability proportional to size. A proportional sample allocation was discarded because this procedure yielded a distribution in which 80 percent of the sample came from three regions, 16 percent from four regions, and 4 percent from five regions. A complete household listing was carried out in all selected EAs to provide the sampling frame for the second stage selection of households. A systematic sample of 27 households per EA was selected in all the regions to provide statistically reliable estimates of key demographic and health variables. Throughout this report, numbers in the tables reflect weighted numbers. Because of the way the sample was designed, the number of cases in some regions appear small since they are weighted to make the regional distribution nationally representative. However, the statistical reliability of estimates depends on the actual number of cases interviewed (i.e. unweighted cases). To ensure statistical reliability, percentages based on 25 to 49 unweighted cases are shown in parentheses and percentages based on fewer than 25 unweighted cases are suppressed.

Chapter 2
Profile of Youth

Background Characteristics

Information on the basic characteristics of the population is essential for interpretation of the survey findings and provides an indication of the representativeness of the survey. Table 2.1 shows the background characteristics of young Ethiopian women and men.

Proportionally, there are more women and men in their teens than in their early twenties. One in two women age 15-24 has never been married, two in five are married or living with a partner, and about 8 percent are divorced, separated or widowed. Nine in ten young men have never been married, 8 percent are married, and 3 percent are formerly married. The majority of respondents (about 80 percent) live in rural areas. Two in five respondents are from the Oromiya Region, and about one in five are from the Amhara and SNNP regions. Two-thirds of young women have no education, just over one-fifth have primary education, and 12 percent have secondary education or higher. In contrast, two-fifths of young men have no education, two-fifths have primary education, and 17 percent have secondary education or higher. Three in ten young women are literate compared with more than one in two young men. One in two youth are Orthodox Christians, about three in ten youth are Muslim and one in six Protestants. About two-fifths of young women and men are Oromos, three-tenths are Amharas, and 6 percent are Tigraways.

Educational Attainment

Education is an important determinant of the quality of life and has a strong impact on youth reproductive health. However, the education sector in Ethiopia remains underdeveloped. The World Bank estimates that in 1997 only 4 percent of the gross national product of the country was used for education (World Bank, 2001). According to the 2000 Ethiopia DHS survey, less than one-third of children age 7-12 who should be attending primary school—the net attendance ratio (NAR)—are doing so at that level, and only 12 percent of secondary-school-age youth (13-18 years) are in school at that level (CSA and ORC Macro, 2001). The gross attendance ratio (GAR), which measures participation at each level of schooling among those age 5-24, was 60 percent for primary school and 17 percent for secondary school.

Figures 2.1 and 2.2 show the educational attainment of male and female youth. The level of education among youth in Ethiopia is very low. At the same time, women are significantly less educated than men at all levels of education. Three in five women age 15-19 and seven in ten women age 20-24 have no education compared with about two in five young men the same age. Among women and men who have attended school, most have only primary education.

Table 2.1 Background characteristics of respondents

Percent distribution of women and men age 15-24, by background chacteristics

	Number of women			Number of men		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Age						
15-19	56.5	3,710	3,584	59.5	600	571
20-24	43.5	2,860	2,844	40.5	408	419
Marital status						
Never married	51.2	3,366	3,493	88.4	891	868
Married	40.0	2,625	2,368	7.9	80	90
Living together	0.7	43	72	0.3	3	10
Divorced / separated	7.7	507	464	3.4	34	22
Widowed	0.4	28	31	0.0	0	0
Residence						
Urban	20.7	1,359	2,128	15.6	157	288
Rural	79.3	5,211	4,300	84.4	851	702
Region						
Tigray	5.9	391	522	5.5	55	69
Affar	1.0	64	302	1.0	10	47
Amhara	22.7	1,488	721	21.1	212	108
Oromiya	42.2	2,775	1,187	44.0	443	202
Somali	1.1	70	310	1.3	13	62
Benishangul-Gumuz	1.0	69	409	1.1	11	70
SNNP	20.0	1,311	807	20.8	210	130
Gambela	0.2	16	330	0.2	2	49
Harari	0.3	18	400	0.3	3	68
Addis Ababa	5.1	335	999	4.3	43	134
Dire Dawa	0.5	34	441	0.4	4	51
Education						
No education	65.1	4,280	3,706	39.5	397	354
Primary	22.4	1,473	1,496	44.0	443	396
Secondary	12.2	804	1,206	16.2	163	228
Higher	0.2	14	20	0.3	3	12
Literacy						
Literate	29.9	1,966	2,404	53.7	541	596
Not literate	69.4	4,559	3,964	46.1	465	391
No card or missing	0.7	45	60	0.2	2	3
Religion						
Orthodox	49.4	3,243	3,056	49.7	501	474
Catholic	1.5	96	61	0.1	1	6
Protestant	15.8	1,035	919	15.7	158	125
Muslim	30.1	1,975	2,231	30.5	307	354
Other	3.4	220	161	4.0	41	31
Ethnic group						
Affar	0.6	41	203	0.9	9	29
Amhara	30.3	1,988	1,843	27.7	280	255
Guragie	5.8	379	416	3.9	39	61
Oromo	37.7	2,477	1,867	39.9	402	316
Sidamo	3.4	220	134	3.0	30	19
Somali	1.1	70	284	1.4	14	50
Tigraway	6.3	412	591	6.4	64	84
Welaita	2.3	150	96	1.8	18	13
Other	12.7	832	994	15.2	153	163
Total	100.0	6,570	6,428	100.0	1,008	990

Figure 2.1 Education levels among men and women age 15-19

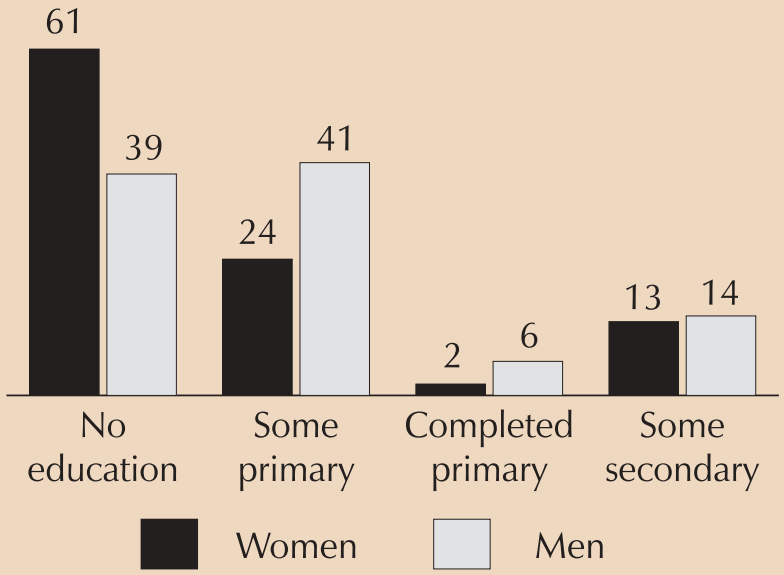
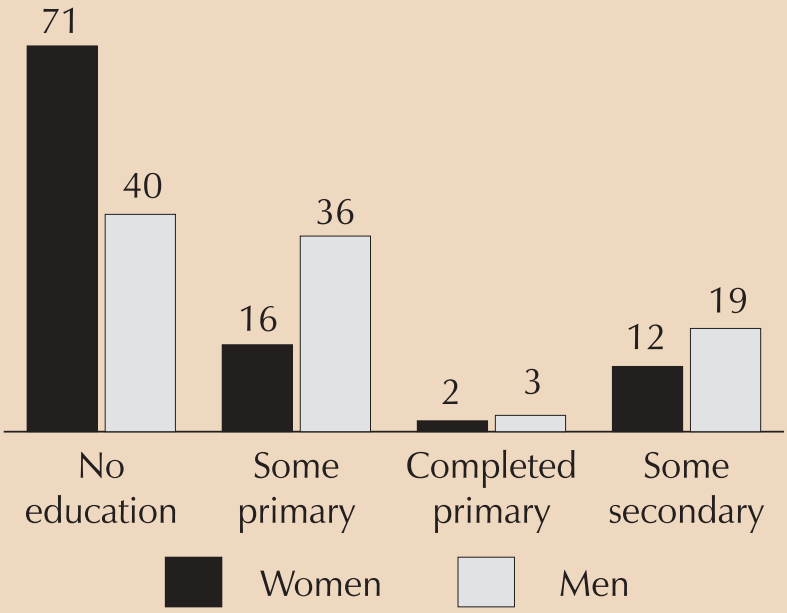


Figure 2.2 Education levels among men and women age 20-24



Employment

Employment during the school-age years may hinder educational attainment for a significant portion of Ethiopian youth. DHS data indicate that a significant number of school-age youth are employed

(Table 2.2). More than one in two youth age 15-24 were employed at the time of the survey, 29 percent in agricultural work and 26 percent in non-agricultural work. Seven percent were not employed at the time of the survey but had worked in the preceding 12 months, while 38 percent had not worked in the 12 months before the survey. Employment was only slightly lower among young people age 15-19 than among those age 20-24.

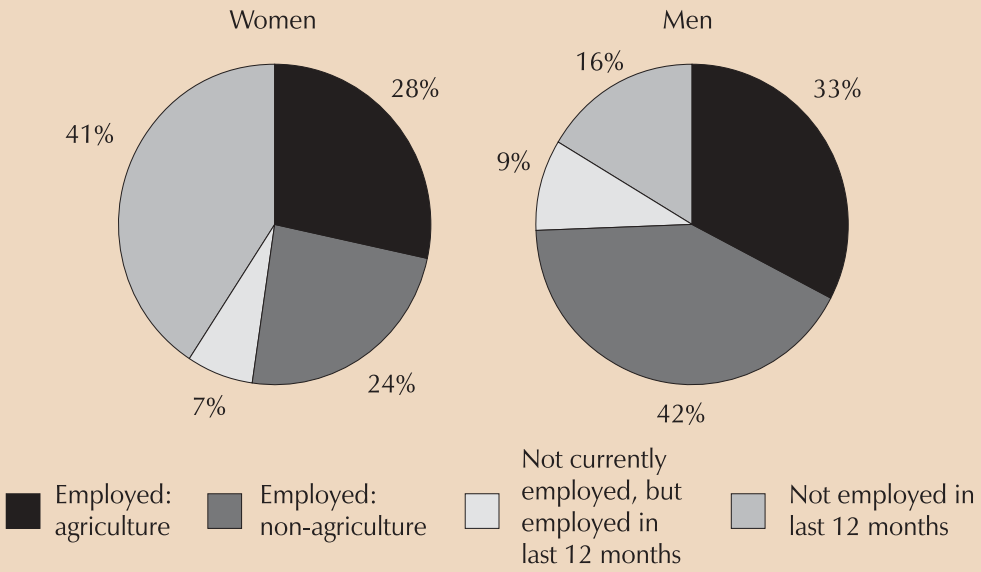
Young men are more likely to be employed than young women (Figure 2.3). Three in four male youth

Table 2.2 Employment

Percent distribution of women and men age 15-24, by employment status according to background chacteristics

	Employed in the 12 months preceding the survey			Not employed in the 12 months preceding the survey	Total	Number
	Currently employed in Agriculture	Currently employed in Non-agriculture	Not currently employed			
Age						
15-19	27.3	24.7	7.3	40.8	100.0	4,310
20-24	31.1	28.4	7.1	33.4	100.0	3,267
Sex						
Women	28.4	23.9	6.9	40.8	100.0	6,570
Men	32.6	41.8	9.2	16.4	100.0	1,008
Residence						
Urban	1.8	38.5	5.1	54.5	100.0	1,515
Rural	35.7	23.2	7.8	33.3	100.0	6,062
Marital status						
Never married	20.7	32.7	6.9	39.6	100.0	4,257
Married / living together	38.8	15.7	7.8	37.7	100.0	2,751
Divorced / separated / widowed	42.6	29.0	6.5	21.9	100.0	569
Region						
Tigray	44.7	16.3	6.9	31.9	100.0	446
Affar	28.6	31.4	1.4	38.6	100.0	75
Amhara	54.4	12.0	7.5	26.1	100.0	1,701
Oromiya	25.3	25.2	7.2	42.3	100.0	3,218
Somali	7.1	31.5	6.9	54.5	100.0	82
Benishangul-Gumuz	52.6	11.3	11.3	24.8	100.0	79
SNNP	11.4	44.3	7.8	36.5	100.0	1,521
Gambela	7.7	29.3	4.7	57.9	100.0	18
Harari	11.8	33.6	5.1	49.4	100.0	21
Addis Ababa	0.0	37.7	5.3	56.9	100.0	378
Dire Dawa	15.5	31.2	6.2	47.1	100.0	38
Education						
No education	37.1	23.1	7.0	32.8	100.0	4,677
Primary	21.7	32.9	8.3	37.1	100.0	1,916
Secondary and higher	4.1	28.4	6.0	61.5	100.0	984
Total	28.9	26.3	7.2	37.6	100.0	7,577

Figure 2.3 Employment status



are employed compared with one in two female youth. While there is little difference by gender in the proportion employed in the agricultural sector, men are nearly twice as likely to be employed in the non-agricultural sector as women.

More than one in two urban youth did not work in the 12 months preceding the survey compared with one in three rural youth. Not surprisingly, rural youth are predominantly engaged in the agricultural sector; however, one in four rural youth are engaged in the non-agricultural sector. The majority of urban youth work at non-agricultural jobs.

Young women and men who are divorced, separated or widowed are more likely to be working than those who are married or not married. Presumably, formerly married respondents are solely responsible for their children and household and have little choice but to work to maintain their family. On the other hand, unmarried youth may have parents and/or siblings to fall back on, while married youth may have their partners for financial security.

Unemployment among youth is highest in the Gambela Region and lowest in the Benishangul-Gumuz Region. More than one in two young women and men are employed in agriculture in the Amhara and Benishangul-Gumuz Regions. At the same time more than two-fifths of youth in the SNNP Region, and about one in three youth living in the Affar, Somali, Gambela, and Harari regions and in Addis Ababa and Dire Dawa are employed in non-agricultural jobs.

Education and employment are inversely related. The proportion unemployed in the 12 months

preceding the survey is twice as high among youth with secondary education or higher than among youth with no education. Although young adults with no education are predominantly employed in the agricultural sector, one in four women and men with no education are also engaged in the non-agricultural sector. Conversely, most youth with at least secondary education are employed in the non-agricultural sector. There are several possible reasons for the lower level of employment among highly educated youth: a substantial portion may still be in school; educated youth may be more reluctant to work in agricultural occupations; and unemployment is generally higher in urban areas, where most non-agricultural jobs are found and where more educated youth are likely to look for jobs.

Exposure to Mass Media

Mass media plays an important role in making health information available to youth. It also has considerable influence in shaping values and ideas in young minds. The DHS survey measured exposure to mass media by asking respondents if they listened to the radio, watched television, or read a newspaper at least once a week. DHS data indicate that Ethiopian youth have very limited exposure to mass media, with more than four in five women and men age 15-24 having no regular exposure to the newspaper, television, or radio (Table 2.3).

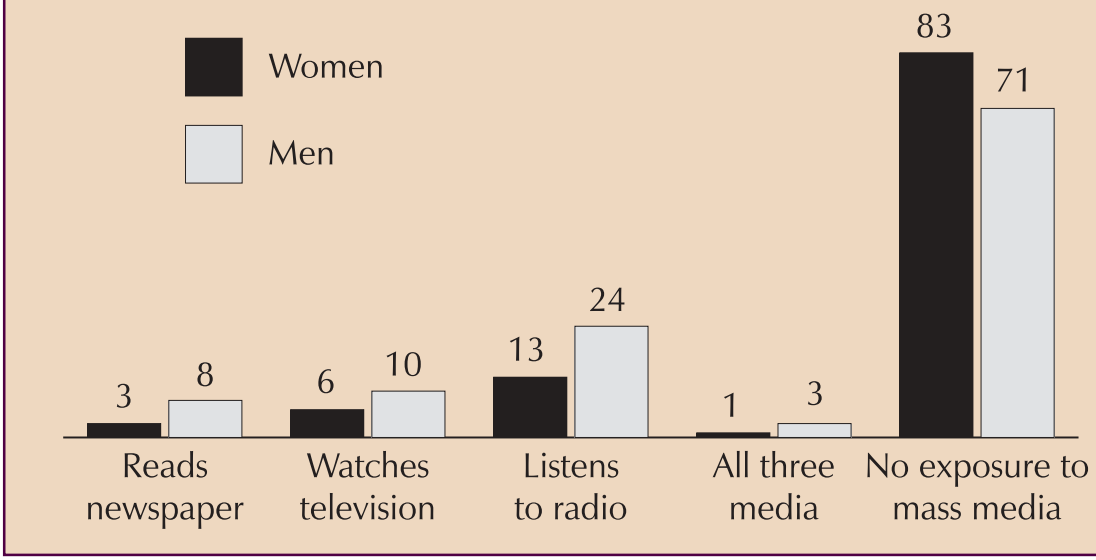
There is little difference by age group in exposure to mass media, with older youth having slightly greater exposure than younger youth. There is an obvious gender difference in media exposure with men having more exposure than women (Figure 2.4). Not surprisingly, urban youth have twice as much exposure to media as rural youth. Media exposure is lowest in the Amhara Region and highest in Addis Ababa, the most urban part of the country. Exposure to the media is positively related to the level of education; it is highest among young people with at least secondary education and lowest among those with no education.

Table 2.3 Exposure to mass media

Percentage of women and men age 15-24, by exposure to mass media according to background chacteristics

	Reads newspaper weekly	Watches television weekly	Listens to radio weekly	Exposed to all three media	No exposure to mass media	Number
Age						
15-19	3.8	7.8	15.9	1.2	79.3	4,310
20-24	2.6	4.9	13.1	0.9	84.3	3,267
Sex						
Women	2.6	6.0	13.3	0.8	83.2	6,570
Men	7.7	10.2	23.9	2.8	70.5	1,008
Residence						
Urban	10.4	28.1	39.8	4.6	46.7	1,515
Rural	1.5	1.2	8.4	0.2	90.2	6,062
Region						
Tigray	4.5	9.3	21.1	2.0	74.2	446
Affar	1.5	8.2	14.0	0.3	79.6	75
Amhara	1.5	4.0	11.5	0.5	86.5	1,701
Oromiya	3.3	3.9	11.8	0.6	84.7	3,218
Somali	4.2	4.2	10.8	0.8	85.0	82
Benishangul-Gumuz	3.0	2.3	14.2	0.0	82.2	79
SNNP	1.5	3.4	13.0	0.7	85.1	1,521
Gambela	2.9	10.6	16.1	1.0	76.7	18
Harari	7.4	28.2	36.2	4.5	55.5	21
Addis Ababa	15.0	46.4	49.9	7.5	30.2	378
Dire Dawa	8.7	40.3	35.2	4.9	48.4	38
Education						
No education	0.0	1.0	4.2	0.0	95.0	4,677
Primary	3.8	6.4	20.5	0.5	74.3	1,916
Secondary and higher	17.5	33.6	53.1	7.1	31.1	984
Total	3.2	6.6	14.7	1.1	81.5	7,577

Figure 2.4 Exposure to mass media among men and women age 15-24



Chapter 3
Sexual Experience and Marriage

Hugh J. Ivory, Lutheran World Relief

Adolescence is a time when many young people experience critical and life-defining challenges such as their first sexual experience, marriage, pregnancy, and parenthood. Adolescent sexual behavior is important not only because of the possible reproductive outcomes, but because risky sexual behavior is associated with sexually transmitted infections such as HIV/AIDS. This chapter includes a discussion of the sexual experience of young adults, their marital status, pregnancy, and motherhood.

Sexual Experience

Young women age 15-24 are more likely to have had sexual intercourse than young men in the same age group. One in two young women are sexually experienced[1], compared with one in three young men (Figure 3.1). This proportion is higher among the older age group (20-24) than the younger age group (15-19). Three in four women age 20-24 have had sex compared with about one in three women age 15-19. Similarly, three times as many men age 20-24 are sexually experienced as men age 15-19.

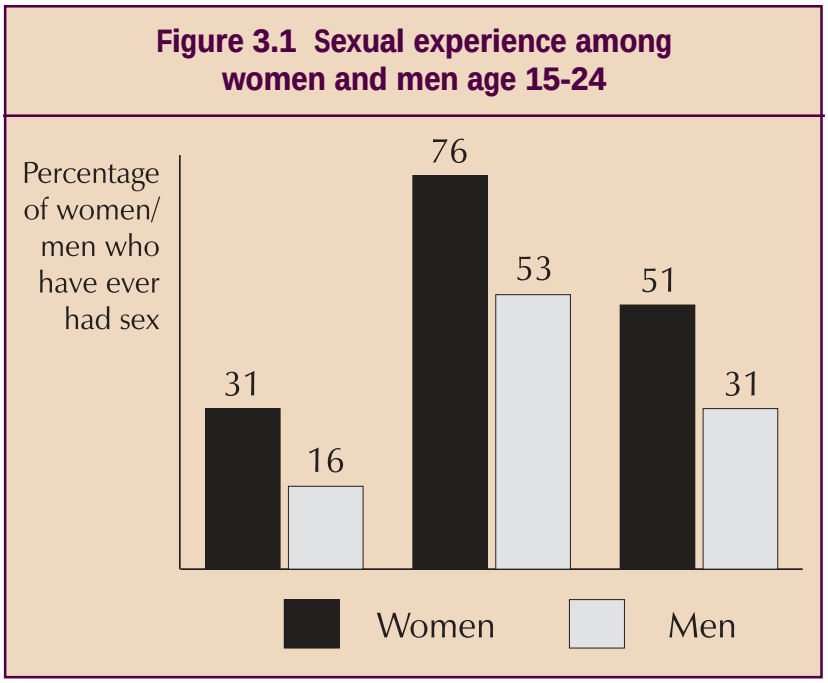
Youth Reproductive Health—Some Facts

- More than 1 billion people in the world are between the ages of 15 and 24, and most live in developing countries.
- One in every 10 births worldwide and 1 in 6 births in developing countries is to women age 15-19.
- Pregnancy-related health risks are much higher among women under age 18, with girls age 10-14, five times more likely to die during pregnancy or childbirth than women age 20-24.
- One in 10 abortions worldwide occurs among women age 15-19; more than 4.4 million women in this age group have an abortion every year, and 40 percent of these abortions take place in unsafe conditions.
- Each day half a million young people are infected with a sexually transmitted disease.
- The majority of sexually active males age 15-19 are unmarried whereas two-thirds of sexually active young women in the same age group are married.
- Only 17 percent of sexually active young people use a contraceptive method.
- The highest rate of new cases of HIV transmission occurs among young people age 15-24.
- By the end of 2000, more than 10 million young people were infected with HIV, and nearly two-thirds were women.

Source: UNFPA, 2001; UNFPA, 2002.

[1] In this report, "sexually experienced" refers to young women and men who have ever had sex and is not restricted to those who have had sex in the month preceding the survey.

Figure 3.1 Sexual experience among women and men age 15-24



Age at Sexual Debut

Early initiation of sex poses health risks for both young women and men. Most young adults who enter into a sexual relationship for the first time do not use any form of contraception, leaving them vulnerable to unintended pregnancies and unplanned parenthood. Unprotected sex also exposes the young to sexually transmitted infections. Young women are especially vulnerable because of their biological susceptibility—i.e., the immaturity of their reproductive organs (Institute of Medicine, 1997).

Sexual experience begins early in Ethiopian society. The median age at which women age 25-49 first had sexual intercourse is 16. Three in ten women in this age group have had sex by age 15, two in three by age 18, and more than 80 percent by age 20 (Table 3.1).

There is a gradual increase in the proportion of young women who have ever had sex. This increase is more pronounced among women age 15-19 than women age 20-24. As shown in Figure 3.2, 11 percent of women age 15 are sexually experienced compared with nearly one in four women age 16, 27 percent of women age 17, and about one in two women age 18 and 19. With the exception of women age 21 (two-thirds of whom are sexually experienced), the percentage of women who have ever had sex increases gradually from 70 percent among women age 20 to 84 percent among women age 24, with the largest percent increase between age 19 and 20. At the same time, age at sexual debut has risen steadily over the years. The 2000 Ethiopia DHS data show that the median age at sexual debut has increased from 15.7 years among women age 45-49 to 18.1 years among women age 20-24 (CSA and ORC Macro, 2001).

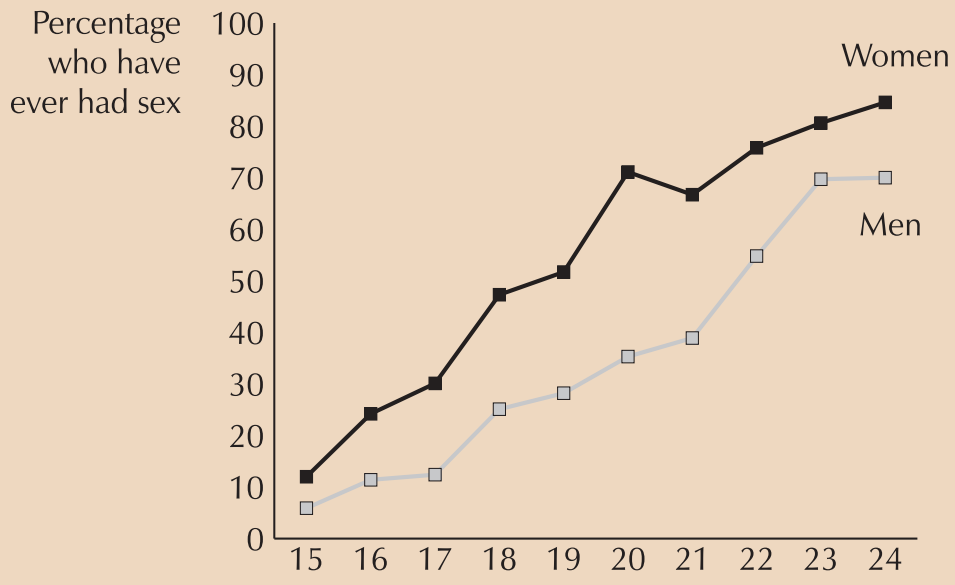
Table 3.1 Age at first sexual intercourse

Percentage of women and men who had first sexual intercourse by specified exact age and percentage who never had intercourse

Current Age	Percentage who had first sexual intercourse by exact age: 15	18	20	22	25	Percentage who never had intercourse	Number
WOMEN							
15-19	13.5	NA	NA	NA	NA	69.3	3,710
20-24	19.4	49.5	65.6	NA	NA	24.6	2,860
25-49	29.8	68.9	81.3	88.3	92.0	2.6	8,797
MEN							
15-19	5.1	NA	NA	NA	NA	84.6	600
20-24	3.2	22.3	39.7	NA	NA	46.8	408
25-49	3.8	24.6	46.7	63.4	78.8	4.0	1,599

NA = Not applicable

Figure 3.2 Percentage of women and men who have ever had sex, by age



On the other hand, men initiate sex an average of four years later than women. The median age at sexual debut among men age 25-59 is 20.3 years. Less than 5 percent of men in this age group are sexually experienced by age 15, one in four by age 18, and one in two by age 20 (Table 3.1). The largest percent increase in men who have had sex is between age 21 and 22. Although the median age at sexual debut among men has increased over the years, this increase is not as marked as it is among women.

Age at First Marriage

Although young women initiate sex at an earlier age than young men, sexual experience for most women is within the context of marriage, in contrast to men who initiate sex before marriage. In fact, the median age at first marriage is identical to the median age at sexual debut for women age 25-49 (CSA and ORC Macro, 2001). However, the median age at first marriage among men age 25-59 is three years later than the median age at first sexual intercourse (CSA and ORC Macro, 2001). Most young adult women who are sexually experienced are married (96 percent) (Figure 3.3). On the other hand, only one-third of sexually experienced young men are married. While there is little difference by age in the percentage of young sexually experienced women who are married, more than twice as many sexually experienced men age 20-24 are married as are those age 15-19. There has been a steady increase in the median age at marriage over the years among women. This trend is similar to the trend in the age at sexual debut (Figure 3.4).

Timing of Sexual Activity

Information on the timing of last sexual intercourse is important because it is often a good measure of women's exposure to the risk of pregnancy. More than two-thirds of young women are sexually active, that is, they had sex in the month preceding the survey, compared with two-fifths of young men. There is no clear pattern in the timing of sexual activity and little variation by age among women (Table 3.2). On the other hand, there is greater variation in the timing of sexual activity by age

Figure 3.3 Sexual experience by marital status

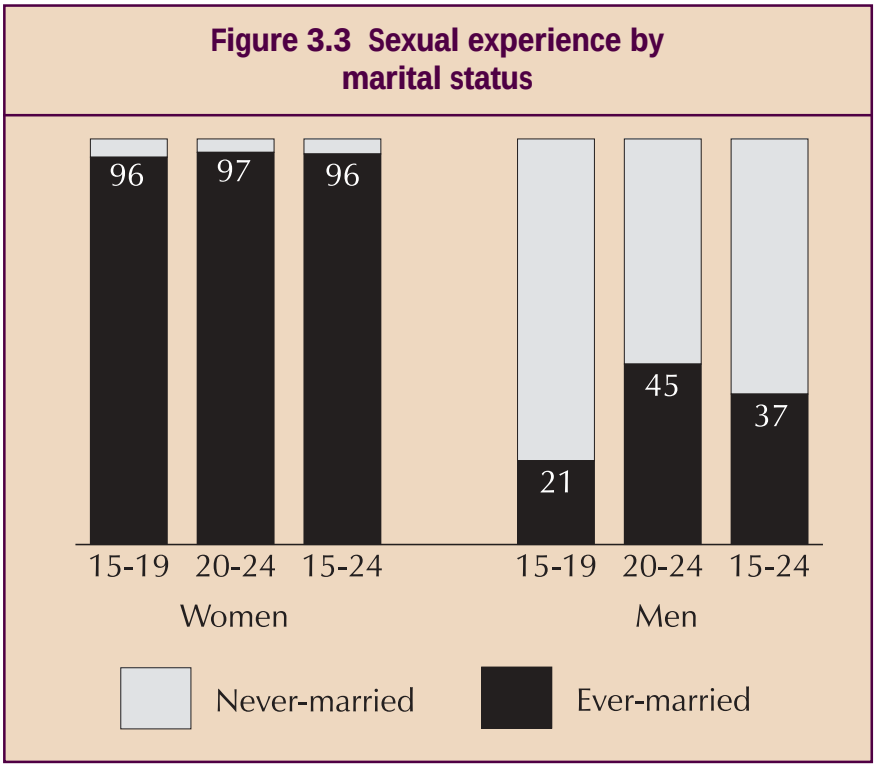


Figure 3.4 Median age at first marriage

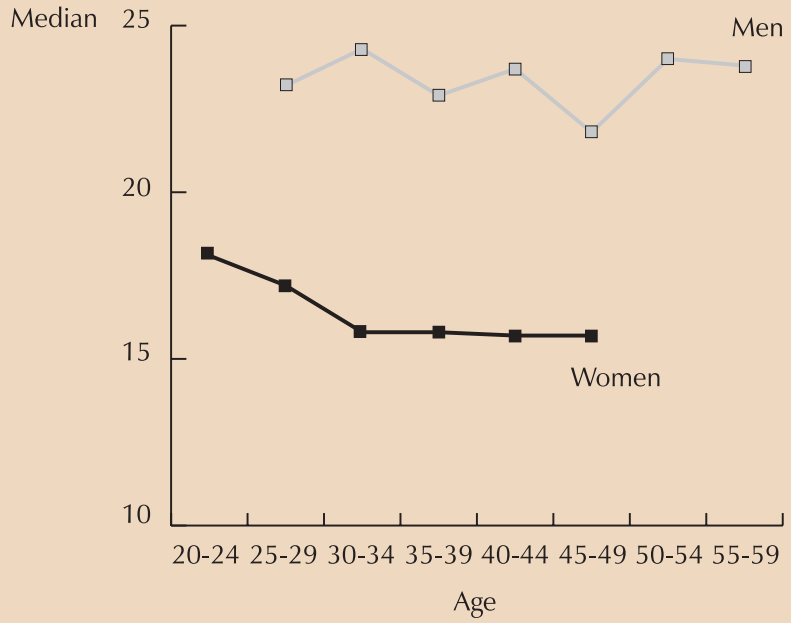


Table 3.2 Recent sexual activity

Percent distribution of women and men age 15-24, by timing of recent sexual activity

	Women				Men			
Current age	Sexually active in last 4 weeks	Not sexually active in last 4 weeks	Total	Number	Sexually active in last 4 weeks	Not sexually active in last 4 weeks	Total	Number
15	56.4	43.6	100.0	107	*	*	100.0	7
16	69.7	30.3	100.0	193	*	*	100.0	13
17	53.2	46.5	100.0	198	*	*	100.0	16
18	67.1	32.9	100.0	391	(34.4)	(65.6)	100.0	40
19	72.5	27.5	100.0	276	(22.2)	(77.8)	100.0	22
20	65.6	34.4	100.0	574	(48.2)	(51.8)	100.0	36
21	74.7	25.3	100.0	283	(28.4)	(71.6)	100.0	25
22	70.0	29.5	100.0	462	48.9	51.1	100.0	46
23	71.0	29.0	100.0	399	38.6	61.4	100.0	57
24	69.3	30.7	100.0	443	55.2	44.8	100.0	53
Total	68.1	31.8	100.0	3,326	39.3	60.7	100.0	315

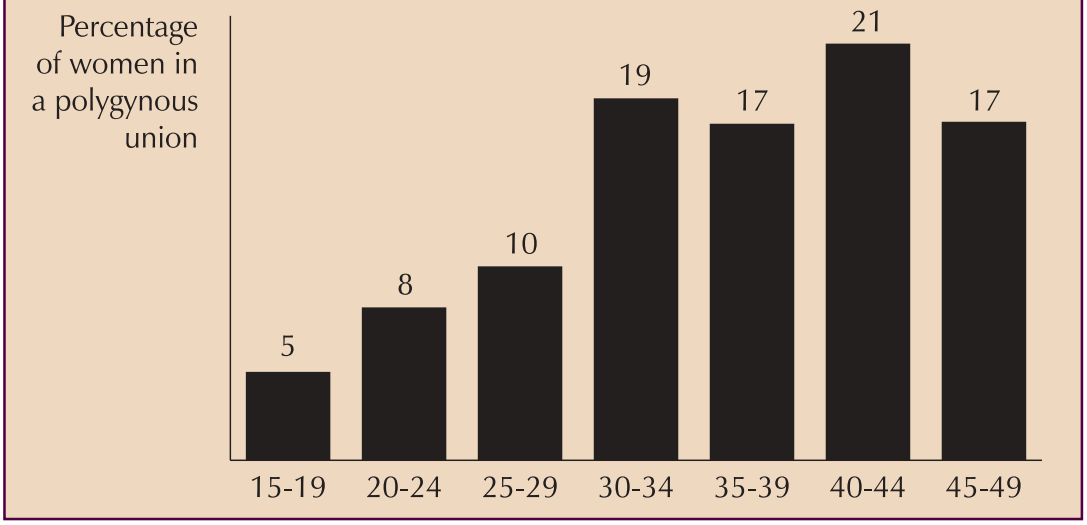
Note: Total includes 3 women with missing information on timing of last sexual intercourse. Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

among men, with recent sexual activity more common among those age 20-24 than teens. Recent sexual activity is also more common among rural than urban youth and among those who are currently married or living together than among those who are not married or are formerly married.

Polygyny

Polygyny has an impact on the reproductive life of young people. Young women who live with older co-wives often play a secondary role in the running of the household, have little autonomy, and occupy a low status in the gender hierarchy. This affects their social life, economic capacity, and fertility desires. More importantly, polygyny exposes young women to increased risk of contracting sexually transmitted diseases. Five percent of women in their teens and 8 percent of women age 20-24 are married to men who have more than one wife (Figure 3.5). On the other hand, only a small proportion

Figure 3.5 Polygyny by age group

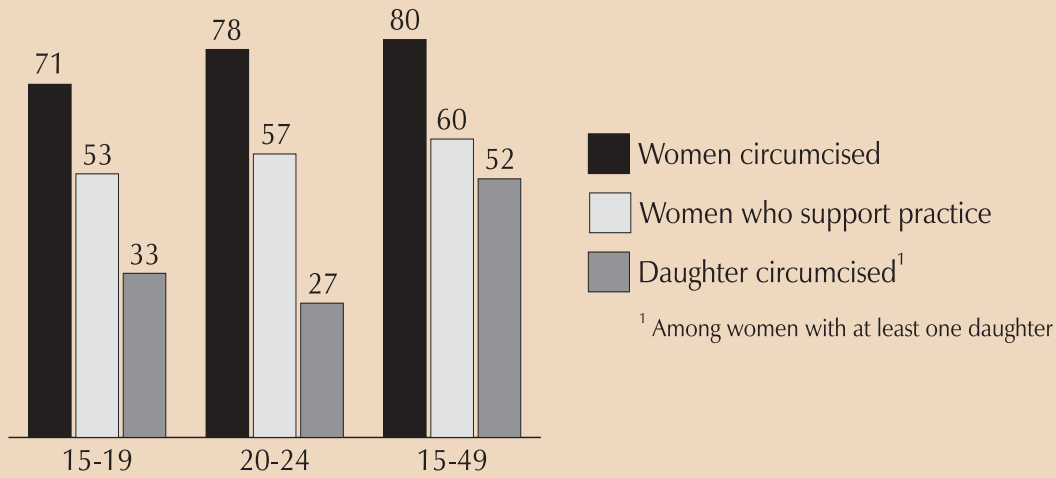


of young men in the same age group have more than one wife, an indication that polygyny is more common among older than younger men, and that when older men take on a second or subsequent wife, that wife is likely to be a young woman.

Female Genital Cutting

The 2000 Ethiopia DHS survey included a series of questions on female circumcision to obtain information about female genital cutting (FGC) in Ethiopia. The practice of FGC is widespread in the country with four in five women age 15-49 circumcised (CSA and ORC Macro, 2001). Among young adults, 71 percent of women age 15-19 and 78 percent of women age 20-24 have been circumcised (Figure 3.6). Although there has been a decline in FGC over the years, as evidenced by the decrease in the percent circumcised in younger age groups, there continues to be widespread support for this harmful practice. Sixty percent of all women in the reproductive age group support the practice with

Figure 3.6 Female genital cutting by age group



more than one in two young adults supporting FGC. In addition, more than one in two women have a daughter who has been circumcised. Among women with at least one daughter, one-third age 15-19 and more than one-fourth age 20-24 also have at least one daughter who has been circumcised. Most daughters are circumcised before one year of age, and nine in ten are circumcised by a traditional circumciser.

Chapter 4
Knowledge and Use of Contraception

Knowledge of contraception is a prerequisite to gaining access to and eventually adopting a family planning method. In the DHS survey, knowledge of contraception is ascertained by asking respondents if they have ever heard of a method of family planning. This is not a measure of how much they know about any specific method. The ability to name or recognize a specific method is a precursor to use. Discussions in this chapter focus on young adults' knowledge and use of a method of family planning, the unmet need for family planning services, future use and reasons for nonuse, and exposure to media messages on family planning.

Family Planning Knowledge

A sizeable percentage of young Ethiopians know of family planning (Table 4.1 and Figure 4.1). Three in four youth age 15-24 know of at least one contraceptive method, with knowledge increasing to over 80 percent among currently married young women and unmarried women who are sexually experienced, and around 90 percent among their male counterparts. Knowledge is somewhat lower among unmarried youth who are not sexually experienced. Men are generally more aware of family planning than women.

Knowledge of modern methods of family planning is substantially higher than knowledge of traditional methods among both women and men (Table 4.1 and Figure 4.2). Knowledge of modern meth-

Table 4.1 Knowledge of contraceptive methods

Percentage of respondents age 15-24 who know any contraceptive method, by marital status, according to specific method

	Women				Men			
	All respondents	Currently married	Unmarried, ever had sex	Unmarried, never had sex	All respondents	Currently married	Unmarried, ever had sex	Unmarried, never had sex
Any method	74.8	83.8	82.3	65.9	77.4	89.7	91.2	71.3
Any modern method	74.1	82.8	81.9	65.4	76.7	86.9	89.4	71.3
Pill	70.5	78.8	78.6	62.1	67.1	79.7	77.7	62.1
IUD	9.0	7.2	12.0	9.9	10.6	10.2	14.9	9.2
Injectables	58.2	66.5	69.6	49.2	48.8	66.0	58.7	43.4
Diaphragm / foam / jelly	4.0	1.9	5.4	5.4	9.8	3.2	11.2	10.1
Condom	33.5	28.0	45.9	35.6	61.4	68.4	76.2	55.6
Female sterilization	19.8	20.6	25.7	17.9	20.8	16.8	27.8	19.0
Male sterilization	4.3	4.2	4.6	4.3	10.2	7.7	12.5	9.6
Implants	12.0	11.4	20.2	10.9	11.9	17.9	13.2	10.8
Any traditional method	22.7	23.2	30.7	20.8	38.2	49.6	57.2	30.5
Periodic abstinence	20.1	19.9	28.1	18.7	34.6	46.2	51.7	27.5
Withdrawal	10.2	8.4	16.3	10.5	24.5	18.7	36.3	21.2
Other method	1.1	1.8	0.9	0.6	1.9	2.6	2.7	1.6
Number	6,570	2,669	658	3,243	1,008	83	232	693

Figure 4.1 Family planning knowledge by marital status

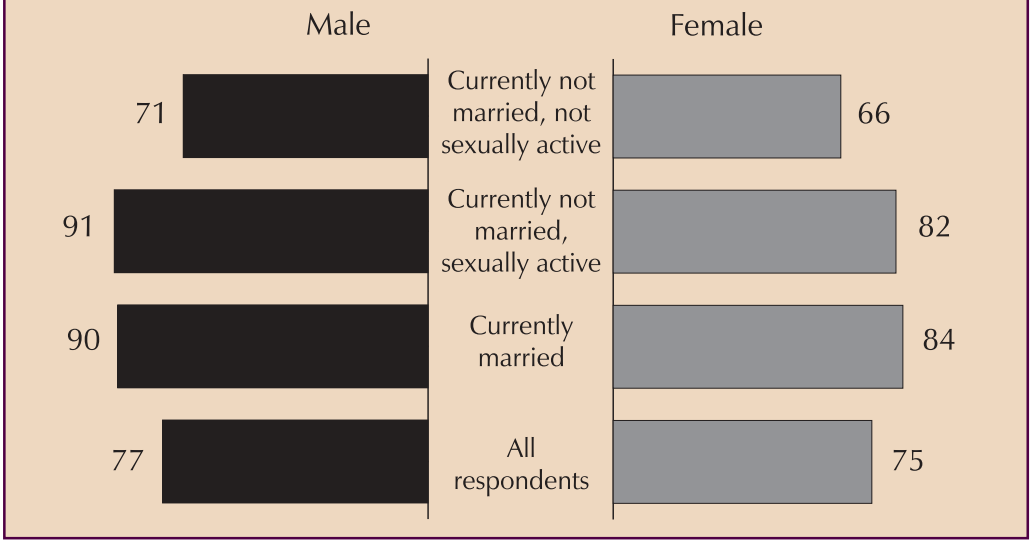
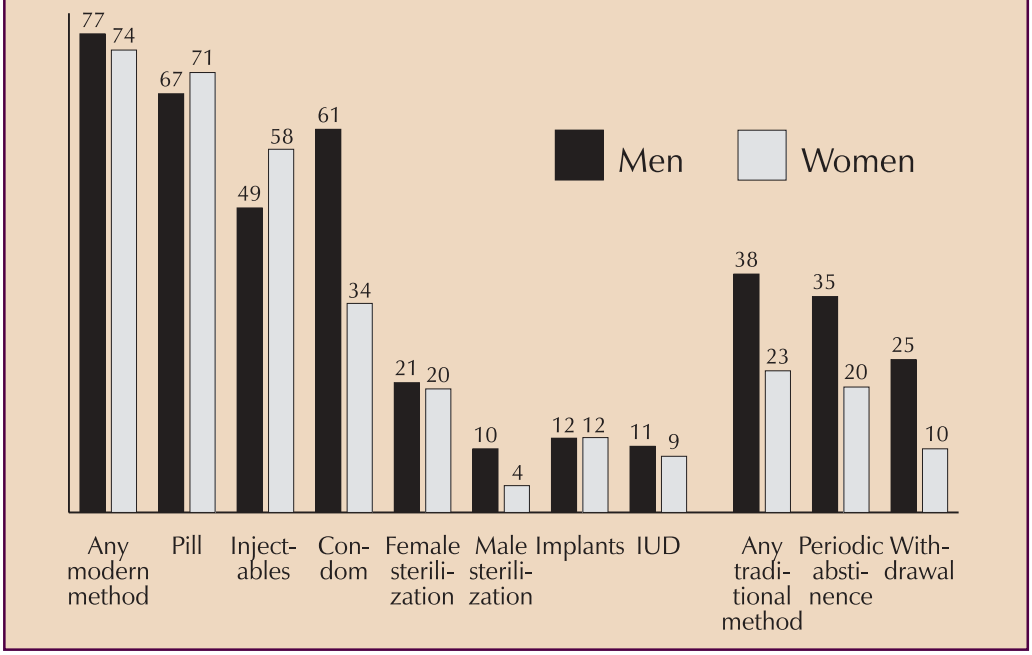


Figure 4.2 Family planning knowledge by method



ods among young women is about three times higher than knowledge of traditional methods. Similarly, knowledge of modern methods among young men is about two times higher than knowledge of traditional methods.

Knowledge varies by method. Young people in Ethiopia are most aware of the pill, with about 70 percent of all women and men having heard of it (Table 4.1 and Figure 4.2). Nearly 60 percent of women are aware of injectables, compared with about 50 percent of men. Men are about twice as

likely to report knowledge of condoms as a method of family planning as women, 61 percent and 34 percent, respectively. One in five young respondents has heard of female sterilization. Young men are more than twice as likely to have heard of male sterilization (10 percent) as young women (4 percent). Among the two most common traditional methods, periodic abstinence is more well known than withdrawal, with a 10 percentage point difference in the proportion of women and men who have heard of the former compared with the latter.

Contraceptive knowledge varies by the demographic and background characteristics of respondents (Table 4.2). Women and men age 20-24 are more likely than those age 15-19 to have heard of contraceptive methods. For example, 83 percent of women age 20-24 have heard of a method compared with 69 percent of women age 15-19. Knowledge is also higher among never-married youth

Table 4.2 Contraceptive knowledge

Percentage of women and men age 15-24 who have knowledge of any contraceptive method by background characteristics

	Women		Men	
	Percent	Number	Percent	Number
Age				
15-19	68.8	3,710	70.7	600
20-24	82.6	2,860	87.2	408
Marital status				
Never married: not sexually experienced	65.9	3,243	71.3	693
Never married: sexually experienced	93.1	123	91.4	198
Ever married	83.1	3,204	89.7	117
Residence				
Urban	93.7	1,359	99.0	157
Rural	69.9	5,211	73.4	851
Region				
Tigray	86.0	391	86.2	55
Affar	65.8	64	(61.5)	10
Amhara	79.0	1,488	76.3	212
Oromiya	73.9	2,775	75.4	443
Somali	59.2	70	74.0	13
Benishangul-Gumuz	62.9	69	69.7	11
SNNP	64.6	1,311	77.3	210
Gambela	73.1	16	(83.7)	2
Harari	83.5	18	87.1	3
Addis Ababa	96.5	335	96.3	43
Dire Dawa	88.7	34	97.7	4
Education				
No education	67.0	4,280	61.7	397
Primary	84.1	1,473	83.0	443
Secondary and higher	99.1	817	100.0	167
Total	74.8	6,570	77.4	1,008

Note: Figures in parentheses are based on 25-49 unweighted cases.

who are sexually experienced than among those who are not sexually experienced. For example, nine in ten sexually experienced men have heard of a method, compared with seven in ten never-married men with no sexual experience. Among women, a higher percentage of sexually experienced women who have never married know of contraceptives than sexually experienced married women. Knowledge is lowest among unmarried women who have never had sex.

Not surprisingly, urban youth are much more likely to have heard of contraceptive methods than rural youth, with knowledge highest in the two predominantly urban administrative areas of Addis Ababa and Dire Dawa. Nevertheless, young women in Dire Dawa are somewhat less likely than young men to have heard of at least one method of family planning. Education has a positive impact on family planning knowledge. Knowledge is universal among young women and men who have at least a secondary level of education, while about four in five youth with primary education and about two-thirds of youth with no education know at least one method of family planning.

A multivariate analysis was carried out to ascertain the strength of each of the demographic and background variables in determining contraceptive knowledge. This analysis confirms some of the findings of the bivariate analysis. Older youth (20-24) are significantly more likely to know a method than younger youth (15-19). Education, especially secondary education, exerts a powerful impact on improving knowledge. For example, knowledge among women with secondary level schooling is fourteen times higher than among those with no education. Women's exposure to the radio increases knowledge significantly. Currently or formerly married women are significantly more likely to know a method than never married women. The strong effect of urban residence seen in the descriptive analysis is somewhat subdued when the influence of other variables are controlled. The impact of media exposure and marital status do not make a significant impact on young men's knowledge of contraception.

Use of Family Planning

Information on ever use of contraception is significant because it provides an indication of the cumulative success of programs promoting the use of family planning. Table 4.3 shows ever use of contraception among young women and men who are sexually experienced. Seventeen percent of women age 15-24 and 19 percent of men in the same age group have used a method of family planning at some time. Ever use is higher among women and men age 20-24 than among teens. Ever use is nearly three times higher among never-married women who are sexually experienced than among ever-married women. However, this difference is less pronounced among men. More than one in two young urban youth have used a method at some time compared with one in ten rural youth. Ever use is twice as high among women with secondary education or higher as among women with primary education, and more than eight times higher than among women with no education. The difference by educa-

Table 4.3 Contraceptive use

Among sexually experienced women and men age 15-24, the percentage who have ever used a method of contraception and the percentage who are currently using a method, by background characteristics

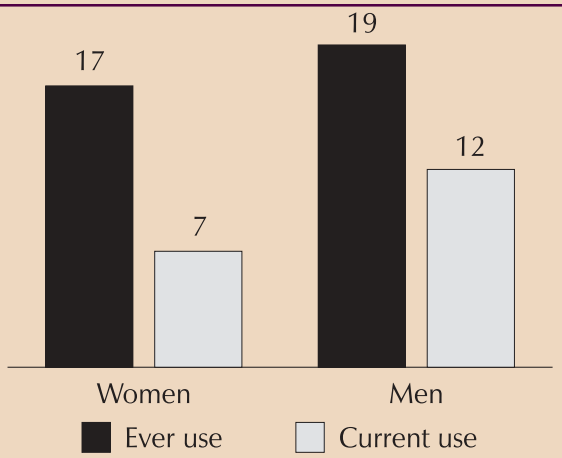
	Women			Men		
	Ever use	Current use	Number	Ever use	Current use	Number
Age						
15-19	11.7	4.8	1,166	16.8	10.3	98
20-24	19.0	8.0	2,161	19.9	12.2	217
Marital status						
Never married: sexually experienced	44.1	29.5	123	22.1	14.2	198
Ever married	15.4	6.0	3,204	13.6	7.3	117
Residence						
Urban	54.7	30.6	471	52.8	29.2	63
Rural	10.2	2.9	2,855	10.4	7.2	251
Region						
Tigray	15.4	7.0	243	*	*	15
Affar	19.7	12.6	43	(28.4)	(11.1)	7
Amhara	14.2	5.0	1,080	(13.8)	(3.5)	60
Oromiya	14.7	5.5	1,254	7.8	7.8	166
Somali	13.4	7.2	31	*	*	5
Benishangul-Gumuz	22.2	11.8	38	*	*	3
SNNP	16.3	6.6	511	(29.1)	(14.2)	40
Gambela	23.9	10.9	11	(32.8)	(13.5)	1
Harari	36.3	23.0	9	(58.8)	(49.0)	1
Addis Ababa	60.2	35.7	92	(85.2)	(58.0)	15
Dire Dawa	52.0	31.1	14	*	*	1
Education						
No education	8.1	2.7	2,567	3.7	2.1	132
Primary	33.6	14.1	512	15.1	10.1	131
Secondary and higher	67.6	34.8	247	67.3	39.6	52
Total	16.5	6.8	3,326	18.9	11.6	315

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicated that a figure is based on less than 25 unweighted cases and has been supressed.

tion in ever use is even more pronounced among young men, with those having at least secondary education more than four times as likely to have used a contraceptive method as those with primary education, and nearly seventeen times as likely as those with no education.

Table 4.3 also shows current use of contraception among young women and men who have ever had sex. Current use refers to the proportion of women and men who reported using a contraceptive method at the time of the survey. It is the most widely used measure of the success of family planning programs. Very few men (12 percent) and women (7 percent) between the ages of 15 and 24 years use contraception. As can be seen in Figure 4.3, most men and women do not use a contraceptive method consistently, as current use is generally much lower than ever use. For example, 17 percent of young

Figure 4.3 Contraceptive use

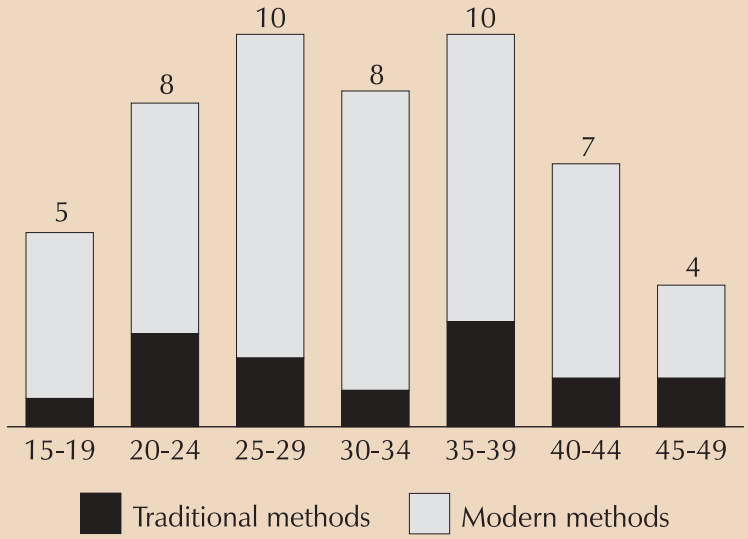


women have used a contraceptive method at some time, while only 7 percent are currently using a method.

A multivariate analysis of the factors that affect contraceptive use shows that the same factors that influence knowledge of contraceptive methods also influence use. Youth age 20-24 and educated youth are significantly more likely to be currently using a contraceptive method than teens and uneducated youth. At the same time, urban women, women who listen to the radio, and ever-married women are significantly more likely to be using contraception than their counterparts (data not shown).

Current use of contraception is lower among the population age 15-24 than among the population age 25-39. As shown in Figure 4.4, current use is 5 percent and 8 percent among sexually experienced

Figure 4.4 Current use of contraception among sexually experienced women age 15-49



young women age 15-19 and 20-24, respectively. Among sexually experienced women age 25-39, current use is 8-10 percent.

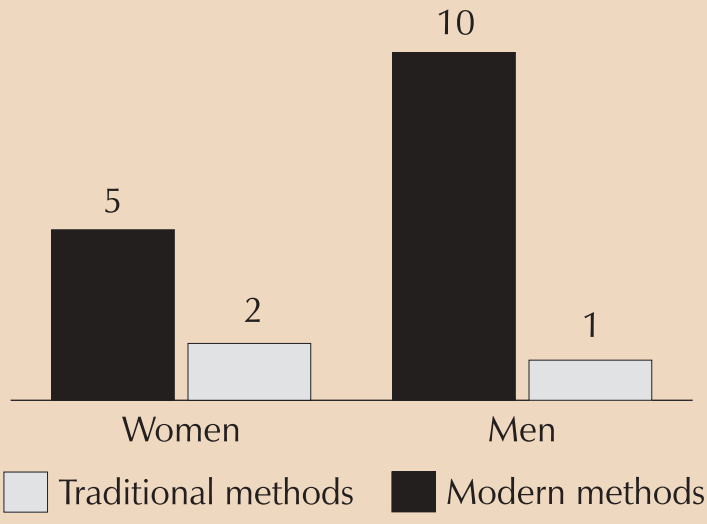
Young adults have a clear preference for modern methods over traditional methods (Table 4.4 and Figure 4.5). Among women, use of modern methods is two-and-a-half time greater than use of traditional methods. Similarly, young men are ten times more likely to report use of a modern method than a traditional method. The modern methods most commonly used by young female users are the pill (2 percent) and injectables (2 percent). Young men are most likely to report using the condom (7 percent), followed by the pill (2 percent) and injectables (1 percent). As noted, the largest discrepancy in reported current use of contraceptive methods is with reference to the condom. Men are eight times more likely to report current use of the condom than women. This difference could largely be

Table 4.4 Current use of contraception

Among sexually experienced women and men age 15-24, the percentage who are currently using a method, by age, according to type of method

	Women			Men		
	15-19	20-24	15-24	15-19	20-24	15-24
Any method	4.8	8.0	6.8	10.3	12.2	11.6
Any modern method	4.1	5.7	5.1	10.2	10.4	10.4
Pill	2.2	2.2	2.2	0.4	2.6	1.9
Injectables	1.1	2.5	2.0	0.0	1.5	1.1
Condom	0.8	0.9	0.9	9.8	6.3	7.4
Any traditional method	0.7	2.3	1.7	0.0	1.8	1.2
Periodic abstinence	0.7	1.9	1.5	0.0	1.7	1.2
Number	1,166	2,161	3,326	98	217	315

Figure 4.5 Current use of contraception among women and men age 15-24

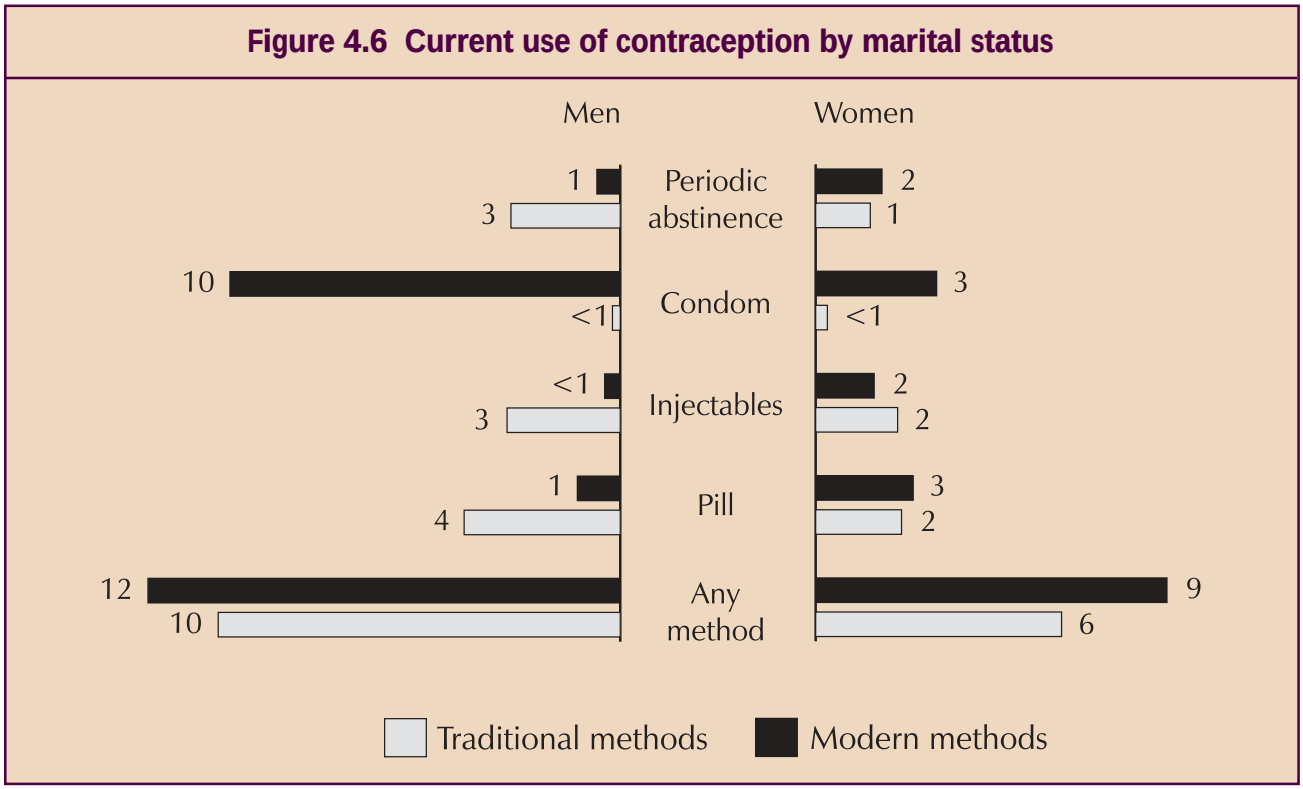


due to men reporting use of condoms with partners other than their wife. But some of the difference may be due to lack of awareness among men of their partner's use of a method, since female methods such as the pill and injectables are less obvious than male methods such as the condom. Periodic abstinence is the traditional method most commonly used by both women and men (2 percent each).

There are differences by method in current use between the two age groups (Table 4.4). Women and men age 20-24 are more than twice as likely to report use of injectables as those age 15-19. Condom use is noticeably higher among men age 20-24 than among men age 15-19. At the same time, men age 20-24 are much more likely (more than twice as likely) to report use of the pill than teenage men. However, there is no difference in the reported use of the pill by age group among women. Reported use of periodic abstinence is also higher among women and men age 20-24 than among those age 15-19.

Unmarried sexually experienced young women and men report higher levels of contraceptive use than their married counterparts (Figure 4.6). Current use is 43 percent and 17 percent higher among sexually experienced unmarried women and men than among married women and men. The most notable difference in method use is with reference to the condom. Unmarried women and men are three times and ten times more likely to report current use of the condom, respectively, than married women and men. On the other hand, married men report greater use of the pill, injectables, and periodic abstinence than unmarried men.

Figure 4.6 Current use of contraception by marital status



Knowledge of Menstrual Cycle

An elementary knowledge of women's physiology is essential for the successful practice of coitus-related methods such as periodic abstinence, withdrawal, condoms, and vaginal methods. This knowledge is particularly critical for the effective practice of periodic abstinence, especially when sexually active young adults may have little access to modern contraceptive methods. Effective use of periodic abstinence depends on the man's knowledge of the method and his cooperation in avoiding sexual intercourse during the middle of the woman's menstrual cycle, when she is most likely to become pregnant.

One-fifth of all young women and one-third of all young men know about periodic abstinence as a method of family planning. However, only 2 percent of women and 1 percent of men reported current use of periodic abstinence. In the 2000 Ethiopia DHS survey, women were asked about their knowledge of the time during a woman's menstrual cycle when a pregnancy is most likely to occur. The question was not asked of men. Overall, about one in ten women age 15-24 know that the most fertile period is halfway between two menstrual periods (Table 4.5). Two in five women do not know when the most fertile period is in a woman's cycle, and one in five stated that a woman is most susceptible to pregnancy just after her period ends. These findings indicate that there is an ongoing need to educate young women about their physiology. Because of the small number of users in this age group, it was not possible to obtain statistically reliable information on knowledge of the fertile period among users of periodic abstinence.

Table 4.5 Knowledge of fertile period

Percentage of sexually experienced and sexually inexperienced women age 15-24 with knowledge of the fertile period during the ovulatory cycle

	Never had sex	Ever had sex	Total
Perceived fertile period			
During her period	1.1	2.1	1.6
After period ended	8.9	32.2	20.7
Middle of the cycle	11.5	12.5	12.0
Before period begins	2.9	2.9	2.9
At any time	23.6	23.8	23.7
Don't know	51.8	26.4	39.0

Unmet Need for Family Planning Services

Despite the shift toward use of contraception among the young, nearly one-third of women age 15-24 have an unmet need for family planning (Table 4.6). These are women who state that they do not

Table 4.6 Need for family planning services

Percentage of sexually experienced women age 15-24 with unmet need and met need for family planning, the total demand for family planning, and the percentage of demand satisfied, by background characteristics

	Unmet need for family planning			Met need for family planning (currently using)			Total demand for family planning			Percentage of demand satisfied	Number
	For spacing	For limiting	Total	For spacing	For limiting	Total	For spacing	For limiting	Total		
Age											
15-19	27.8	3.6	31.4	3.2	1.5	4.8	31.0	5.2	36.1	13.2	1,166
20-24	26.9	5.4	32.2	6.3	1.6	8.0	33.2	7.0	40.2	19.8	2,161
Marital status											
Currently married	33.0	5.7	38.6	5.2	1.1	6.3	38.2	6.8	44.9	14.0	2,669
Not currently married, sexually experienced	3.6	1.1	4.7	5.4	3.6	9.0	9.0	4.7	13.7	65.7	658
Residence											
Urban	13.4	4.5	18.0	25.6	5.0	30.6	39.1	9.5	48.6	63.0	471
Rural	29.4	4.8	34.2	1.9	1.0	2.9	31.3	5.8	37.2	7.8	2,855
Region											
Tigray	19.6	1.1	20.7	6.0	1.1	7.0	25.6	2.1	27.8	25.4	243
Affar	10.4	3.0	13.4	7.5	5.1	12.6	17.8	8.1	25.9	48.4	43
Amhara	26.1	6.5	32.6	2.7	2.4	5.0	28.8	8.8	37.6	13.4	1,080
Oromiya	28.7	4.8	33.5	4.7	0.8	5.5	33.4	5.6	39.0	14.2	1,254
Somali	8.2	4.0	12.2	5.1	2.0	7.2	13.4	6.0	19.4	37.0	31
Benishangul-Gumuz	24.9	4.6	29.6	10.2	1.6	11.8	35.2	6.2	41.4	28.6	38
SNNP	35.7	3.3	39.0	5.4	1.2	6.6	41.1	4.5	45.6	14.6	511
Gambela	28.4	11.7	40.1	9.1	1.8	10.9	37.5	13.5	51.1	21.4	11
Harari	16.6	7.3	23.9	17.7	5.2	23.0	34.3	12.5	46.8	49.0	9
Addis Ababa	10.1	2.4	12.5	31.5	4.2	35.7	41.6	6.6	48.2	74.1	92
Dire Dawa	10.6	1.8	12.4	27.0	4.2	31.1	37.5	6.0	43.5	71.5	14
Education											
No education	27.0	4.5	31.5	2.0	0.7	2.7	29.0	5.2	34.2	7.9	2,567
Primary	30.4	6.8	37.1	10.3	3.8	14.1	40.7	10.5	51.2	27.5	512
Secondary and higher	22.1	3.2	25.3	28.8	6.0	34.8	50.9	9.2	60.1	57.9	247
Total	27.2	4.8	31.9	5.2	1.6	6.8	32.4	6.4	38.8	17.6	3,326

want any more children or want to delay their next birth by two or more years, but who are not using a method of contraception. Not surprisingly, a greater proportion of young women want to space births than want to limit births. Twenty-seven percent of young women have an unmet need for spacing compared with 5 percent of young women with an unmet need for limiting.

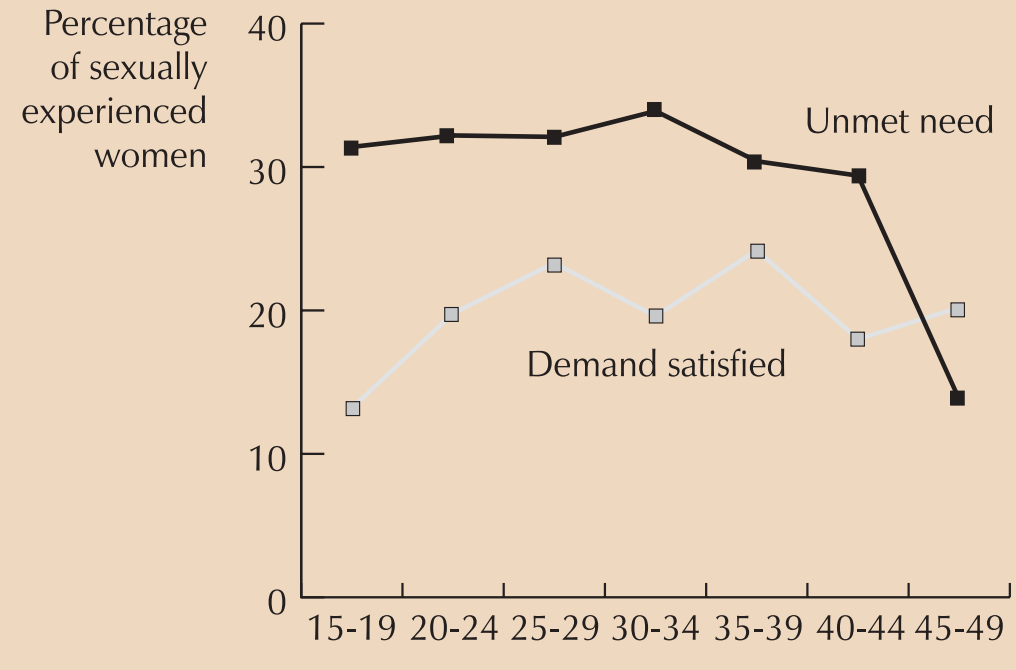
There is little difference in levels of unmet need between women age 15-19 and women age 20-24. Yet family planning services are more likely to address the needs of young adults than teens. Use among women age 20-24 is nearly twice that among women age 15-19. As a result, the percentage of the total demand satisfied among teens is 33 percent lower than among their older counterparts. In fact, data from the DHS survey show that teenage Ethiopian women have the highest level of unmet

need and the lowest level of demand satisfied, compared with women in the other older age groups (Figure 4.7).

Unmet need varies markedly by place of residence (Table 4.6). Unmet need among young rural women is much higher than among young urban women, with the need for spacing more than twice as high among the former than the latter group of women. The percentage of rural women whose demand for unmet need is satisfied is eight times less than that for urban women. The Gambela Region has the highest proportion of women with unmet need and the Amhara Region the lowest proportion of women whose demand for unmet need is satisfied. Conversely, young female residents of the Somali Region have the lowest unmet need, while Addis Ababa has the highest proportion of women whose unmet need for family planning is being met. The demand for family planning varies by level of education. Women with no education are seven times less likely than women with secondary education or higher and three times less likely than women with primary education to have the demand for family planning satisfied.

These findings underscore the importance of family planning service providers to recognize and address the needs of young women, rural women, and women with little or no education.

Figure 4.7 Unmet need for family planning and percentage of demand satisfied



Missed Opportunities

Family planning providers do have the opportunity to discuss contraceptive use with women during field visits to women's homes, or when they visit a health facility (for any reason at all). The DHS survey gathered information on contact of nonusers with family planning providers, including missed opportunities to discuss family planning between providers and sexually experienced young women who are not currently using a method of contraception. As seen in Figure 4.8, providers usually do not take advantage of contact with nonusers to discuss family planning. The majority of young women (90 percent or more) never discussed family planning with a fieldworker or at a health facility.

Use of contraception among women age 15-24 is generally lower than use among women age 25 and above. This could be because young women usually want to start a family soon after marriage and delay the use of family planning until after they have achieved their desired family size, or because service providers fail to recognize the contraceptive needs of young women.

Future Use of Contraception

Figure 4.9 shows that more than one in two women and two in three men who are currently not using a method of family planning intend to use a method sometime in the future. About two-fifths of

Figure 4.8 Missed opportunities to discuss family planning

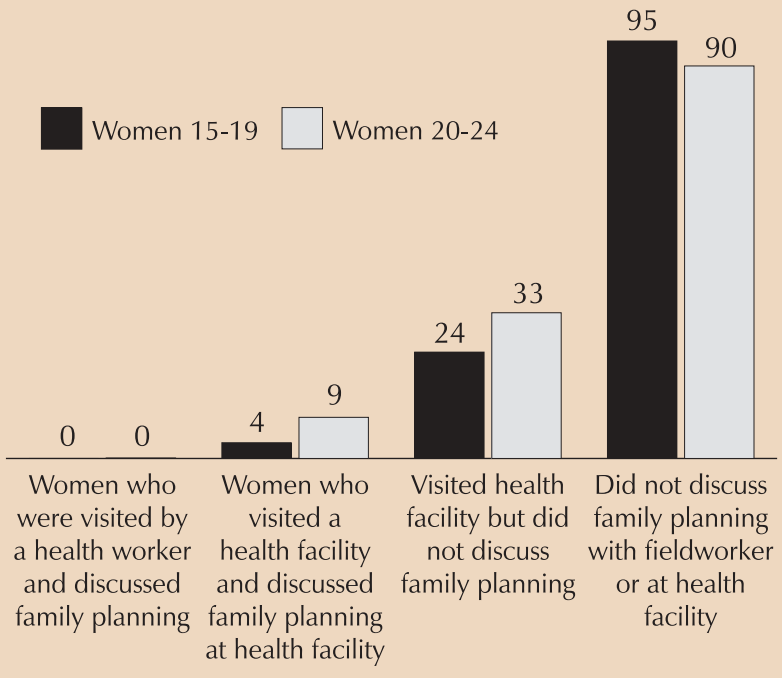
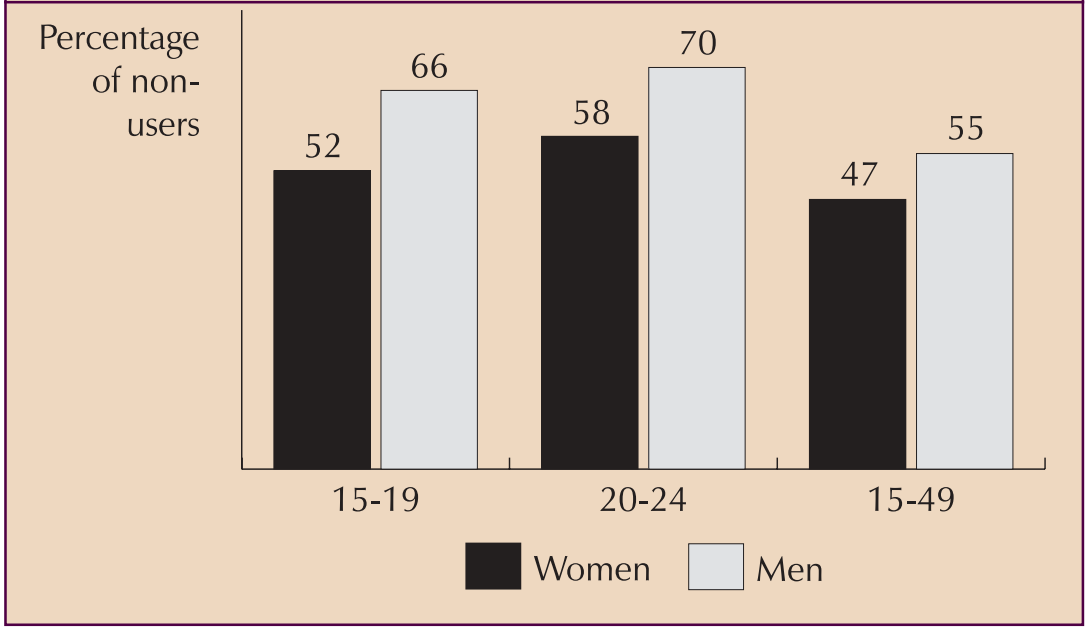


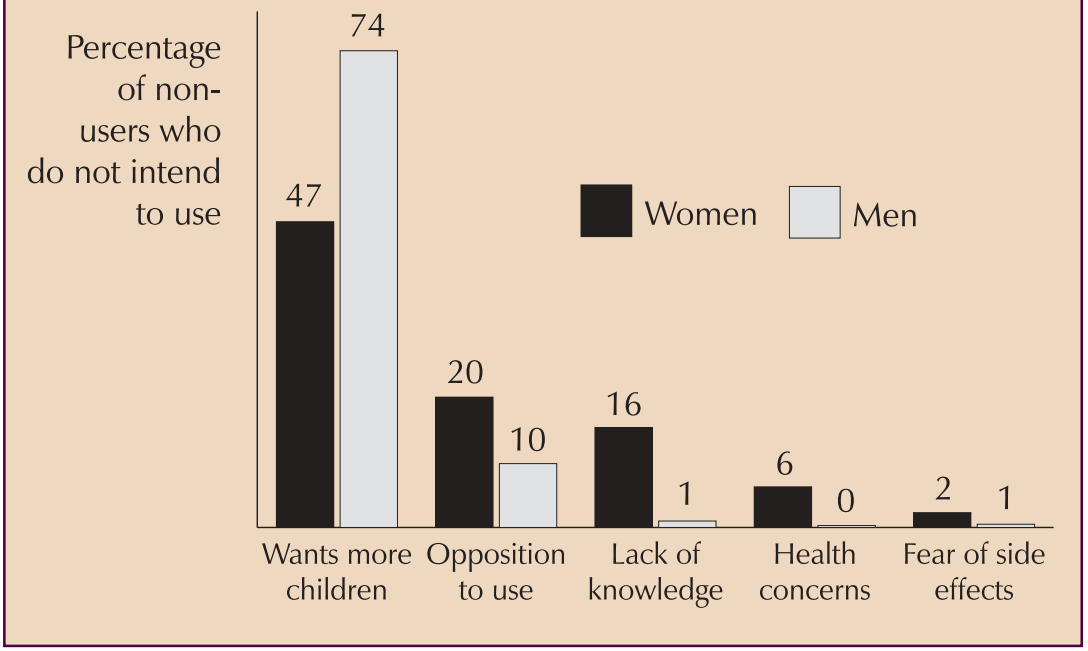
Figure 4.9 Future use of contraception



women and one-fourth of men do not intend to use a method of family planning in the future.

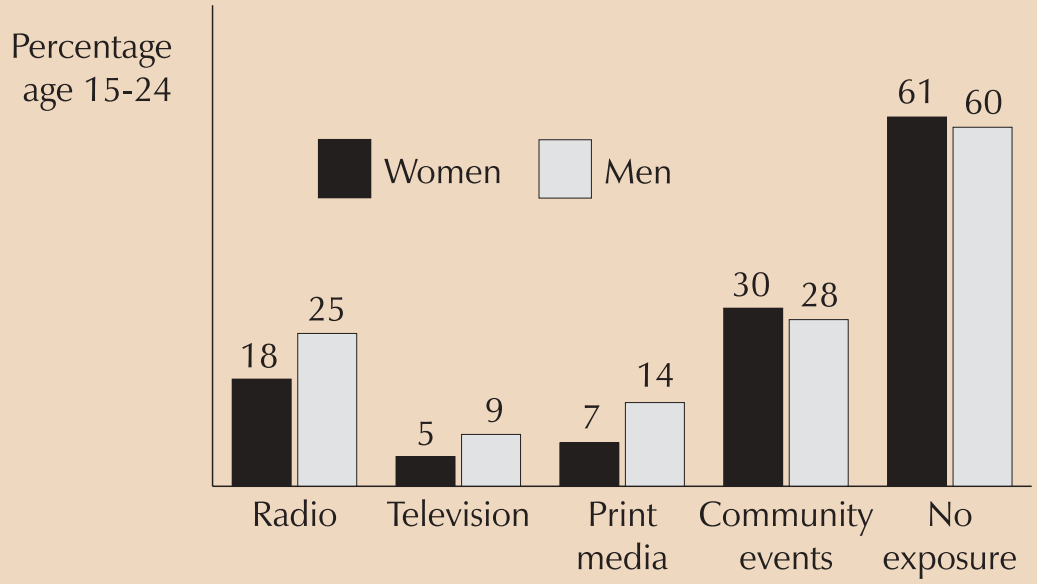
It is critical for programmatic purposes to ascertain why young women and men do not intend to use a method of contraception in the future. As shown in Figure 4.10, the primary reason for not intending to use in the future is desire for more children. However, one in five women and one in ten men

Figure 4.10 Reasons for nonuse of contraception in the future



report that they do not intend to use because they, their husband or partner, or others are opposed to use, or for religious reasons. A sizeable proportion of young women (16 percent) also mentioned lack of knowledge of a method or a source for a method as a reason for not intending to use in the future. The two latter reasons emphasize the importance of targeting young adults with information, education, and counseling campaigns. Unfortunately, most young adults have little exposure to family planning messages (see Figure 4.11). Three-fifths of young adults have had no exposure to family planning messages in the media.

Figure 4.11 Exposure to family planning messages



Chapter 5
Fertility and Childbearing

Ethiopia is characterized by rapid population growth, a direct result of a high level of fertility. As a consequence, the majority of its population is young—under 25 years of age. Most young women marry in their teens and have children at a relatively young age, thus contributing to the continuing population momentum. This chapter highlights fertility and childbearing among the young adult population, their ideal family size, the proportion of unintended pregnancies, and how young women cope with unplanned pregnancies.

Fertility

At current fertility levels, an Ethiopian woman will have an average of about 6 children by the end of her reproductive years. Childbearing begins early with the number of births among women age 15-19 at 110 per 1,000 women, and among women age 20-24 at 244 per 1,000 (Table 5.1). DHS data show that over the last two decades, fertility has declined among all age groups of women. However, this decline has been greatest among teens, with a 43 percent decline (Figure 5.1). Nevertheless, at the current fertility rate, young adults will have nearly two children by age 25.

The data show further evidence that childbearing in Ethiopia begins at an early age. Among all teenage women, 13 percent have given birth to at least one child, and among all women in their early twenties, more than one-third have two or more children (CSA and ORC Macro, 2001). In addition, more than 50 percent of women age 30 and above have had their first birth in their teens, and even among the cohort age 20-24, more that two-fifths have had a birth before age 20.

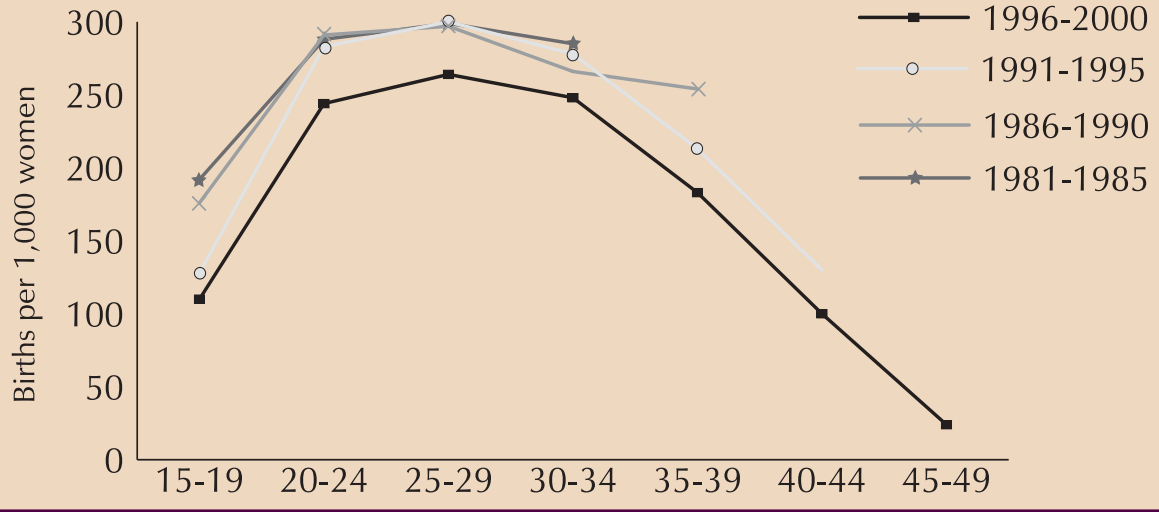
Table 5.1 Trends in fertility

Age-specific fertility rates (per 1,000 women) and total fertility rates

Age	1990 NFFS[1]	2000 Ethiopia DHS[2]		
		Urban	Rural	Total
15-19	95	60	123	110
20-24	275	149	266	244
25-29	289	156	289	264
30-34	257	160	264	248
35-39	199	97	199	183
40-44	105	33	109	100
45-49	56	4	27	24
Total fertility	6.4	3.3	6.4	5.9

[1] CSA, 1993
[2] CSA and ORC Macro, 2001

Figure 5.1 Trends in age-specific fertility rates



Pregnancy and Motherhood

Thirty-seven percent of young women age 15-24 have begun childbearing—34 percent of mothers have at least one child and another 3 percent were pregnant with their first child at the time of the survey (Table 5.2). Teenage pregnancy and childbearing increases from 1 percent among women age 15 to 40 percent among women age 19, with those pregnant with their first child increasing from less than 1 percent among the youngest teen to 6 percent among the oldest (Figure 5.2). The percent of mothers continues to increase beyond age 19 to 75 percent among women age 24, while the percent pregnant with their first child declines after age 19 to 3 percent among women age 24.

Teenage pregnancy is higher among rural women than urban women and is highest in the Oromiya Region and lowest in Addis Ababa. Education influences pregnancy and childbearing at an early age. Three in four sexually experienced women with little or no education are mothers or pregnant with their first child at a young age compared with two in three women with secondary education or higher.

Ideal Family Size

Information on the ideal family size is important because it provides an indication of the total number of children women who have not started childbearing will have in the future, and is also a measure of the extent of unwanted births among older and high parity women. Women and men were asked how many children they would like to have in their whole life if they could choose the exact number of children to have. There is a clear trend toward a smaller ideal family size among Ethiopians. The mean ideal family size has declined from 6.7 children among women age 45-49 at the time of the

Table 5.2 Teenage pregnancy and motherhood

Percentage of women age 15-24 who are mothers or pregnant with their first child, by background characteristics

	Percentage who are:		Percentage who have begun childbearing	Number
	Mothers	Pregnant with first child		
Age				
15	0.7	0.5	1.2	892
16	3.5	3.0	6.5	798
17	12.0	3.5	15.5	659
18	22.0	5.4	27.4	827
19	33.8	5.9	39.7	534
20	52.5	3.1	55.6	807
21	56.3	3.3	59.7	424
22	60.4	3.4	63.8	610
23	70.0	1.6	71.7	495
24	75.0	2.6	77.6	523
Residence				
Urban	20.5	2.3	22.9	1,359
Rural	37.7	3.4	41.2	5,211
Region				
Tigray	38.8	2.1	40.9	391
Affar	39.4	3.6	42.9	64
Amhara	44.4	2.9	47.3	1,488
Oromiya	33.7	3.7	37.4	2,775
Somali	30.4	3.4	33.8	70
Benishangul-Gumuz	37.7	3.2	40.9	69
SNNP	28.0	3.3	31.3	1,311
Gambela	48.6	3.7	52.3	16
Harari	31.1	3.8	34.9	18
Addis Ababa	11.6	1.1	12.7	335
Dire Dawa	16.5	4.3	20.8	34
Education				
No education	41.0	3.9	44.8	4,280
Primary	23.3	2.0	25.3	1,473
Secondary and higher	18.3	1.8	20.1	817
Total	34.2	3.2	37.4	6,570

survey to 4.2 children among women in their teens (CSA and ORC Macro, 2001). Similarly, older men age 45-49 have a larger mean ideal family size than younger men, decreasing from 9.7 children (among men age 45-49) to 4.5 children (among men age 15-19). This trend is also noticeable among the female youth population age 15-24 whose mean ideal number of children is 4.5 (Figure 5.3). The mean ideal number of children ranges from a high of 5.3 children among young adults age 23 to a low of 4 children among teens age 15, with an obvious hike between ages 19 and 20 and ages 22 and 23. Although men have a higher ideal family size than women, in general, the male-female difference in mean ideal family size is less obvious among the young male population (age 15-24) in contrast to the three-child difference in the adult population age 45-49. The mean ideal number of children among male youths age 15-24 is 4.7 children; it ranges from a high of 5.7 children among men age 23 to a low of 4.1 children among men age 19, and displays a somewhat erratic pattern by age.

Figure 5.2 Teenage pregnancy and motherhood

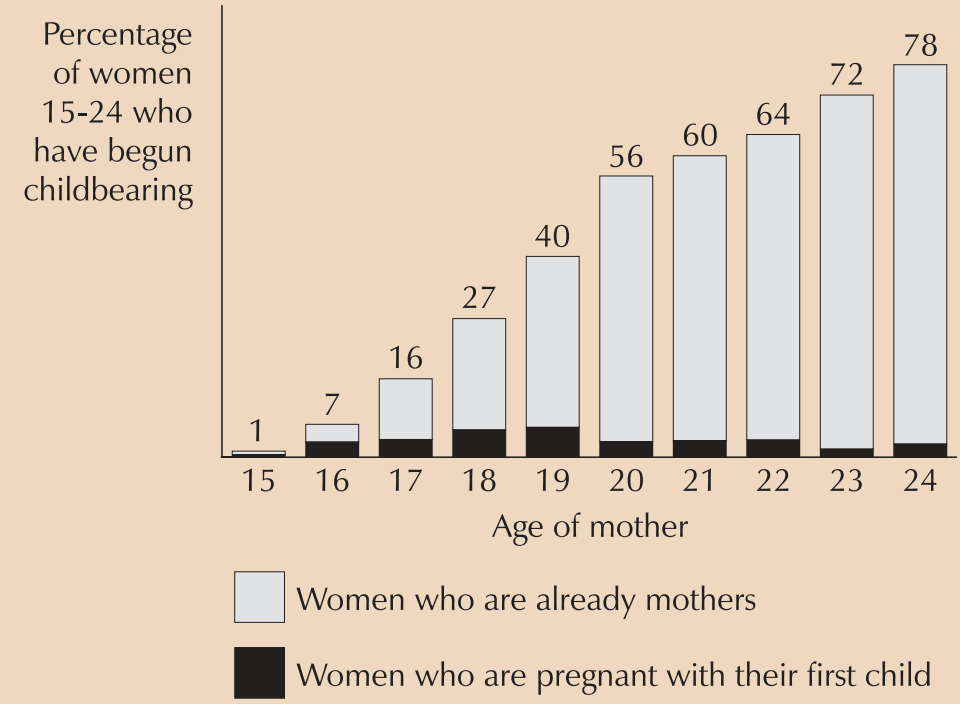
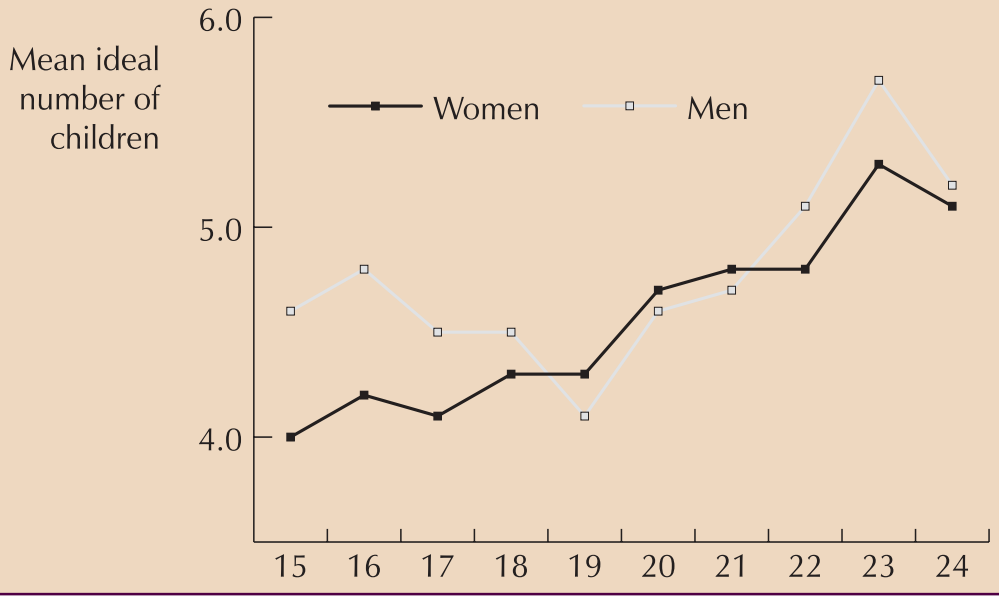
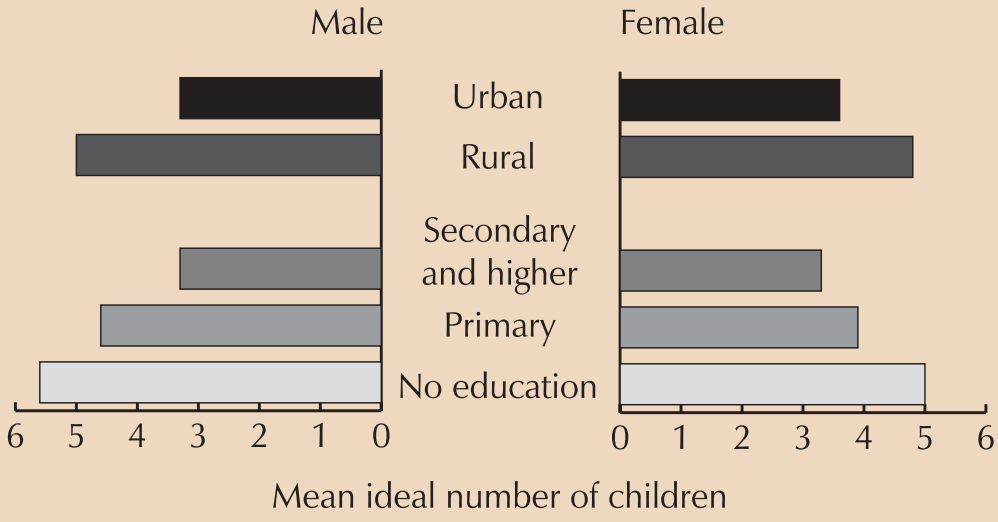


Figure 5.3 Mean ideal number of children by gender



The ideal family size is influenced to a large extent by respondents' place of residence and education (Figure 5.4). Young urban women and men have a smaller ideal family size than rural women and men, and the ideal number of children varies inversely with education.

Figure 5.4 Mean ideal number of children by residence and education

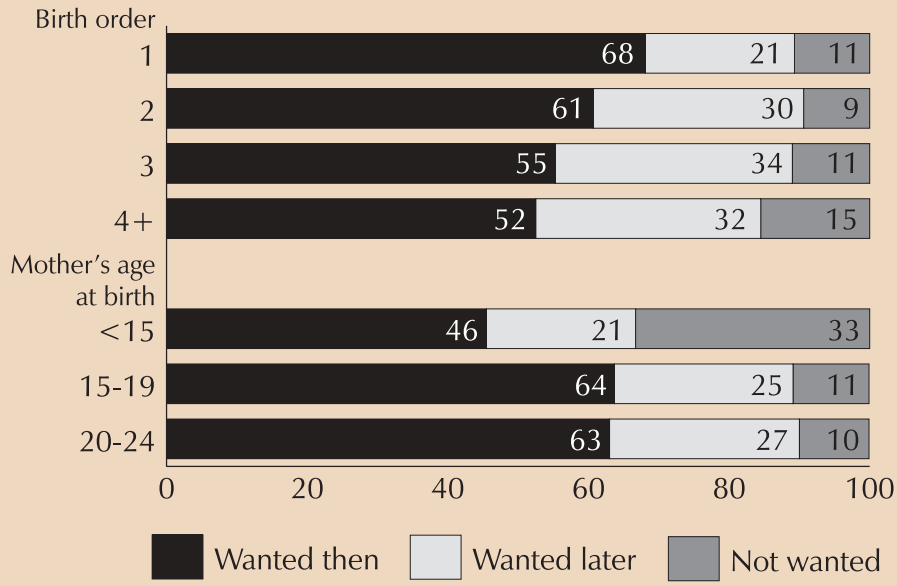


Unintended Births

Young adults in Ethiopia are vulnerable to unintended pregnancies, because they initiate sex at a relatively early age, are not knowledgeable about their sexuality, are unlikely to use contraception, have little access to family planning information and services, and often have little control over their reproductive health. Information on unintended pregnancies was collected from women through a series of questions about each of their children born in the five years before the survey. Similar information was also collected with reference to a current pregnancy.

A sizeable proportion of births to young women are reported to be unintended (Figure 5.5). More than half of all births to women under age 15, and more than one in three births to women age 15-19 and 20-24, at the time of birth, is unintended. One in three births to women at a very young age (< 15 years) is reported to be unwanted, in contrast to one in ten births to women age 15-24. About one in five births to young women is also reported as mistimed. Not surprisingly, unplanned pregnancies among youths also increase with parity. For example, one-third of first births are unwanted or mistimed, whereas one in two births of parity four and above is unwanted or mistimed.

Figure 5.5 Are births planned?



Unsafe Abortions

In an environment where access to contraceptive knowledge and use by young adults is minimal and where knowledge of reproductive health is low, unintended pregnancies place young adults in a dilemma. Induced abortions in Ethiopia are legal only under extenuating circumstances. Most young women who do not want to carry a pregnancy to its full term resort to unsafe abortions.

The 2000 Ethiopia DHS survey did not collect information on induced abortions but did include a series of questions to gauge the proportion of pregnancies that ended in a stillbirth or early loss. Even though information on early pregnancy losses cannot be classified as induced or spontaneous abortions, these data are informative in providing some indication of the extent of terminated pregnancies among young women and the potential health risks faced by young adults. It is important to note that information on pregnancy loss is subject to substantial underestimation.

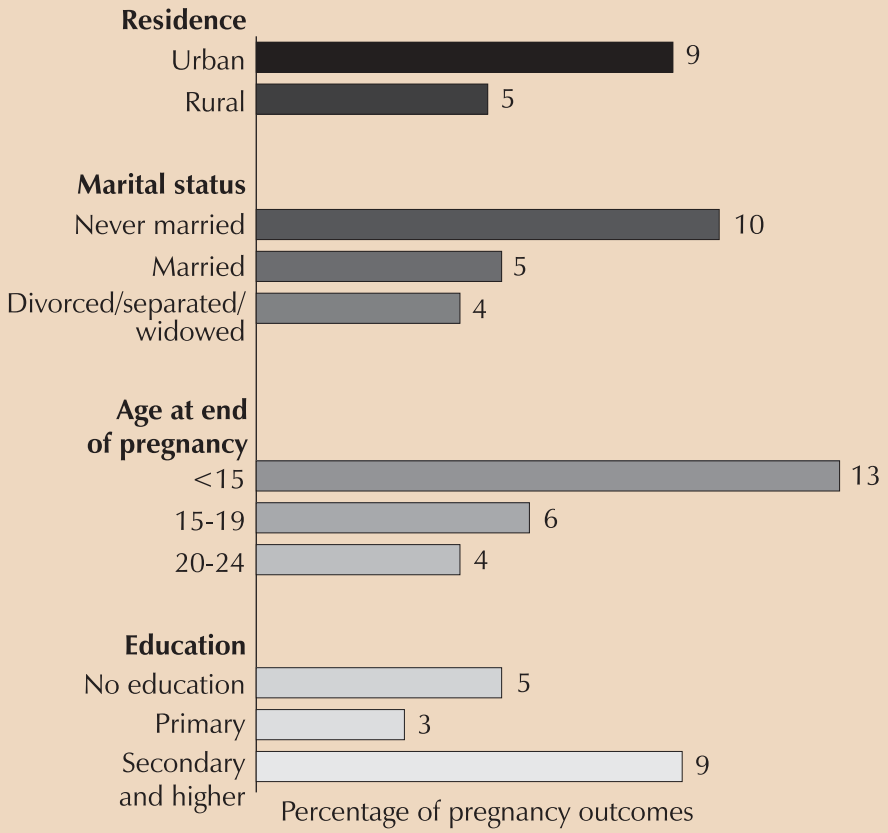
Five percent of pregnancies to young women ended in a miscarriage or abortion. Pregnancy terminations are higher in urban (9 percent) than rural areas (5 percent) (Figure 5.6). The proportion of pregnancies terminated varies by demographic and background characteristics. Young women are three times (and twice) as likely to experience a miscarriage (or abortion) when they are under age 15 than when they are age 20-24 (or 15-19). Women who have never been married are twice as likely to have terminated a pregnancy as currently married or formerly married women.

Pregnancy terminations are highest among young women with at least a secondary level of education

(9 percent) and lowest among women with primary education (3 percent). Pregnancy terminations also rise with the number of pregnancies in the preceding five years—from 4 percent among women who have had one pregnancy to 13 percent among women who have had 3 or more pregnancies.

These results underscore the importance of addressing the unmet need of young adults by providing access to basic reproductive health information that would enable them to take control of reproductive health decisions.

Figure 5.6 Pregnancy terminations (miscarriages/abortions)



Chapter 6
Maternal and Child Health

Health Implications of Early Childbearing

Young women are more vulnerable to pregnancy complications because of their physiological immaturity. In addition, their inexperience with childcare practices influences maternal and child health. Early childbearing contributes to high fertility and increases competition among siblings for food and other economic resources, thus contributing to malnutrition and other childhood illnesses. Frequent childbearing at a young age drains maternal strength and contributes to maternal malnutrition. Early childbearing also greatly reduces young mothers' educational and employment opportunities.

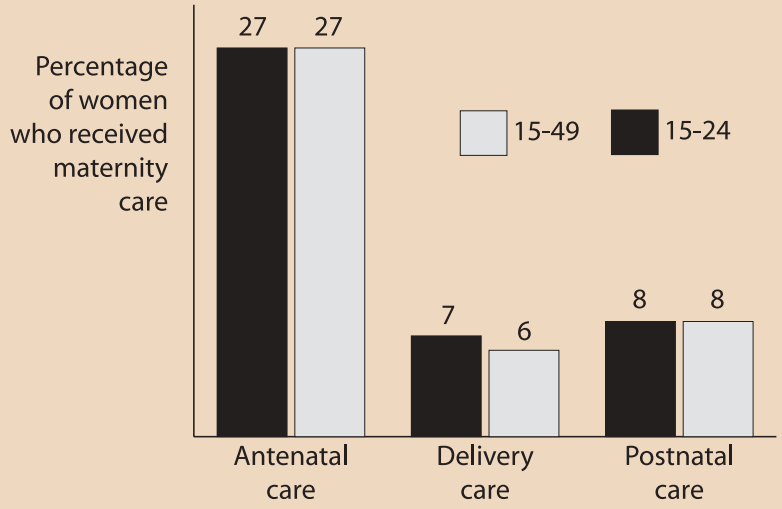
As seen in Chapter 5, most women in Ethiopia give birth in their teens. Studies have shown that pregnancy-related complications are the major cause of health-related problems among women age 15-19 (Bambra, 1999). This chapter presents information on utilization of reproductive health services by young adults and discusses some health implications of early childbearing on young women and their children.

Maternal Health

Antenatal Care

Most young mothers in Ethiopia (> 70 percent) do not receive antenatal care during pregnancy. Only one in four women age 15-24 who have had at least one live birth in the five years preceding the survey have received antenatal care services from a health professional (doctor, nurse, midwife) (Figure 6.1). Young mothers are not disadvantaged in receiving professional maternity care compared

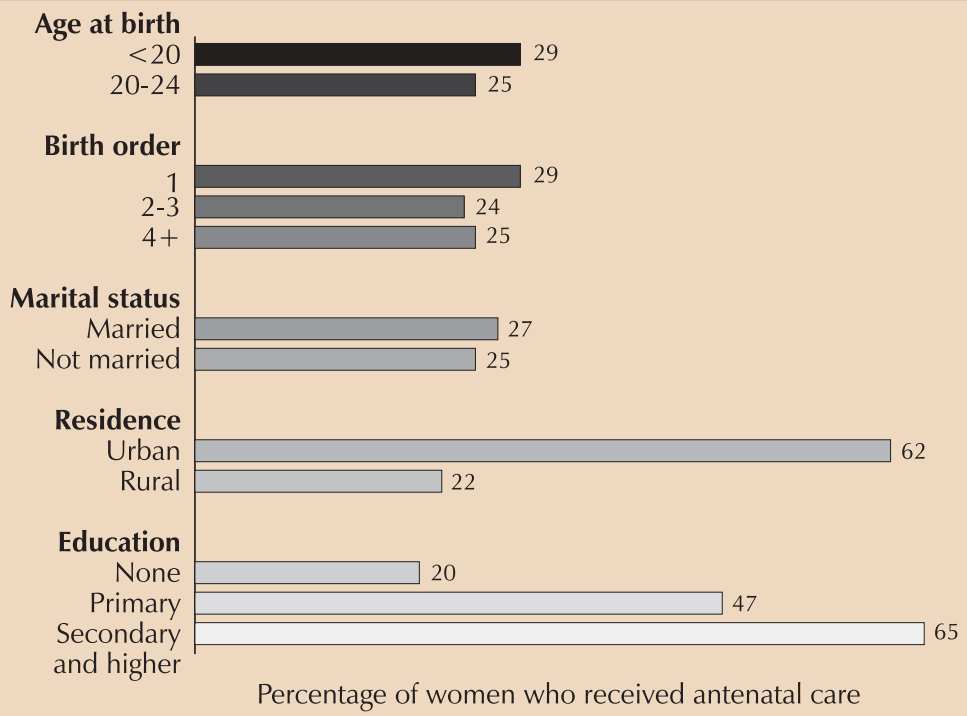
Figure 6.1 Maternity care



Note: Refers to percentage of women age 15-24 who received antenatal care from a doctor, nurse, or midwife for the most recent birth in the five years preceding the survey

with other mothers. Those who were less than 20 years of age when their child was born are slightly more likely to have received antenatal care services from a health professional than mothers whose age at birth is between 20 and 24 (Figure 6.2). Mothers pregnant with their first child are also slightly more likely to receive professional health services. Young urban mothers are three times as likely to receive professional antenatal care than young rural mothers. There is little difference in antenatal care received by the marital status of young mothers. Educated mothers are much more likely to receive care from a health professional during pregnancy.

Figure 6.2 Antenatal care



Note: Refers to percentage of women age 15-24 who received antenatal care from a doctor, nurse, or midwife for the most recent birth in the five years preceding the survey

In order to monitor and prevent adverse pregnancies, health professionals recommend an average of 12 antenatal care visits throughout a pregnancy and advise pregnant women to initiate the first visit within the first three months of pregnancy. The median number of antenatal visits among young women age 15-24 is 2.4—about five times less than the recommended number of visits; the median duration of pregnancy at first visit is 5.6 months (Figure 6.3). There is no difference in the frequency of antenatal visits by mother's age, and a small difference in timing of first visit. Teenage mothers make their first visit slightly later than mothers in their early twenties. At the same time, unmarried mothers visit more frequently and make their first visit earlier than married mothers.

An essential component of good quality antenatal care is, among other things, teaching women how

to recognize the danger signs associated with pregnancy complications. One in five young women was informed about pregnancy complications (Figure 6.4). In general, there is little difference in the quality of antenatal care received between teenage mothers (age <20) and young mothers age 20-24, with the former group of mothers only slightly more likely to be informed about pregnancy complica-

Figure 6.3 Frequency and timing of antenatal visits

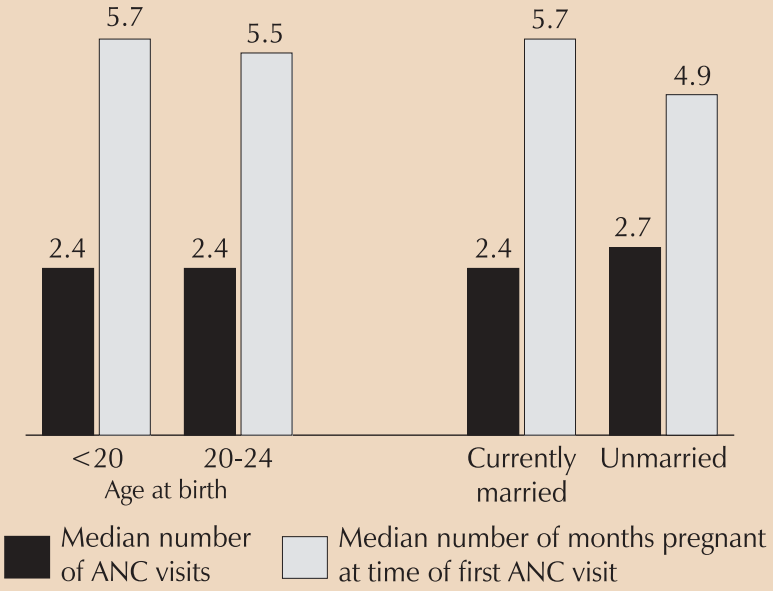


Figure 6.4 Quality of antenatal care

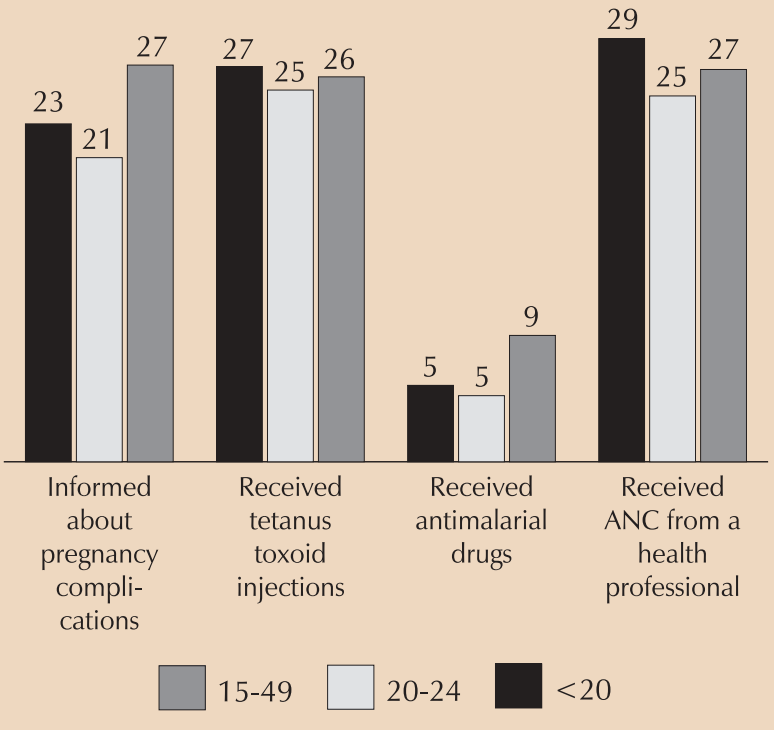
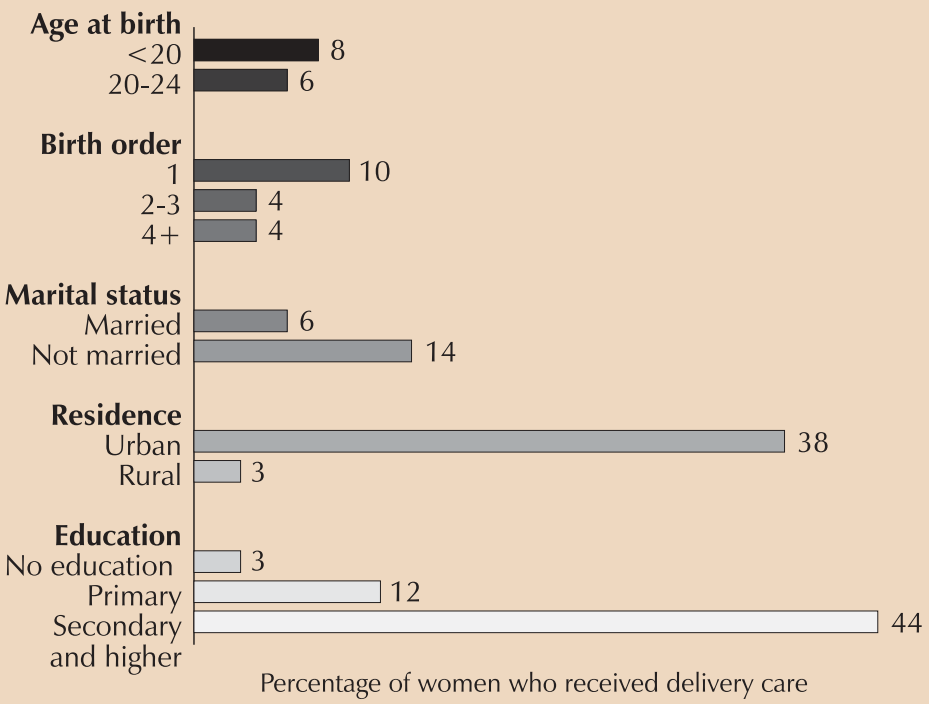


Figure 6.5 Delivery care



Note: Refers to percentage of women age 15-24 who received delivery care from a doctor, nurse, or midwife for the most recent birth in the five years preceding the survey

tions and who received quality care (Figure 6.4). In general, as discussed earlier, urban residence and education have a positive effect on quality of care. Mothers of first births are more likely to be informed about pregnancy complications than mothers with two or more live births, as are unmarried mothers rather than currently married mothers.

Delivery Care

A very small percentage of Ethiopian mothers (7 percent) receive delivery assistance from health professionals (Figure 6.5). Young mothers under age 25 are much more likely to be assisted at delivery by health professionals than older mothers. Noteworthy is the marked difference in professional assistance at delivery by place of residence. Urban mothers are 12 times more likely than rural mothers to receive professional assistance at delivery.

Only 6 percent of births to young mothers take place in a health facility. Since professional assistance is predominantly provided within a health setting, differences by demographic and socioeconomic characteristics mirror differences found in delivery care received from health professionals.

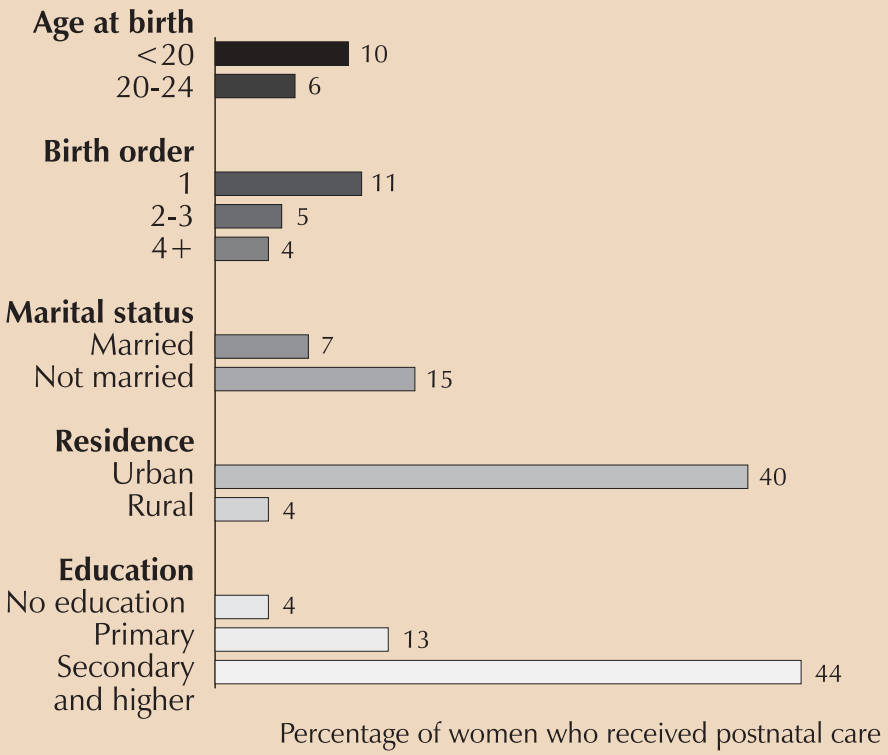
Postnatal Care

Safe motherhood programs emphasize the importance of follow-on visits within 48 hours of a delivery—the period during which the risk of maternal and neonatal deaths are high. Fewer than one in ten mothers in Ethiopia receive a postnatal check-up from a medical professional within the first two days of delivery. Deliveries that take place within a health institution are assumed to receive postnatal care within the first 48 hours. As discussed in the earlier section, this percentage is very low in Ethiopia. In addition, less than 2 percent of mothers who had a delivery outside an institutional setting received postnatal care from a health professional.

Mothers who are in their teens at delivery, mothers of first births, urban mothers, mothers not currently married, and highly educated mothers are somewhat more likely to receive postnatal care from a medical professional within the first two crucial days following delivery (Figure 6.6).

Education and residence emerge as powerful predictors of utilization of maternity care services when the influence of other variables in controlled, within a multivariate framework. Women who have

Figure 6.6 Postnatal care



Note: Refers to percentage of women age 15-24 who received postnatal care from a doctor, nurse, or midwife for the most recent birth in the five years preceding the survey

some education are much more likely to have accessed maternity care services from a health professional than uneducated women, as are women who reside in urban areas. In addition, women are significantly more likely to receive professional health care at delivery for first births. Women are also more likely to go to a health professional for a postnatal check-up if they have been exposed to the radio.

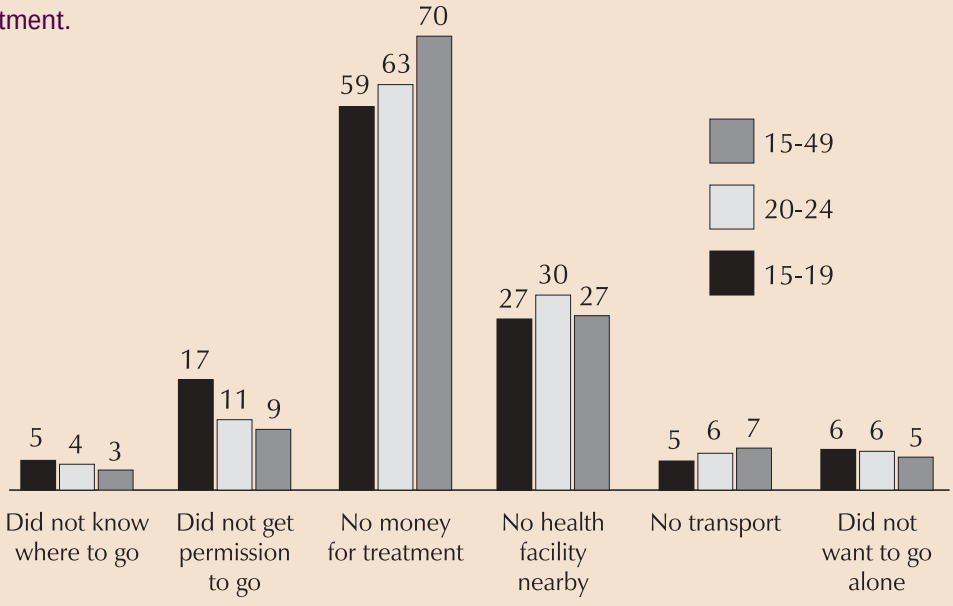
Child Health

Childhood Mortality

Numerous studies have linked young maternal age to an elevated risk of child mortality. This is because 1) pregnancies that occur before mothers have attained full maternal growth or physical maturity may result in a greater risk of complications during pregnancy or childbirth (Aitken and Walls, 1986); and 2) young women who become pregnant are less likely to receive early and adequate prenatal care, are more likely to be from a socioeconomically disadvantaged environment, and are less likely to be able to care for their children because they are psychologically immature (Geronimus, 1987). In addition, there is also the possibility that children born to very young mothers are more likely to be unplanned and therefore not wanted.

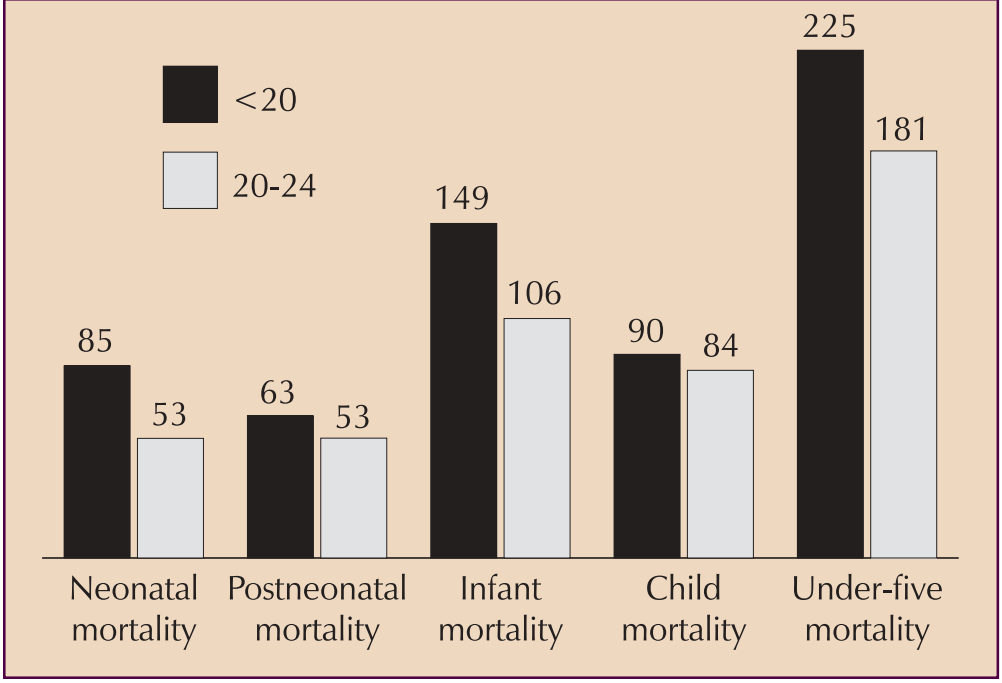
Problems in Accessing Health Care

The Ethiopia DHS included a series of questions to ascertain the reasons women did not seek medical care for themselves the last time they were sick. Three-fifths of young women stated that lack of money was an important reason. Young women are more likely than older women to have problems getting permission to go for treatment.



Ethiopia experiences some of the highest rates of infant and child mortality in the world. The data show that children born to mothers in their teens have a substantially higher risk of dying young. For example, the probability of dying within the first month of life (the neonatal mortality rate) among children born to teen mothers is 60 percent higher than among children born to mothers in their early twenties (Figure 6.7). Similarly, infant mortality and under-five mortality is 40 percent and 25 percent higher, respectively, to mothers in their teens than mothers in their early twenties.

Figure 6.7 Childhood mortality by mother's age



Immunization and Childhood Illnesses

Universal vaccination remains exceptionally low in Ethiopia. Only 17 percent of all children, age 12-23 months are fully vaccinated at the time of the survey (that is, they have received BCG, measles, and three doses each of DPT and polio vaccines). Mothers in their early twenties are less likely to have children fully vaccinated than mothers in their teens (Figure 6.8). A similar pattern is seen in the percentage of children taken to a health facility for the treatment of common childhood illnesses. Mothers in their early twenties are less likely than teen mothers to take their children to a health facility or provider for the treatment of acute respiratory infections, fever, and/or diarrhea (Figure 6.9). This is in contrast to popular belief that teen mothers are less able to take care of their children's health because of their emotional immaturity and lower status in the household to make important health decisions independent of their spouse and older household members. One possible explanation for why teen mothers are more likely to take their children to a health facility for treatment may be the confounding effect of education. As seen in Chapter 2, women in their teens are more edu-

Figure 6.8 Children age 12-23 months fully vaccinated

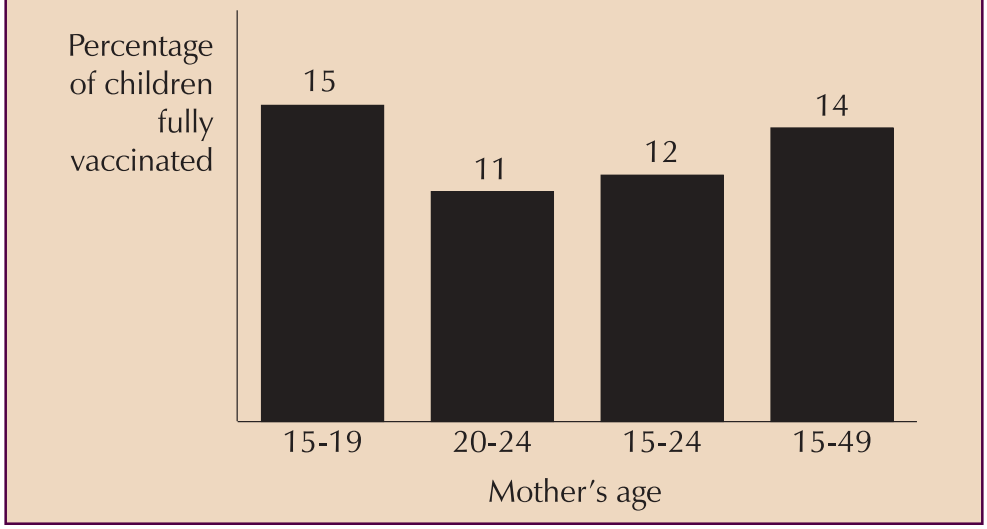
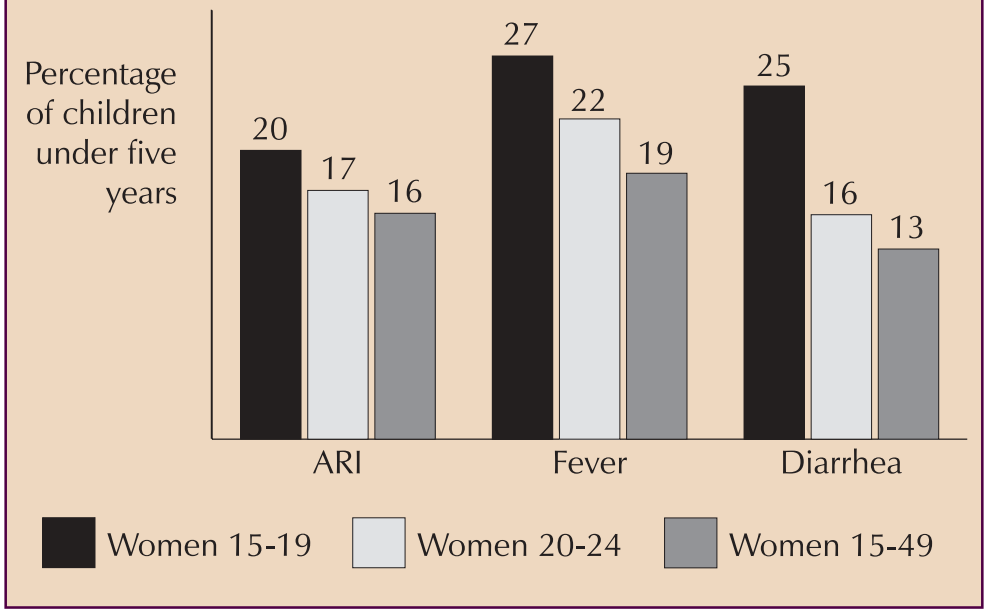


Figure 6.9 Treatment of childhood illnesses

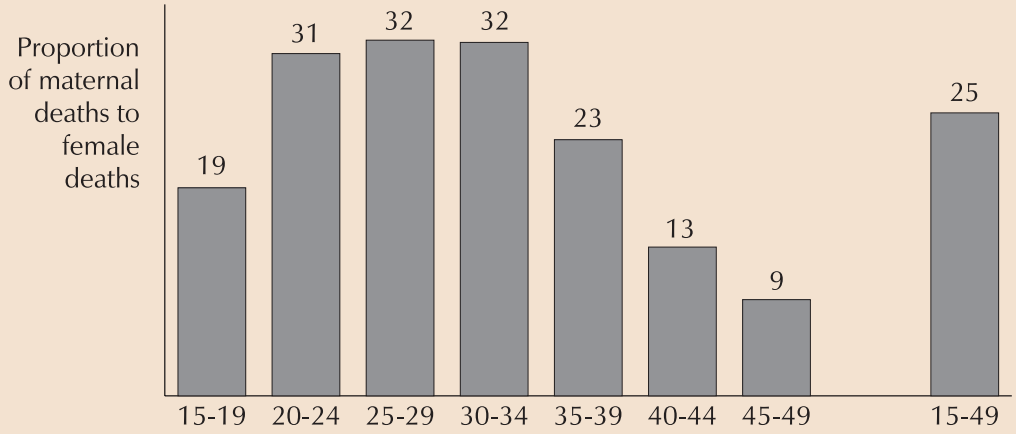
Percentage of children under five years taken to a health provider for treatment



cated than women in their early twenties, and education as we know exerts a powerful positive impact on health care knowledge and utilization, and its impact may be especially obvious in an environment where the majority of women remain poorly educated.

Maternal mortality

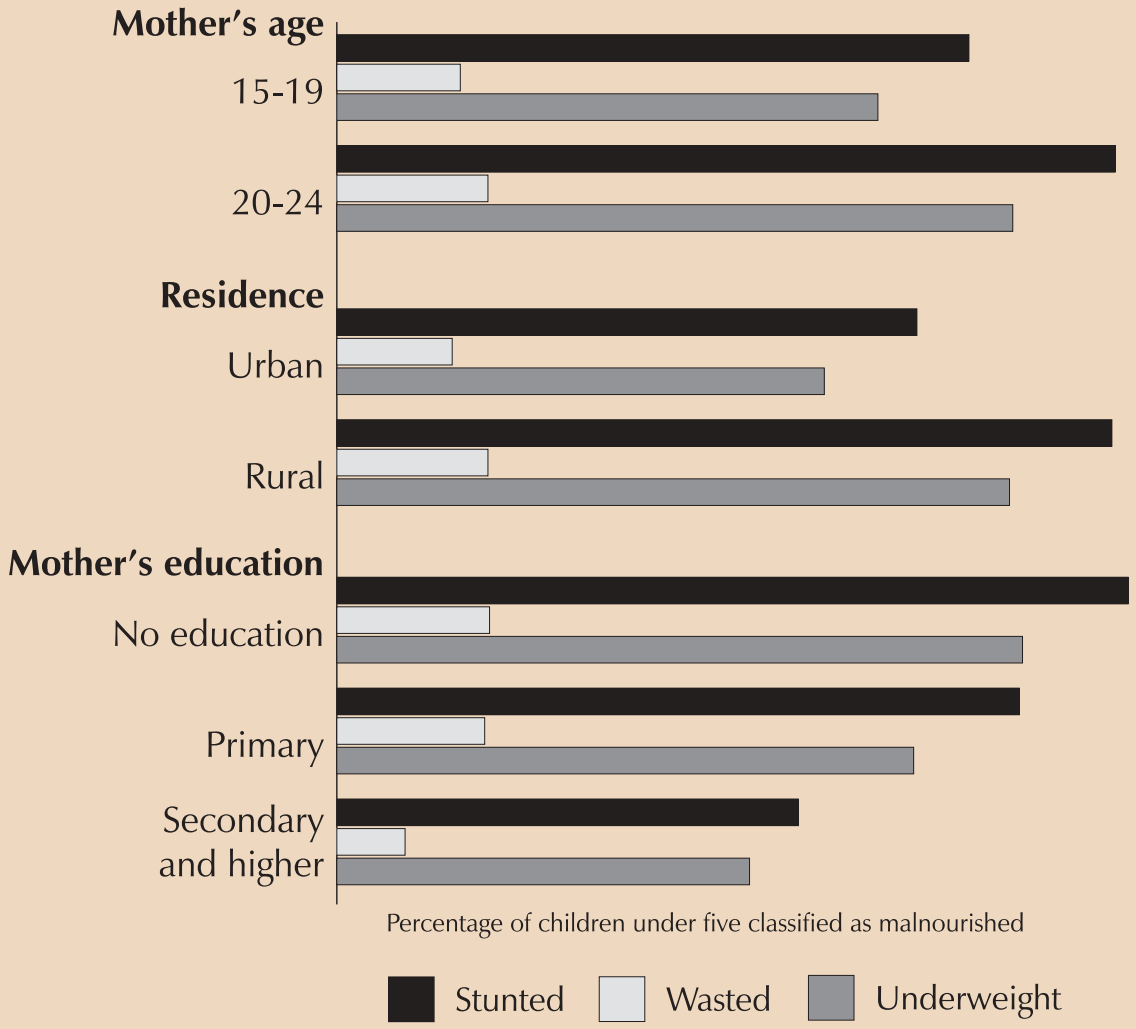
Studies have found that women who give birth in their early teens face an increased risk of maternal mortality (Harrison and Rossiter, 1985); that is, any death during pregnancy, childbirth, or within two months after the birth or termination of a pregnancy. The Ethiopia DHS gathered information on maternal mortality for the period seven years before the survey. Maternal deaths in Ethiopia are relatively high; however, for each age group, maternal mortality is a relatively rare occurrence and, as such, the age-specific pattern should be interpreted with caution. Nearly one in five deaths to women in their teens and three in ten deaths to women in their early twenties is due to maternity-related causes, compared with one in four deaths to women age 15-49.



Nutritional Status of Children

Data from the DHS survey indicate that chronic malnutrition among Ethiopian children is high, with more than one in two children under age five stunted, one in ten wasted (that is, thin for their height), and nearly one in two underweight. To find out about malnutrition among children of young mothers, the DHS data were analyzed for mothers age 15-24. Children born to young mothers are slightly better off in terms of nutritional status than children of older mothers. For example, 46 percent of children under five to mothers age 15-24 are stunted, 9 percent are wasted, and 40 percent are underweight (compared with 51 percent of children under five to mothers age 15-49 who are stunted, 11 percent who are wasted, and 47 percent who are underweight). Children of teenage mothers are slightly better off nutritionally than children of mothers in their early twenties (Figure 6.10).

Figure 6.10 Nutritional status of children under five years



Chapter 7
HIV/AIDS and Other Sexually Transmitted Diseases

Acquired Immune Deficiency Syndrome (AIDS) was first recognized internationally in 1981. Since the epidemic began 20 years ago, more than 60 million people worldwide have been infected with the virus. AIDS is the leading cause of death in sub-Saharan countries and the fourth largest killer in the world (UNAIDS, 2002). As of 2001, an estimated 40 million adults and children around the world were living with the human immunodeficiency virus (HIV)—28 million alone in sub-Saharan Africa (UNAIDS, 2002). The majority of new infections in the developing world are among young adults. Every minute, five people under 25 are infected with HIV (UNFPA, 2002). One in three persons living with HIV/AIDS is age 15-24 and most of them are unaware that they carry the virus. Millions more have little or no knowledge of the disease and do not know how to protect themselves or take measures to prevent the spread of the disease. Women and girls are most vulnerable to infection. This is especially so in developing countries, where women are 37 times more likely to have HIV/AIDS than women in developed countries. At the same time, men in developing countries, who command much more power than women, are nine times more likely than men in developed countries to have HIV/AIDS (UNFPA, 2002).

HIV/AIDS cases have been reported in Ethiopia since the early 1980s. Although the prevalence of HIV was very low in the early 1980s, it has been increasing rapidly over the past few years. It is currently estimated that about 3 million Ethiopians live with HIV/AIDS, a prevalence of about 7 percent (MOH, 2002b). According to the HIV sentinel surveillance of mothers seeking antenatal care, prevalence is 11 percent among those age 15-19 and 15 percent among those age 20-24 (MOH, 2000a). By the year 2010, the total HIV population is projected to grow by more than one million overall and by 910,000 among those age 10-24 (MOH, 2000b).

Knowledge of HIV/AIDS

The DHS data show that most young Ethiopians have heard of AIDS, with men somewhat more likely than women to have heard of the infection. More than four in five young women and nine in ten young men age 15-24 are aware of AIDS (Table 7.1). A relatively high percentage of youth (70 percent of women and 84 percent of men) believe that there is a way to avoid getting AIDS.

Teens are less likely to have heard of AIDS than youth in their twenties (Table 7.1). Awareness is also higher among ever-married than never-married youth and among those who are sexually experienced than among those who have never had sex (Figure 7.1). Urban youth and youth in more urban areas of the country (Addis Ababa, Dire Dawa, Harari) are much more likely to have heard about AIDS than their rural counterparts. Education exerts a powerful influence; nearly all youth with primary or higher levels of education are aware of the infection.

Table 7.1 Knowledge of AIDS

Percentage of women and men age 15-24 who have heard of AIDS and who believe there is a way to avoid AIDS, by background characteristics

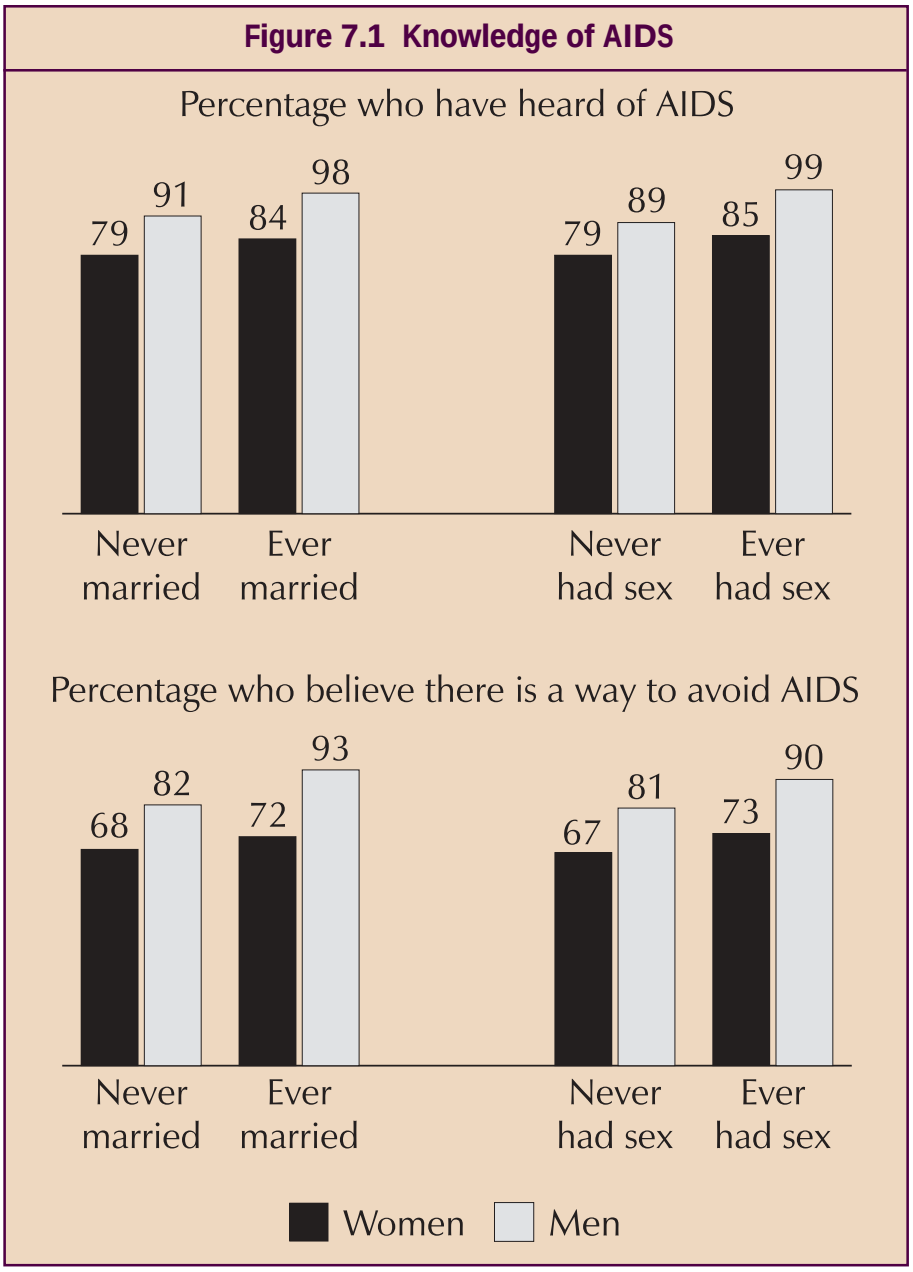
	Women			Men		
	Knows AIDS	Believes there is a way to avoid AIDS	Total	Knows AIDS	Believes there is a way to avoid AIDS	Total
Age						
15-16	73.3	61.7	1,690	78.7	69.7	236
17-18	82.0	69.0	1,486	93.5	86.5	285
19-20	83.9	72.0	1,341	93.9	86.9	180
21-22	86.5	73.4	1,034	97.2	87.6	149
23-24	87.8	77.3	1,018	99.9	91.8	157
Marital status						
Never married	79.3	67.7	3,366	90.8	82.4	891
Ever married	84.2	71.8	3,204	98.3	92.9	117
Sexual experience						
Never had sex	78.8	66.8	3,243	88.5	80.8	693
Ever had sex	84.6	72.5	3,326	98.6	90.0	315
Residence						
Urban	95.9	92.9	1,359	99.4	99.3	157
Rural	78.0	63.6	5,211	90.2	80.7	851
Region						
Tigray	87.5	82.8	391	90.9	88.7	55
Affar	66.7	49.2	64	(82.3)	(61.5)	10
Amhara	82.4	75.4	1,488	91.4	85.1	212
Oromiya	81.6	66.8	2,775	93.3	83.4	443
Somali	61.9	41.2	70	82.6	63.7	13
Benishangul-Gumuz	69.4	63.9	69	91.9	85.1	11
SNNP	77.2	61.5	1,311	88.4	80.4	210
Gambela	75.7	65.7	16	(78.1)	(71.9)	2
Harari	90.1	71.3	18	94.4	91.3	3
Addis Ababa	98.9	96.0	335	97.8	97.8	43
Dire Dawa	93.5	77.5	34	97.7	97.7	4
Education						
No education	74.0	58.0	4,280	83.4	68.8	397
Primary	94.2	87.1	1,473	95.9	91.0	443
Secondary and higher	100.0	99.6	817	100.0	99.2	167
Total	81.7	69.7	6,570	91.6	83.6	1,008

Note: Figures in parentheses are based on 25-49 unweighted cases.

Knowledge of Ways to Avoid HIV/AIDS

Effective knowledge of HIV/AIDS is contingent on knowledge of ways to avoid contracting the virus. Despite that AIDS awareness is relatively high among youth in Ethiopia, one in four young women and more than one in ten young men have not heard of AIDS or know whether AIDS can be avoided. To gain further insight into the depth of knowledge of HIV/AIDS, respondents were asked about safe

Figure 7.1 Knowledge of AIDS

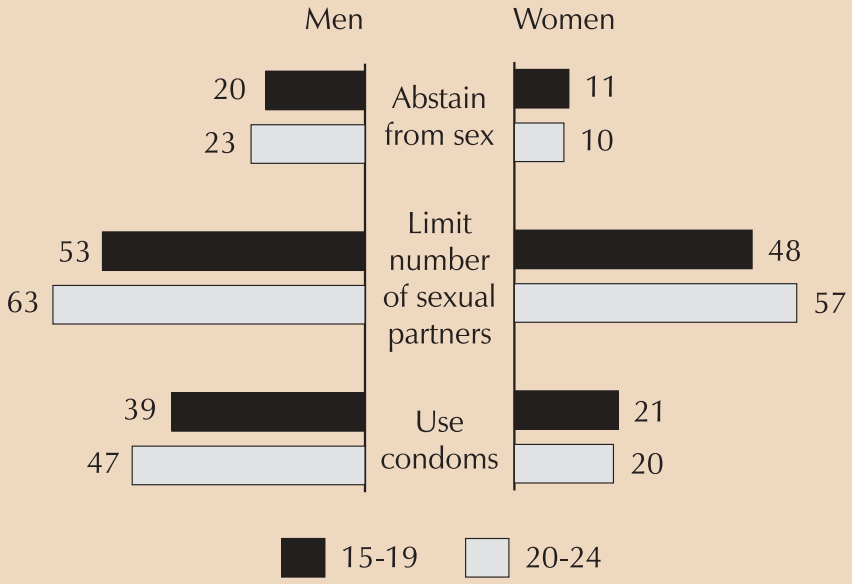


behavior and practices associated with ways to avoid contracting HIV/AIDS. Nearly a third of young women and a sixth of young men do not know of a specific way to avoid the infection. There is little difference by age among young women; however, men in their teens are less knowledgeable than men in their early twenties.

Three programmatically important ways to avoid the transmission of HIV/AIDS are abstaining from sex, using condoms, and limiting the number of sexual partners. Figure 7.2 shows spontaneous[1] knowledge of these ways, by sex and age. A multivariate analysis was carried out to examine the determi-

[1] When probed, 37 percent of young women and 63 percent of young men mentioned using condoms, and 63 percent of young women and 81 percent of young men mentioned limiting the number of sexual partners and limiting sex to one partner/staying faithful to one partner, as important ways to avoid AIDS.

Figure 7.2 Knowledge of ways to avoid AIDS



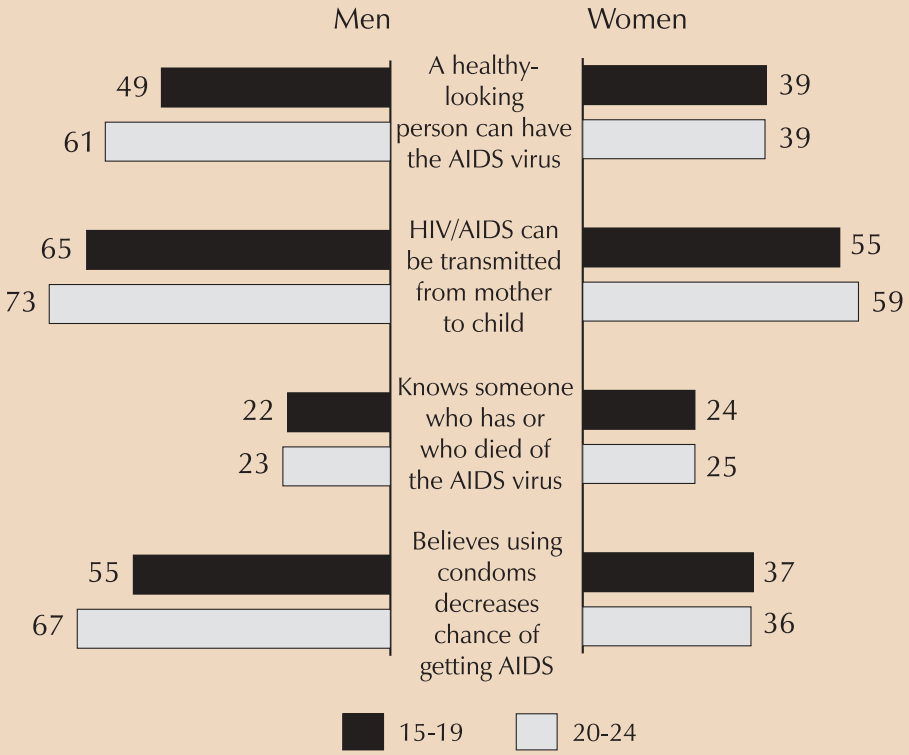
Note: Knowledge here refers to spontaneous (without prompting) mention of these specific ways.

nants of the knowledge of programmatically important ways to avoid HIV/AIDS. This analysis underscores the importance of education. Young women and men who have primary education are 4 times and 7 times more likely, respectively, to know of at least one of the three programmatically important ways to avoid HIV/AIDS than women and men with no education. The impact of education is even stronger with exposure to secondary-level schooling, with youth about 50 times more knowledgeable than youth with no education. Listening to the radio weekly significantly improves knowledge among both women and men. Residing in urban areas is significant in improving knowledge among women and men. Ever-married women and women who are currently working are also much more likely to know of at least one way of avoiding HIV/AIDS than never-married women and unemployed women. These two variables were not found to be significant enough to affect men's knowledge.

Knowledge of HIV/AIDS-related Issues

Respondents with knowledge of AIDS were also asked about a number of related questions on HIV/AIDS (Figure 7.3). As observed earlier, there is little difference by age in knowledge of HIV/AIDS-related issues among young women. However, a larger percentage of young men in their early twenties are likely to be aware of HIV/AIDS-related issues than young men in their teens.

Figure 7.3 Knowledge of HIV/AIDS-related issues

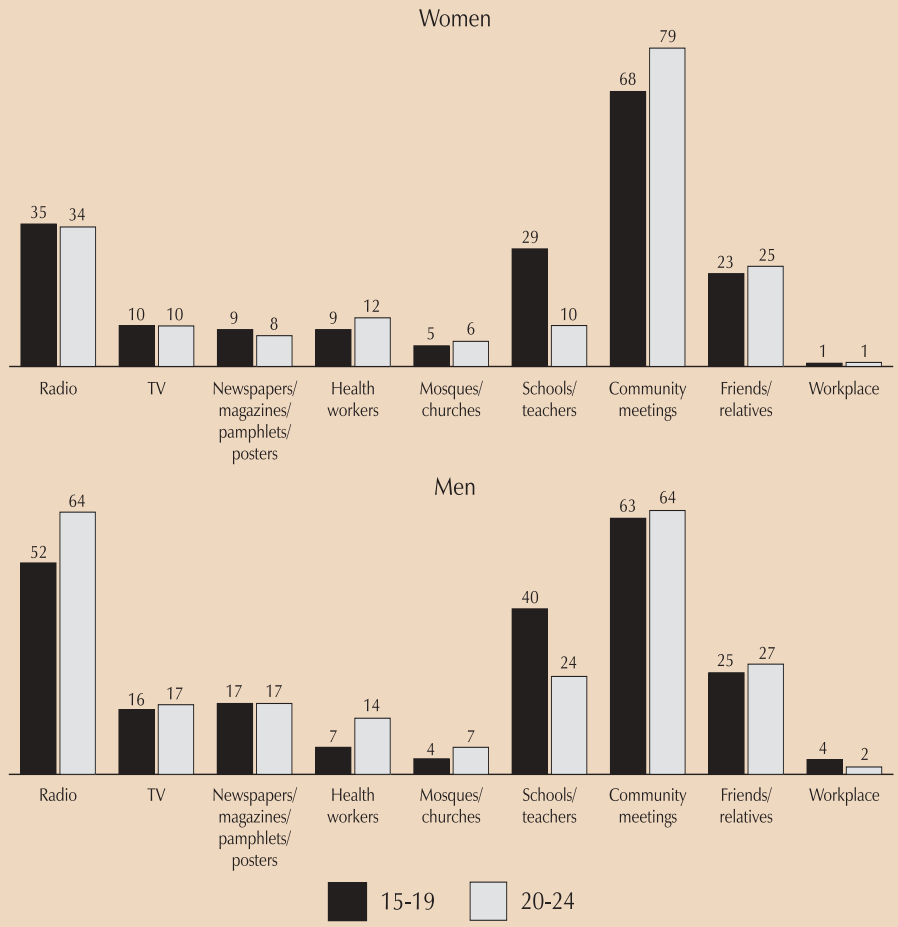


Sources of HIV/AIDS Information

HIV/AIDS is an immense challenge among youth in developing countries. Ethiopia, in particular, has one of the highest HIV/AIDS prevalence rates in sub-Saharan Africa. Information on HIV/AIDS needs to be available in all sectors to create an environment conducive for educating youth about the epidemic.

Community meetings are by far the most important source of information on HIV/AIDS among youth in Ethiopia, with about three in four women and two in three men who have heard of AIDS having heard it from this source (Figure 7.4). This emphasizes the importance of collective meetings and the ease with which the right information on the infection can be transmitted to young people. The most important media source is the radio, with over one-third of women and half of men having heard of AIDS through this media.

Figure 7.4 Sources of HIV/AIDS-related information



Discussing HIV/AIDS Prevention

As mentioned earlier, young women are more vulnerable to HIV/AIDS infection than young men. A number of social, cultural, and biological factors may contribute to this greater vulnerability among girls than boys. Using condoms has been proven to be an effective means of preventing the transmission of HIV/AIDS. However, its use is contingent on the cooperation of men. Women may be shy, or culturally reticent, to ask men to use a condom. More often than not, a man is older than his female partner and this, coupled with a male-dominated relationship, may render women powerless to insist on condom use. Although condoms are supposedly freely available from government health facilities, DHS data show that only 16 percent of young women in Ethiopia know a source for condoms, and 15 percent say they could get one if they wanted (Figure 7.5). Knowledge and access is lower among women age 15-19, ever-married women, and uneducated women. DHS data also show that condom use is extremely low among young women (Figure 7.6). Less than 2 percent of sexually active women age 15-24 have used a condom during their last sexual intercourse with any partner. Condom use is substantially higher with a noncohabiting partner than with a cohabiting partner. Condom use among

Figure 7.5 Knowledge of source of condoms and access to condoms among women age 15-24

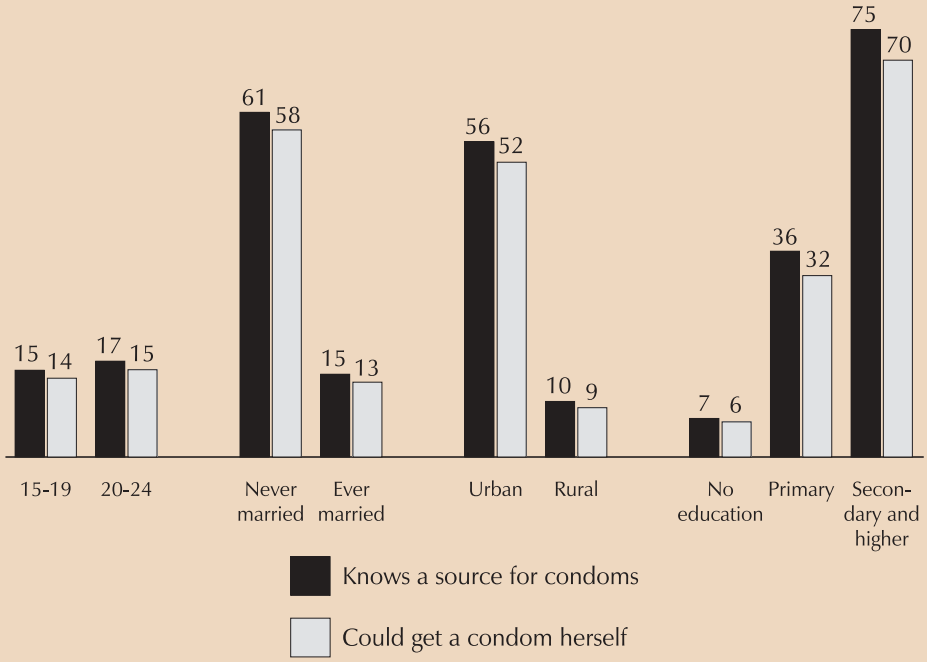
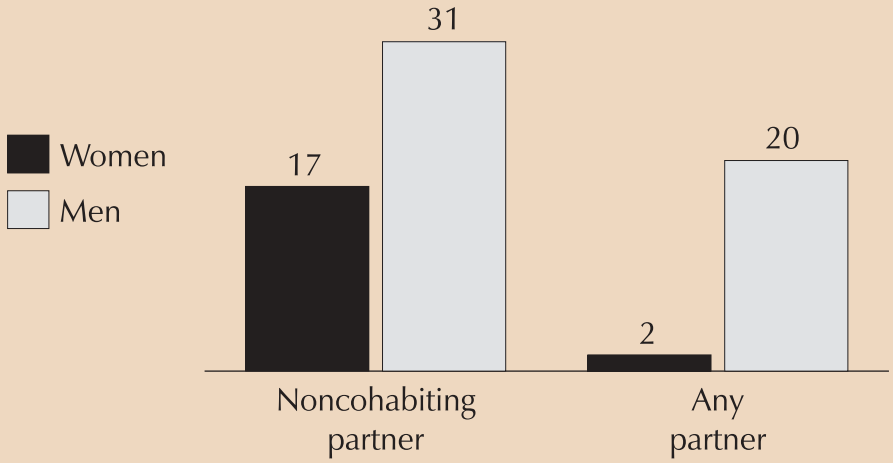


Figure 7.6 Use of condoms

Percentage of respondents who used a condom

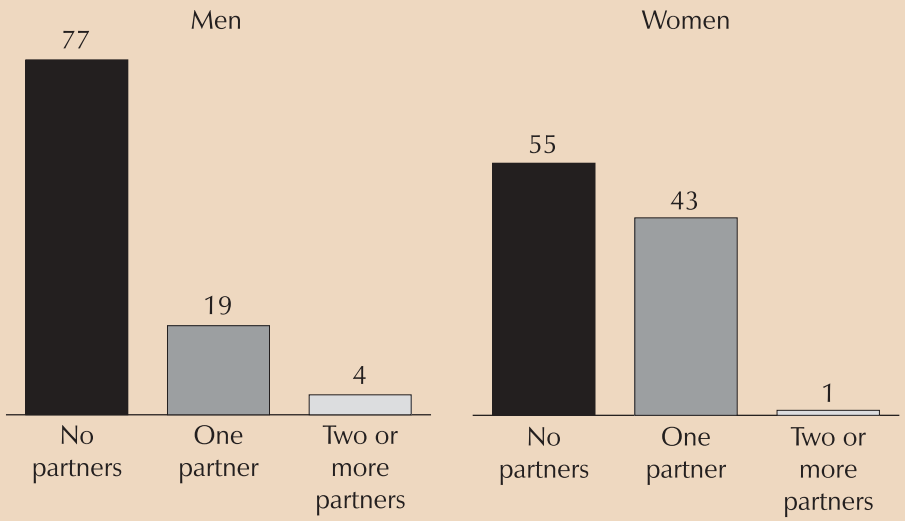


Note: Data refer to use at last sexual intercourse by youth age 15-24 who have been sexually active in the one year preceding the survey. The percentage of women and men who used a condom with a spouse or cohabiting partner is less than half a percent and 0 percent, respectively, and is not shown.

men is much higher: one in five sexually active men age 15-24 has used a condom with any partner at last intercourse. Use with a noncohabiting partner is twice as high among men as among their female counterparts. Condom use with a spouse or cohabiting partner is almost nonexistent.

In most societies, infidelity, which increases the exposure and risk to HIV/AIDS among women, is more acceptable and therefore more commonly reported among men (than women). DHS data show that just over 1 percent of unmarried women and 4 percent of unmarried men age 15-24 have had more than one sexual partner in the 12 months preceding the survey (Figure 7.7).

Figure 7.7 Number of sexual partners

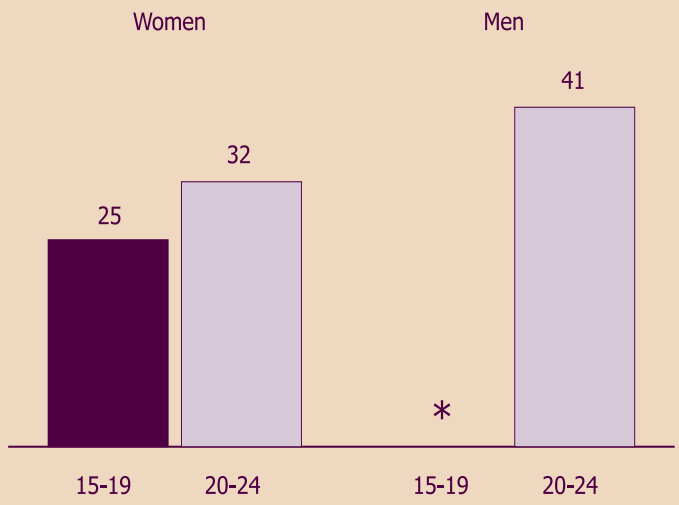


Very young women are biologically more prone to contracting sexually transmitted infections than men or older women (Institute of Medicine, 1997). Discussion of HIV/AIDS prevention among the young is therefore a critical component of any program aimed at controlling the spread of infection. DHS data show that there is much scope for improvement in this area. Only 30 percent of young married women and 38 percent of young married men have ever discussed HIV/AIDS prevention with their partners (Figure 7.8). Ongoing research at the Miz-Hasab Research Center shows that discussing sex and sexuality is considered taboo in Ethiopian society (MHRC and ICRW, 2002). Since HIV/AIDS is mainly transmitted through sexual relations, its discussion and disclosure is highly sensitive.

Social Aspects of HIV/AIDS

One of the critical issues involved in tackling HIV/AIDS is giving care and support to people living with the infection. Stigmatization of AIDS patients is common because the disease is fatal, is usually

Figure 7.8 Discussion of HIV/AIDS prevention



Note: Due to small numbers, this percentage is not shown.

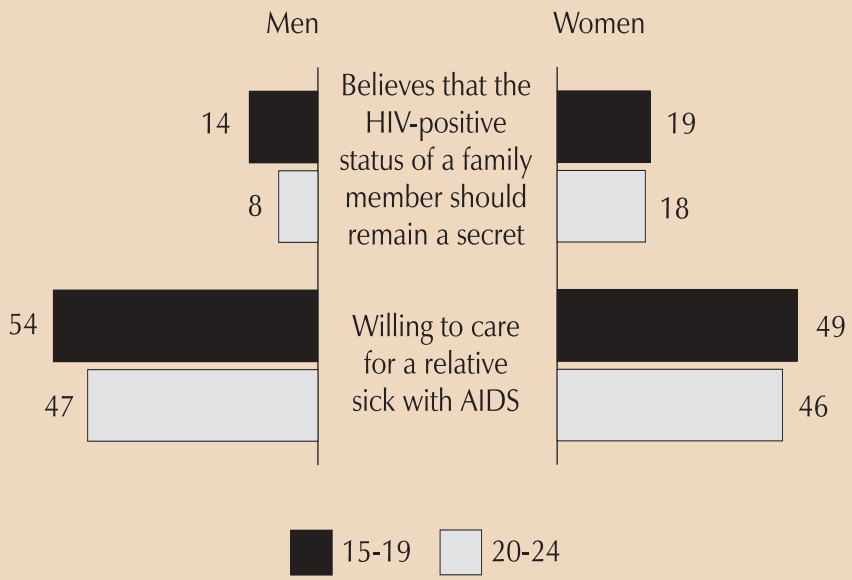
accompanied by long periods of suffering, and is often an outcome of unsafe sexual practices. The stigma associated with HIV/AIDS causes discrimination and this has posed serious obstacles to confronting the epidemic. Stigma and discrimination discourage young people from taking preventive measures against HIV/AIDS, like using condoms, seeking treatment for infections, voluntary counseling and testing, and informing their sexual partner. Stigma and discrimination are a result of ignorance about the disease and traditional and religious beliefs about sex, sexuality, and sexually transmitted diseases. Research has shown that stigmatization is a big problem in Ethiopia (MHRC and ICRW, 2002).

The DHS data show that only 18 percent of young women age 15-24 and 12 percent of young men in the same age group believe that a person infected with HIV/AIDS should be allowed to keep this fact private. Figure 7.9 shows this information by age. At the same time, about one in two young women and men report they are willing to care for a relative with HIV/AIDS.

Testing for HIV/AIDS

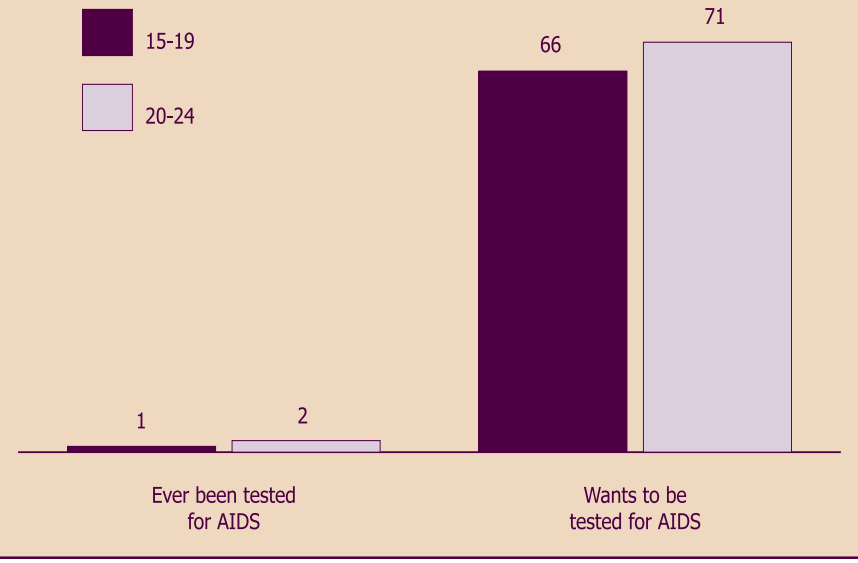
In spite of the fact that the level of HIV/AIDS is high in Ethiopia, AIDS testing has been limited to antenatal clinics and to high-risk groups. Voluntary counseling and testing (VCT) although encouraged has attracted few people, even though ongoing research suggests that most women and men support VCT (MHRC and ICRW, 2002).

Figure 7.9 Social aspects of HIV/AIDS



The DHS data show that two in three men age 15-24 who have heard of AIDS want to be tested for the infection (Figure 7.10). Men in their teens are only slightly less likely to want VCT than men in their early twenties. A similar question was not asked of women.

Figure 7.10 Voluntary counseling and testing among young men



Knowledge of STI Symptoms

Sexually transmitted infections (STI) are an additional risk for young Ethiopians. DHS data show that more than half of women age 15-19 and two in five women age 20-24 have no knowledge of STIs (CSA and ORC Macro, 2001). At the same time, two-fifths of teen men age 15-19 and one-quarter of men in their early twenties (20-24) have no knowledge of STIs. Figure 7.11 shows knowledge of signs and symptoms of STIs in a man or a woman among young women and men age 15-24 by age. Teens are less knowledgeable about STIs than youth in their early twenties.

Traditional beliefs and ignorance prevent many youth from seeking proper treatment once infected with an STI. The 2000 DHS survey reported that, "One in two men with STIs or associated symptoms did not seek medical advice or treatment, one in three sought advice or treatment from a government medical facility, and 15 percent sought advice or treatment from a private medical facility…. Survey results also show that 54 percent of men with an STI or associated symptoms did not inform their partner, and 58 percent took no action to protect their partner" (CSA and ORC Macro, 2001: 172).

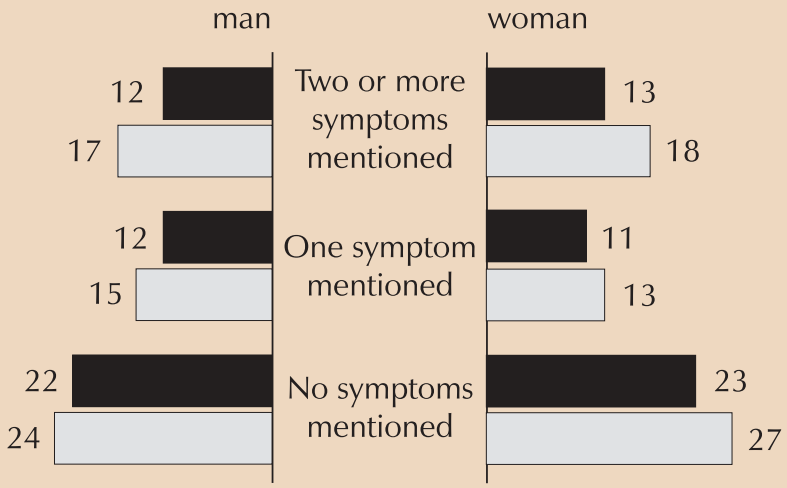
The way forward: A ten-step strategy to prevent HIV/AIDS

- End the silence, stigma, and shame
- Provide young people with knowledge and information
- Equip young people with life skills to put knowledge into practice
- Provide youth-friendly health services
- Promote voluntary and confidential HIV counseling and testing
- Work with young people and promote their participation in HIV/AIDS prevention programs
- Encourage young people living with the infection to share their experience with HIV/AIDS
- Create safe and supportive environments
- Reach out to young people most at risk
- Strengthen partnerships, mobilize resources from all sectors, and monitor progress

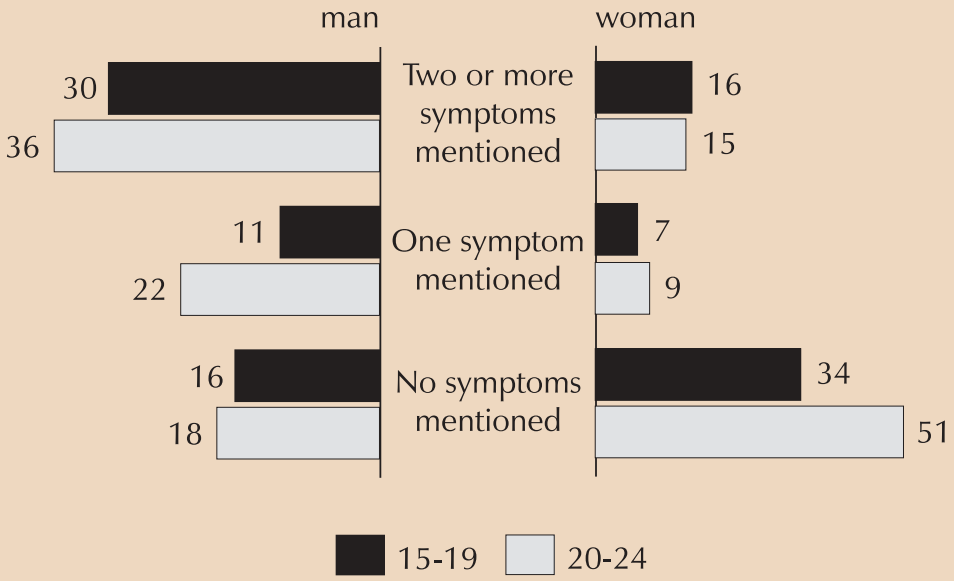
Source: UNICEF, UNAIDS, WHO. 2002.

Figure 7.11 Knowledge of STI signs and symptoms

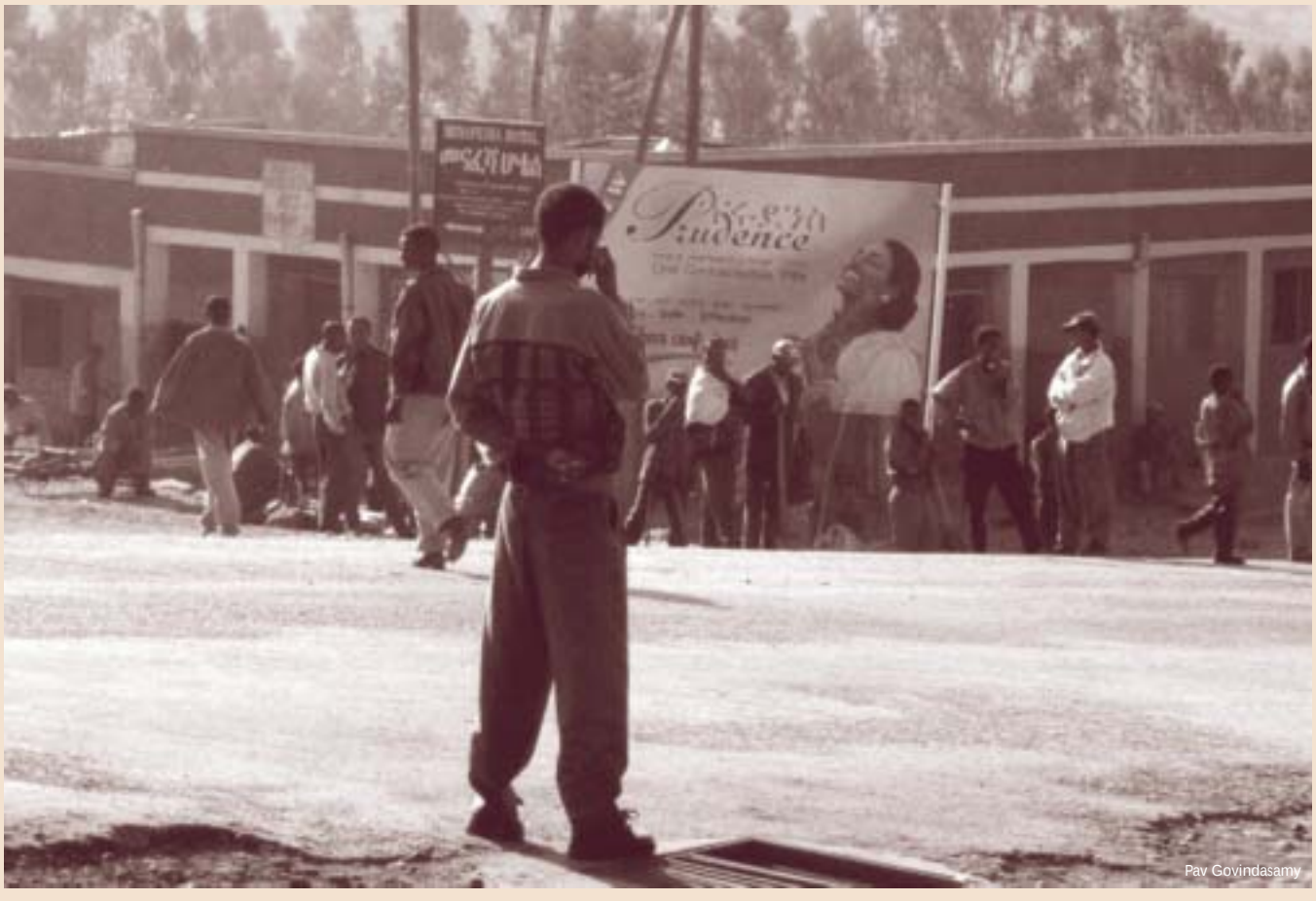
Percentage of women age 15-24 with knowledge of signs and symptoms associated with STIs in a:



Percentage of men age 15-24 with knowledge of signs and symptoms associated with STIs in a:



Chapter 8
Programmatic Implications and Policy Recommendations



Ethiopian youth constitute a third of the population. Because of their key role in society youth need to be given a special focus in health and social programs. Youth are confronted with a myriad of economic, social, and health challenges. The Ethiopian government is addressing the problems faced by young adults through various policies and development programs that address the economic, political, health, educational and other social needs of young people. The government has set up a ministry to specifically deal with youth needs. Many programs are being implemented through the Ministry of Health, the Department of Women's Affairs, and the Organization for Social Services for AIDS (OSSA); and exemplary work is being carried out by several NGOs. However, these programs have limited coverage or lack the focus and specificity essential to address the reproductive needs of youth throughout the country. Focused policies and programs employing a multi-sectoral approach are essential if the existing adverse situation faced by young adults is to be reversed.

Findings from the DHS survey show that although the level of education has risen over the past few decades, the majority of young women and a sizeable proportion of young men remain uneducated. The gender gap continues to persist with school enrollment, employment, and exposure to the media much lower among young women than young men. Sexual experience, especially among women, begins early in Ethiopian society with half of women in the reproductive age group (15-49) having initiated sex by age 16. Sexual experience among teenage women is on the increase. While most sexually active young women are married, young men initiate sex an average of four years before marriage. The practice of female genital cutting is widespread in the country and this practice continues to receive support even among young women. Knowledge of contraceptive methods is relatively high among both young women and men. However, the majority of sexually experienced youth in Ethiopia do not use contraceptives. Nearly one-third of young women express a need for family planning services. At the same time a sizeable proportion of young women do not intend to use family planning in the future because of opposition to use of lack of knowledge. Childbearing begins early in Ethiopian society, and by the end of her reproductive years a woman would have had an average of 6 children. At this rate, young adults will have nearly 2 children by age 24. A sizeable proportion of all births to young women are reported as unintended. Pregnancy terminations are higher among women in their teens than in the twenties. Despite the fact that pregnancy-related complications are especially high among young women, utilization of basic maternal health services is low, with most women not having access to trained health professionals during pregnancy, at delivery, or during the postpartum period. The prevalence of HIV/AIDS is relatively high in Ethiopia, and youth are the most vulnerable group, especially young women.

The preceding chapters have shown that young people in Ethiopia are in a vulnerable state and that the problems they face are complex. Policies and programs that deal with youth reproductive health

need to address some key areas for improving the general health and well being of young people in Ethiopia. These are summarized below.

Access to Reproductive Health Information and Services

Young people in Ethiopia are disadvantaged relative to older people in their ability to access information and services for their reproductive needs because of the absence of a youth-friendly service delivery system. There is an inherent bias in the health care system against the young. This is due in part to the cultural tradition that girls marry at a young age to preserve their chastity, and are encouraged to bear children soon after. There is reluctance on the part of health care providers to inform young women, and especially young unmarried women, about the health implications of bearing children at a very young age, and to inform and encourage them to adopt family planning to delay the onset of childbearing. At the same time, there is little recognition that the very young are at increased risk of complications from pregnancy and delivery, and hence need encouragement to seek out professional health care.

Targeted family planning services can prevent high-risk and unwanted pregnancies and have the potential to significantly reduce maternal and childhood mortality. Increased access to information about family planning and improved contraceptive services for young women at risk could facilitate improvements in coverage, quality, and effectiveness, of maternity care services. Health programs should be geared toward educating health care providers to be more sensitive to the special needs of young women, including training health personnel to recognize and deal with all aspects of youth reproductive health. Programs should be geared toward all youth whether female or male or married or unmarried. Residence plays a major role in access to education, health services, employment opportunities, and exposure to the mass media. Most youth in rural areas have little access to information on reproductive health and sexually transmitted diseases. They have limited knowledge about effective use of contraception, the negative effects of early marriage and childbearing on the health of young mothers, or the effect of having many children on the quality of life. The young in Ethiopia, and especially rural youth, are also more vulnerable to harmful traditional practices. An effective and successful youth reproductive health program should encompass both urban and rural young.

Eliminate Harmful Traditional Practices

Ethiopian women face many disadvantages. They have fewer opportunities to access education, health services, and social and economic services. They are victims of harmful traditional practices, and bear the burden of having many children, managing household matters, and working predominantly in agriculture. As seen in this report, young women in rural areas have little access to reproductive

health and family planning services and minimal exposure to mass media. They marry young and bear children soon after; some are victims of abduction and rape. Young women have little knowledge of reproductive health, and limited power and control over their reproductive lives. Female genital cutting is widespread. All of these factors have contributed to young women having a higher probability of exposure to infectious diseases such as HIV/AIDS. Family planning knowledge is low, especially among rural women, and use is minimal. Women are also more vulnerable to divorce and separation and many migrate to urban areas in search of financial support and eventually end up taking menial jobs because they have little or no education, or are forced into prostitution. Young urban women, though better off than their rural counterparts have less access to information, education, and employment than men. Premarital sex, which is relatively higher among urban than rural women, increases their exposure to sexually transmitted diseases. Unwanted pregnancy and abortions are more common among young urban women than young rural women, increasing the probability of exposure to reproductive health complications and infections. Many are at increased risk of being infected with HIV/AIDS.

Policies and programs to address youth reproductive health need to consider the varied circumstances facing urban and rural women and should be more context-specific. There should be intervention programs that put a stop to early marriage, rape, abduction, and other harmful traditional practices. Education is essential to empower women with decisionmaking capability. Affirmative measures need to be in place to secure employment for women. Education should go hand-in-hand with help in securing gainful employment aimed at minimizing the risks faced by this vulnerable group. Schools and health facilities should be used as a forum to inform women about these harmful traditional practices and provide avenues for them to seek help if they are in an exploitative environment.

Information, Education, and Counseling on HIV/AIDS

HIV/AIDS is fast becoming the number one threat to young Ethiopians. Although a relatively large proportion of youth have heard of AIDS, specific knowledge about the infection is limited. This has negative implications for adopting safe practices to avoid contracting HIV/AIDS and to help contain the spread of the infection. Much improvement is needed in educating youth about HIV/AIDS and other STIs and in publicizing the risk factors associated with HIV infection. Since community meetings are important forums for youth education, this avenue needs to be exploited to the fullest to inform youth about harmful sexual practices, to promote safe sex, and to expand knowledge about STIs. Programs should be implemented in health care centers to expand voluntary counseling and testing (VCT) services, to encourage youth to come to these centers for testing, and to provide follow-on care for those who tested positive. The general public and especially religious leaders need to be co-opted into designing programs to educate youth, that would at the same time tackle some of their

own inherent biases about the infection and be a helpful self-educating process. Programs should address the cultural biases that hinder and prevent youth and especially young women from protecting themselves against HIV/AIDS. The government needs to recognize the gravity of the situation facing youth in the country and seek help from external donors to address the spread of the epidemic, through improving the health care system and infrastructure.

Low attendance in schools, unemployment, poor living conditions, and high mobility among urban youth encourage risky behavior and the spread of HIV/AIDS. Although HIV/AIDS has also been the cause of death among many educated and well-to-do groups, the disease is disproportionately higher among high-risk groups such as the unemployed, out-of-school youth, urban youth employed in low paying jobs, and commercial sex workers.

The Ethiopian government has taken some initial encouraging steps to address and combat the spread of HIV/AIDS and other STIs. However, existing education campaigns focus on the modes of prevention, without sufficient attention to care and support of persons living with HIV/AIDS. At the same time disclosure and openness to VCT services is minimal. More attention is needed to address the economic needs of youth by encouraging them to complete their basic education and by expanding employment opportunities to secure sustainable income and hope for the future.

Educate Today's Youth

Education is the basis for social, economic, and behavioral change. In order for education to meet its intended objectives, it must be well thought out and educational programs should be designed to solve the social, economic, and cultural problems of targeted groups. Education programs should be relevant for the needs of today's youth. They should prepare young people for a sustainable and independent life after schooling has ended. Many urban youth who finish high school are unemployed because their education is not focused on acquiring marketable skills, and because the economy has not grown fast enough to absorb them. The lack of a social support system in the urban environment—away from friends and family—is an additional burden on young people. They have lots of time on their hands and few alternatives to channel their energy.

The Ethiopian government has recognized the gaps in its education system and is attempting to emphasize a purposeful education that is more relevant to the needs of the country. An education policy aimed at making education, particularly primary education, accessible to all children of school age, has been introduced. The government has initiated an education sector development program that expands access, equity, relevance and quality. It has revised the curriculum to emphasize vocational and adult education. The present trend toward making secondary education more vocation focused is

believed to be more relevant to the needs of the country and today's youth, and will better prepare young people to accept adult responsibilities in a work environment.

However, a lot has to be done to make education accessible to rural women and to retain children in the educational system. The school dropout rate for children in rural areas, particularly females, is high and somewhat discouraging. The proportion of youth attending secondary and higher education continues to be very low. Moreover, the school curriculum has given little attention to adolescent reproductive health. Sex education, with a focus on adolescent sexual needs, reproductive health, sexuality, and family planning, need to be incorporated into the existing school curriculum. Youth need to be educated about their physiology, risky sexual behavior, and HIV/AIDS and other STIs.

Added attention should be given to educating parents of youth to continue providing social support during this critical period in their lives.

Improve Exposure to Mass Media

Mass media plays a critical role in educating the public by sensitizing the audience to pertinent issues affecting the community. Exposure to the media impacts knowledge, attitudes and behavior. Rural youth have little access to mass media. The radio is the most important source of information for most youth in the country, especially in rural areas. Television is a more popular media source in urban areas. The usefulness of printed media is dependent on the level of education of the audience. It is critical that information on youth reproductive health be transmitted to a wide audience and one way to do this is to increase exposure to the media. Community meetings are another important way to promote critical information in Ethiopia, and this strategy needs to be exploited to the fullest. Youth clubs are increasingly being recognized as an important avenue for disseminating reproductive health information to the young. Media content needs to be sensitive and relevant to youth to be successful in encouraging them to adopt or modify behaviors. Reproductive health information should be attractive, informational, and focused. Programs should be geared toward all youth irrespective of residence. Attempts should be made to broadcast programs relevant to youth in all the local languages. Innovative means should be employed to inform and maintain the interest of uneducated youth. For example, traveling dramas or musical shows have been successful in exposing youth to important messages on HIV/AIDS transmission. Media exposure among youth and the wider acceptance of media messages would improve if youth themselves were involved in writing, directing and promoting context-specific messages.

Good media content requires highly trained, imaginative staff. A well thought out media program can effect major changes in attitudes and behavior. Therefore, programs geared toward addressing youth reproductive health should consider media exposure a crucial component of success.

Access to Employment Opportunities

Unemployment is a serious problem among all youth and is especially serious among urban youth. Most young people are engaged in agriculture primarily because the country's economy is predominantly dependent on agriculture and is therefore the main source of employment. At the same time, because of the low level of education among most Ethiopians, and the relatively small service-oriented sector, there are limited alternative sources of employment for young and poorly educated youth. A large proportion of youth not in school end up being underemployed, idle away their time, or become engaged in illegal activities detrimental to their health and well-being. Moreover, the high mobility of youth in search of gainful employment has had a negative impact on their ability to acquire valuable work experience, engage in meaningful and lasting relationships, and mature and take on adult roles in society.

Programs to address youth reproductive health need to provide alternatives for youth who drop out of school at an early age. Besides taking measures to encourage youth to stay in school until the completion of their studies, education should be geared toward vocational training. This would provide greater opportunity for young people to enter a trade upon leaving school and to sustain themselves. Programs should also consider providing initial monetary assistance through loans or grants to encourage young graduates to start and maintain small businesses. Employers should encourage participation in after-work education programs. On-the-job training should form a core part of all employers curriculum. Programs should also focus on funding more recreational facilities to attract out-of-school and unemployed youth and to focus their energy in more meaningful ways.

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