Trends in Youth Reproductive Health in Ethiopia, 2000 and 2005

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April 2008

the David & Lucile Packard FOUNDATION

MACRO INTERNATIONAL INC.

This report is based on an in-depth analysis of the 2000 and 2005 Ethiopia Demographic and Health Surveys (DHS). Funding for this study comes from the David and Lucile Packard Foundation.

The authors wish to thank Christopher Gramer and Erica Nybro for word processing assistance and creativity in the design and layout of the report and Dr. Sidney Moore of Macro International Inc. for editing the report; and Dr. Berna Torr of the Rand Corporation for her help with the multivariate analysis.

Additional information on this report and the 2000 and 2005 Ethiopia DHS surveys may be obtained from Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 (telephone: 301-572-0200; fax: 301-572-0999; email: reports@macrointernational.com; internet: www.measuredhs.com).

Suggested citation:
Moore, Zhuzhi, Pav Govindasamy, Julie DaVanzo, Genene Bizuneh, and Albert Themme. 2008. *Trends in Youth Reproductive Health in Ethiopia, 2000 and 2005.* Calverton, Maryland: Macro International Inc.

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FOREWORD

Data collected from the 2000 and the 2005 Demographic and Health Surveys show that Ethiopia has come a long way in five years. Contraceptive prevalence has increased 150 percent, infant mortality has declined by almost 50 percent, HIV/AIDS infection rate stabilized in general and, in some cases, reduced. There are signs of stronger commitment to reproductive health by government, both at the federal and regional levels: the millennium reproductive health goals plan to reach 8.5 million women by the end of this Ethiopian calendar year. Over 20,000 health extension workers are spread throughout the country to convey the gospel of primary health care with exemplary dedication. And progressive laws have been passed that, if implemented properly, will protect the reproductive health rights of women and young girls. Ethiopia has seen phenomenal expansion of health services in the last five years. These are all good signs and we should celebrate this achievement.

However, a lot more needs to be done. The Ethiopian population is approaching the 80 million mark and increasing by over 2 million a year. Contraceptive prevalence at 14 percent is still low, especially in light of the fact that almost half of all women in Ethiopia would like to postpone or stop childbearing. Young girls continue to be married off at very early ages in spite of the fact that the law forbids marriage before the age of 18. School drop out for girls, especially at the secondary level, is high, and other harmful traditional practices are still rampant. In general, the indicators for primary health care in Ethiopia continue to be of great concern.

The Packard Foundation has been supporting reproductive health and related programs in Ethiopia for the last nine years. During that period, the foundation has provided over $60 million to its development partners for activities ranging from family planning service delivery, youth sexual and reproductive health education and services, advocacy, leadership development and capacity building. Most of this investment was made for activities in Western Oromiya and Northern Amhara. We are looking forward to a comprehensive evaluation of the Foundation's program during the course of this year.

This report shows the impact of the Foundation-supported youth program, and the result is encouraging. While some of it is a reflection of the general improvement in the country in the knowledge, attitude and practice of young people, it is however important to note that our programs are having significantly higher impact. This was achieved thanks to the many individuals and organizations that have selflessly dedicated their efforts and time to improving the reproductive health situation of young people in this country. They deserve to be congratulated.

The Foundation will study this and the upcoming evaluation reports with the view to improving its assistance program in the country. Already, we are looking at related issues including girls' education, population, environment and health as other means of strengthening reproductive health programs. We will consult with and inform our partners how this new approach rolls out.

I would like to thank the government, our partners and grantees for their contribution to the success of our program in Ethiopia. I would also like to thank Macro International Inc. for conducting this important analysis for the benefit of youth reproductive health programmers and managers. Finally, this would not have been possible without the dedication and strong support to the program by the Foundation's trustees, management and program staff. We are grateful for their continued interest in the wellbeing of our country.

Sahlu Haile
Senior Program Advisor, Population
Packard Foundation

SUMMARY OF FINDINGS

The data for this study come from the 2000 and 2005 Ethiopia Demographic and Health Surveys (EDHS). The report is based on an in-depth analysis of 6,570 women and 1,008 men age 15-24 interviewed in the 2000 EDHS and 5,813 women and 2,399 men age 15-24 interviewed in the 2005 EDHS. 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 in the year 2000 and 14,070 women age 15-49 and 6,033 men age 15-59 interviewed in the year 2005.

There are many positive developments for youth in Ethiopia. Nonetheless, there remains room for substantial improvement.

Overall, youth are more highly educated than their older peers. However, educational attainment among youth remains low, with half of young women and one-fourth of young men having no education. On all levels, young men are more educated than young women. The proportion of young respondents with no education decreased between 2000 and 2005, while the proportion of youth attending all levels of education increased during the period. Literacy levels among youth increased dramatically between 2000 and 2005. However, literacy levels among female youth remained substantially lower than levels among male youth.

Young women are less likely to be employed than young men. Seven in ten young men were currently employed at the time of the 2005 EDHS, but only about three in ten young women were. Both young women and young men are less likely to be employed than their older counterparts.

Youth in Ethiopia have more exposure to mass media than older people do. Over time, this exposure has been increasing although levels are still low—in 2005, seven in ten persons age 15-24 did not have weekly exposure to any form of mass media.

Sexual experience and marriage

Adolescent sexual behavior is an area of great interest because the period between sexual initiation and marriage is for many young people a time of sexual experimentation. Data show that at all ages, young women are more likely to have [ever] had sexual intercourse than young men, and the percentage of youth who have ever had sexual intercourse increases substantially with age for both sexes. Sexual experience is almost universal among male and female respondents age 25-49. Comparison of the 2000 and 2005 data suggest that there has been an increase in the age at first sexual intercourse; fewer women and men age 15-24 in the 2005 survey had [ever] had sexual intercourse than the same age group in the 2000 survey.

In Ethiopia, marriage marks the point in a woman's life when childbearing becomes socially acceptable. Age at first marriage has a major effect on childbearing because women who marry early have, on average, a longer period of exposure to pregnancy and a greater number of lifetime births. Women in Ethiopia marry much younger than men, and men are much less likely to have married by a specific age than women. However, the male-female gap in the proportion ever married becomes narrower with age and is much smaller for the 25-49 age group compared with the 15-24 age group. Between the 2000 and 2005 surveys, the percentage of young women who were ever married decreased at all ages, except among women age 22. For young men, the percentage ever married decreased slightly for those age 15-18, but increased somewhat for men age 19-24.

At each year of age, the percentage of young women 15-24 who have ever been married is similar to, but typically slightly lower than, the percentage who have ever had sexual intercourse. In contrast, at each age the percentage of young men 15-24 ever married is considerably lower than the percentage who have ever had sexual intercourse, suggesting that sexual intercourse prior to marriage is much more common among men than women.

The 2005 EDHS data show that, at each year of age between 15 and 24, young women are much more likely to have been sexually active in the four weeks before the survey than young men, presumably because (as seen earlier), women in this age group are more likely to be currently married than men. However, among respondents age 25-49, men are somewhat more likely to have been sexually active in the four weeks before the survey than women. The overall percentage with recent sexual exposure decreased slightly between 2000 and 2005 for young women, but not for young men.

Knowledge and use of contraception

Most young women and men of reproductive age know about contraception. Knowledge of modern methods of family planning is substantially higher than knowledge of traditional methods among both women and men. Contraceptive knowledge increased markedly between 2000 and 2005 among youth, especially for those age 15-19 and those who never had sexual intercourse, though these groups remain less knowledgeable that older respondents and those with sexual experience. Again, differentials have narrowed over the years, but still remain.

Contraceptive use by sexually experienced youth is increasing, but they are more likely to use effective methods than in the past. Among sexually experienced youth, the percentage using a method of contraception at the time of the survey doubled between 2000 and 2005. However, it must be noted that in 2005 over three-quarters of all women age 15-24 who had some sexual experience had never used a contraceptive method.

Although, on average, levels of education remain low, the improvements in educational attainment are encouraging, and have a direct impact on knowledge, attitudes and behaviors of youth. For example, young women age 15-24 with secondary or higher education are much more likely to be using a contraceptive method than those with primary or no education.

Over half of all women and men age 15-24 had been exposed to a message about family planning in the past 12 months, according to the 2005 EDHS. Women are most likely to receive these messages at community events; men are most likely to receive them over the radio. Community events appear to be an effective way to inform women about family planning, especially because they have lower exposure to mass media than men. Both young men and women were more likely to have been exposed to information about family planning in 2005 than in 2000. The increase in exposure to family planning messages between the two surveys is greater among women than men for all media sources.

Fertility and childbearing

Overall, between the 2000 and 2005 EDHS surveys, the total fertility rate (TFR) among women age 15-49 in urban areas declined from 3.0 to 2.4 children per woman, however the rate remained unchanged at 6.0 children per woman in rural areas. The national TFR changed very little over the five-year period, declining from 5.5 to 5.4 children per woman.

Childbearing starts at an early age. More than one-third of women age 15-24 in Ethiopia have begun childbearing; this is the same proportion as in 2000. Unlike the contraceptive knowledge and use, where differentials were smaller in 2005 than in 2000, education differentials in fertility increased over this period. The percentage of women age 15-24 with no education who were mothers increased from 45 percent to 55 percent between 2000 and 2005, while the percentage with secondary education who were mothers decreased from 20 percent to 14 percent over the period.

The number of children that young people in Ethiopia consider to be ideal is considerably smaller than the number considered ideal by older Ethiopians. This is true for both women and men.

For women age 15-24, overall unmet need and unmet need for spacing were slightly lower in 2005 than in 2000, but unmet need for limiting increased slightly, reflecting the increase in the percentage of women who want no more children. In 2005, unmet need among young women age 15-24 was nearly three times greater among women in rural areas than those in urban areas.

Maternal and child health

The health care that a mother receives during pregnancy, at the time of delivery and soon after delivery is important for the survival and well-being of both mother and child. For young women, pregnancy complications can have serious consequences because of their physiological immaturity. The majority of young mothers in Ethiopia, seven in ten, do not receive antenatal care during pregnancy. Less than one in ten (7 percent) receives delivery assistance from a health professional, and only 6 percent receive postnatal care within two days of the birth. The percentage of women who received antenatal care and whose births were delivered by a health professional changed only slightly between 2000 and 2005.

Infant and child mortality rates are falling in Ethiopia, but they remain among the highest in the world. Data from the 2005 EDHS indicate that around one in eight children do not survive to their fifth birthday. Children born to women under age 20 have much higher rates of neonatal, postneonatal, infant, child, and under-five mortality than children born to older mothers because, in general, childhood mortality rates are inversely related to the mother's age at the time of the birth. An exception however is mortality rates among children of first-parity mothers; these are higher for older women (age 25 or older) than younger women (age 15-24).

Between 2000 and 2005, there was substantial improvement in the health care for sick children of women age 15-24. This was especially true in the case of children under five years of age with fever who were taken to a health provider for treatment—the percentage doubled over the five-year period. It is encouraging that young mothers are more likely than older mothers to take their sick children to a health provider for treatment. Nonetheless, the vast majority of children are not treated when they are sick—another area needing improvement.

Many Ethiopian children under five years of age are malnourished, particularly those with older mothers, those living in rural areas, and those whose mothers have little or no education. Stunting and underweight are more common than wasting. The incidences of stunting and wasting fell between 2000 and 2005, but they remain high, especially for children age 9 months and older, who, for all three nutrition indicators, are much more likely to be malnourished than those younger than 9 months of age.

HIV/AIDS and other sexually transmitted infections (STIs)

Nearly all Ethiopians of reproductive age—90 percent or more, all age groups, both women and men—have heard of AIDS, but very few have been tested for HIV, the virus that causes AIDS. In each age group, men are more likely than women to have heard of AIDS. In general, for both men and women, respondents age 15-19 are less knowledgeable about AIDS than older respondents.

Among youth, knowledge of how HIV is transmitted is far from universal. However, young men age 15-24 are generally more knowledgeable than young women about all aspects of HIV/AIDS—particularly the knowledge that the risk of transmission can be reduced by using condoms and by limiting sexual activity to one uninfected partner. It is encouraging that knowledge about AIDS and its means of transmission increased between 2000 and 2005 for Ethiopians age 15-24, with the exception of one indicator—belief among young men that limiting sexual intercourse to one uninfected partner decreases the risk of getting AIDS. The increase was seen particularly for knowing that the AIDS virus can be transmitted through breastfeeding; this indicator increased by around 30 percentage points for both men and women.

It is also encouraging that risky sexual behavior among youth decreased markedly between 2000 and 2005. The percentage who had more than one partner and the percentage who had higher-risk sexual intercourse were both much lower in 2005 than in 2000. In 2000, nearly two-thirds of men age 15-24 had higher-risk sexual intercourse in the 12 months before the survey, compared with about one-third in 2005. It should be noted, however, that less than three-tenths of young women and half of young men reported using a condom the last time they had higher-risk sexual intercourse.

The vast majority of Ethiopians, more than nine in ten, have never been tested for HIV. For both men and women, those in the age group 20-24 were the most likely to have been tested and the most likely to have received the test results.

An assessment of Packard-supported programs in Amhara and Oromiya

This report also considers the differences between youth in the areas of Amhara and Oromiya, where programs supported by the Packard Foundation are operating, and youth in the same regions that do not have Packard-supported programs. Although the number of observations for the Packard areas are relatively small, the comparison between youth living in the Packard versus non-Packard areas suggest that the programs targeting youth are making progress toward their goals of reducing fertility and improving reproductive health among youth in Ethiopia.

Overall, the percentage of women and men age 15-24 who have ever had sexual intercourse is lower in the Packard than in non-Packard areas. This difference is much more pronounced among young women than young men. Between the 2000 and 2005 surveys, the proportion of young women and young men who had [ever] had sexual intercourse generally decreased in both the Packard and non-Packard areas. This decline is more pronounced in the Packard areas, particularly among young men. Furthermore, sexual activity in the four weeks before the survey was slightly lower among young women and men age 15-24 in the Packard areas than among those in the non-Packard areas.

In 2005, the proportion of young women age 15-24 who were married was lower in the Packard areas than in the non-Packard areas. The percentage married has declined somewhat among young women between

2000 and 2005 irrespective of residence. Data for men show a similar pattern; in 2005, the percentage of young men age 15-24 who were married was lower in the Packard areas than in the non-Packard areas.

Ever use of contraception and current use of contraception among sexually experienced women age 15-24 are higher in the Packard areas than in the non-Packard areas, though the difference in current use between the two areas is smaller than that for ever use. The difference is mainly due to the greater use of injectables and the pill by women in the Packard areas compared with women in the non-Packard areas. Furthermore, young men age 15-24 in the Packard areas are much more likely to have [ever] used a method of contraception, particularly condoms, compared with young men in the non-Packard areas.

In 2005, young men age 15-24 in the Packard areas were more likely to report being exposed to at least one family planning message than those in the non-Packard areas. The Packard-non-Packard difference among young men is primarily the result of their greater exposure to community events and the print media. On the other hand, young women in the Packard areas were less likely to report being exposed to family planning messages than their counterparts in the non-Packard areas, irrespective of type of media.

The 2005 EDHS data show that unmet need among currently married women age 15-24 is lower in the Packard areas than in the non-Packard areas (28 percent versus 40 percent). This is true for both unmet need for spacing and unmet need for limiting. The decline in unmet need among young women in the Packard areas between 2000 and 2005 was the result of declines in both components of unmet need. By contrast, unmet need for limiting among young women in the non-Packard areas increased slightly between the two surveys, and unmet need for spacing remained the same.

Over the past five years, there has been a noticeable improvement in the treatment of sick children of mothers age 15-24 in both the Packard and non-Packard areas; however, children in the Packard areas who were sick with ARI or diarrhea were more likely to be taken to a provider for treatment than children in the non-Packard areas. On the other hand, the increase in the percentage of children of young mothers who were taken to a health provider for the treatment of fever was greater in the non-Packard areas than in the Packard areas.

The survey data show that the percentage of young women and young men who had more than one partner decreased substantially over the five years between the surveys in both the Packard and non-Packard areas. For young women, the change is seen larger among those in the Packard areas, while for young men, the change is more pronounced among those in the non-Packard areas. The percentage of young women who had higher-risk sexual intercourse in the 12 months before the survey decreased considerably between 2000 and 2005 for those in the Packard areas, while it increased slightly among young women in the non-Packard areas. For young men, the percentage who had higher-risk sexual intercourse decreased noticeably between the two surveys, with the rate of decrease being somewhat higher among young men in the non-Packard areas.

Programmatic implications

There are many intervention programs targeting adolescents and youth in Ethiopia, and substantial progress has been made in improving the overall health and wellbeing of Ethiopian youth. Nonetheless, there remains considerable room for improvement, and Ethiopian youth face many challenges. There are several key areas in which the policies and programs dealing with youth reproductive health need to be reviewed in order to implement changes that will improve the general health and well being of young people. These areas

are as follows: improving education, increasing access to mass media, increasing employment opportunities; continuing to improve reproductive health services and contraceptive knowledge and use; improving/eliminating certain practices such as early sexual initiation, early marriage and childbearing; and continuing to provide information, education, and counseling on HIV/AIDS and other STIs.

Finally, programs targeting youth can increase their impact by making use of the venues most frequently attended by youth, where they can promote a range of youth-friendly IEC activities. The program planners need to design programs around the characteristics of the target group, paying special attention to the circumstances of young people in local settings, particularly, vulnerable, hard-to-reach subgroups of adolescents including girls (Erulkar et al., 2006). In this way, youth programs can focus their activities and messages to address the reproductive needs of youth throughout the country. Youth programs should continue to employ a multi-sectoral approach to address issues faced by youth.

Chapter 1

Youth Reproductive Health: An Overview

1.1 INTRODUCTION

Ethiopia is situated in the Horn of Africa. It borders Sudan on the west, Eritrea on the north, Djibouti and Somalia on the east, and Kenya on the south. The total area of the country is about 1.1 million square kilometers. Ethiopia has a total population of 77 million and an annual growth rate of 2 percent. Despite the steady increase in the proportion of the urban population over the years, Ethiopia has remained one of the least urbanized countries in the world, with only 15 percent of the population living in urban areas in 2006 (PRB, 2007a).

The country is one of the least developed in the world, with a per capita gross national income in 2006 of US$160 and a gross domestic product of roughly US$11 billion (World Bank, 2007). Poverty is widespread, with slightly less than half of the population living below the basic needs poverty line (Library of Congress, 2005).

Reproductive health (RH) in general and adolescent reproductive health (ARH) in particular is of growing concern in most developing countries. Sub-Saharan Africa is the youngest region of the world, with 44 percent of its population under age 15 in 2006 (PRB, 2007b). In Ethiopia, 11 percent of the population in 2007 is age 15-19, and 20 percent is age 15-24[1] (U.S. Census Bureau, International Data Base). Moreover, since Ethiopia is typical of a country with a youthful population (43 percent of the population of Ethiopia in 2007 is under 15 years of age [U.S. Census Bureau, International Data Base]), the number of adolescents will increase further in the future.

High population growth has led to the rapid growth of the number of people of working age. The relatively slow creation of new jobs in the modern sector combined with fewer farming opportunities for the next generation is resulting in growing unemployment and under-employment, especially among young people who have less marketable skills and experience, but who tend to live with their families, and hence often are not subject to the same immediate pressures to find work that apply to older married men and women (MoFED, 2005).

Lack of education, unemployment, and extreme poverty exacerbates and perpetuates the reproductive health problems faced by Ethiopian youth. The economic, political, and social situation in the country has given rise to fundamental concerns about the health and well-being of young mothers, the health and social development of children born to these young women, the well-being of young men exposed to sexually transmitted infections or who quit school early to support young families, and society's losses and obligations incurred because of adolescents and their children.

1.2 PROBLEMS FACED BY YOUTH

Ethiopian youth face many challenges. Sexual initiation often occurs at an early age due to traditions and poor living conditions. Traditional practices such as early marriage, marriage by abduction, and female genital cutting adversely affect the health and wellbeing of young people. Rape and sexual coercion are common among young women in both urban and rural settings. Sexually transmitted diseases pose

[1] This report focuses on women and men age 15-24. In this report "youth" refers to those age 15-24 and "adolescent" refers to those age 15-19. (The term "youth" or "young adult" is often used to refer to women and men age 10-24, while the term "adolescent" usually refers to women and men age 10-19. However, the Ethiopia DHS surveys did not collect information on persons age 10-14.)

considerable risk to the youth population because of the practice of having multiple sexual partners and the limited use of condoms. Unintended pregnancies, pregnancies that occur within short intervals, and abortions pose serious health risks to young women. In addition, drug trafficking and drug abuse among the youth population continue to be of concern.

Ethiopia's population is projected to increase to 108 million by the year 2025 (PRB, 2007a), becoming Africa's second-most populous country after Nigeria. This rapid population increase will continue to strain the government's ability to provide health care and education to young people and create conditions for even greater unemployment, poverty, and resource depletion.

The 2005 National Labor Force Survey conducted by the Central Statistical Agency (CSA) indicated that 1.8 million economically active people age 10 or older in Ethiopia were unemployed (CSA, 2006). More than half (54 percent) of the unemployed were youth. Twice as many unemployed youth were females (66 percent) than males (34 percent), indicating the magnitude of the problems facing young women in Ethiopia.

Besides unsustainable population growth, HIV/AIDS is becoming an increasingly worrisome concern for Ethiopian youth. Results from the 2005 Ethiopian Demographic and Health Survey (EDHS) indicate that 1.4 percent of Ethiopian adults age 15-49 are infected with HIV. Data show that the number of women age 15-19 years who tested positive for HIV is much higher than the number of males in the same age group. This discrepancy is attributed to the earlier age at marriage among women and sexual intercourse between young women and older men (CSA and ORC Macro, 2006). Among pregnant women in Ethiopia, those with the highest HIV prevalence were young women age 15-24, with an estimated prevalence of 12.1 percent (MOH, 2002).

Gender inequality is another major problem that impacts youth reproductive health and wellbeing in Ethiopia. Gender inequality manifests itself in the low status of women and girls in the society as well as within the family, in the fewer educational opportunities for girls, in the lack of participation of males in family planning and AIDS-prevention activities, and in the harmful traditional practices against young girls (FHI/YouthNet, 2004).

1.3 Addressing Youth Problems

There is consensus among the governmental and non-governmental institutions and agencies in Ethiopia that youth health and wellbeing relies on improved educational opportunities, improved economic opportunities, cultural expansion and the end of the long-held harmful traditional practices. Efforts have been made by the government and its partners to design and implement strategies, policies and programs to address the reproductive health, HIV/AIDS and gender issues of the most vulnerable age group of the country—youth. Their efforts are summarized briefly below.

Government Programs and Policies

The Ministry of Health (MOH) has been conducting various ARH activities under its Family Health Department. As part of its National Reproductive Health Task Force, it has formed an Adolescent Reproductive Health Technical Subcommittee (also known as the Adolescent Reproductive Health Taskforce) to coordinate activities related to ARH and oversee implementation of the Ministry's program.

In 2002, the Family Health Department of the MOH developed the Five-Year Action Plan for Adolescent Reproductive Health in Ethiopia (2002-2007). The main goals of the plan are (1) to increase access and utilization of ARH services by youth, and (2) to cause positive RH behavior change among youth by providing better information and knowledge on reproductive health issues. Specific strategies to achieve these goals include: promotion of a positive policy and program environment; provision of knowledge and skills; and provision of quality reproductive health services for youth through youth centers, peer education, and counseling and service linkages through an efficient referral system (FHI/YouthNet, 2004).

In 2007, the MOH launched the Adolescent and Youth Reproductive Health Strategy (AYRH) designed primarily to address the problems associated with early marriage and pregnancies and abortions, polygamy, female circumcision, abduction and rape, and poor access to healthcare. The AYRH will be implemented over a period of eight years and is targeted at those age 10-24 years. This strategy calls for immediate tailored and targeted interventions to meet the diverse needs and realities of young people and reflects the commitment of the Ethiopian government to improving the reproductive health status of young Ethiopians (Plusnews Information Service, 2007).

The Ministry of Youth and Sports (the then Ministry of Youth, Sports, and Culture (MYSC)) was created in 2001 and has the responsibility to initiate policy and laws relating to youth and, upon their approval, follow-up on their implementation. The Ethiopian Youth Network, which has been supported extensively by the Ministry, has developed a Youth Charter and Three-Year Plan of Action for youth sexual and reproductive health. Reducing HIV/AIDS and unemployment are two important goals of the Plan of Action. More specifically, the Ministry has facilitated the provision of land for establishing 11 youth centers (one in each region) to the Ethiopian Youth Network (FHI/YouthNet, 2004).

The then MYSC recently developed a National Youth Policy, which was endorsed by the Council of Ministers on March, 2004. The policy addresses HIV/AIDS very directly, and gives some attention on other aspects of reproductive health for youth. The policy aims at enabling youth to participate in an organized manner in the process of building a democratic system, good governance and development endeavors, and benefit fairly from the outcomes (MYSC, 2005).

The National Office of Population (NOP) was established in 1993 following the country's adoption in the same year of an explicit population policy. The major objective of the population policy is to close the gap between high population growth and low economic productivity (TGE, 1993). Several strategies outlined in the 1993 population policy are specifically targeted at youth. These strategies include: reducing the high attrition rate of females in the educational system, providing career counseling in secondary schools and universities, establishing youth reproductive health counseling centers, and raising the minimum age of marriage for girls from 15 to 18. This latter aim was achieved with the recently passed Family Law (FHI/YouthNet, 2004).

Non-governmental Organizations (NGOs)

In 2003, a team from the YouthNet Program was asked by USAID/Ethiopia to conduct an assessment of youth reproductive health programs in Ethiopia. Below is a summary of the findings from the team on youth-related activities and programs designed and implemented by some of the major NGOs in Ethiopia (FHI/YouthNet, 2004). Included below is also a description of the active grantees of the David and Lucile Packard Foundation/Ethiopia in the area of youth reproductive health.

Consortium of Reproductive Health Associations (CORHA) is the principal network of NGOs working in reproductive health in Ethiopia. To facilitate its work in advocacy, CORHA began a national reproductive health advocacy network in 2002. Adolescent reproductive health is one of the advocacy issues being addressed by the network.

Ethiopia is one of five countries on which the ***David and Lucile Packard Foundation***'s developing country grantmaking is concentrated. The specific goal of the Packard Foundation's population program in Ethiopia is to help the country reduce its population growth rate by increasing access to reproductive health and family planning options, especially for young people. This goal supports the population policy of the government of Ethiopia. The program seeks to: (1) expand family planning and reproductive health service delivery in an innovative and cost-effective way that ensures quality while increasing coverage, (2) expand youth access to modern family planning and reproductive health services and information, and (3) foster a social environment receptive to family planning and reproductive health practices.

Over four million young Ethiopians get access to reproductive health information and services funded by the Foundation throughout the country. The Foundation supports over 200 in-school and out-of-school youth clubs that cater to the reproductive health needs of young people and provides youth-friendly services in sixteen clinics and educational centers.

The Packard ARH program incorporates skills training and entrepreneurship development programs to young people. The Foundation has established two training centers in Kombolcha and Jimma to provide diversified life and entrepreneurial skills training, and RH services. The ARH program also initiated a pilot youth microfinance scheme in the North Wollo zone. The in-school-youth (ISY) and out-of-school youth (OSY) clubs support and strengthen youth self-help and peer education initiatives through entertainment-education.

The Foundation undertakes these activities by providing grants and working closely with a number of grantees. These Packard grantees undertake a series of interrelated, complementary programs and projects:

Family Guidance Association of Ethiopia (FGAE) is the local affiliate of the International Planned Parenthood Federation (IPPF). FGAE has been a pioneer in providing reproductive health information and services in Ethiopia. FGAE's Packard funded project provides access to and use of sexual and reproductive services and information for adults and young people. The project established nine youth clinics to address the unmet reproductive health needs of rural youth. Through this project FGAE recruited more than 100,000 new family planning acceptors and served over 300,000 clients with different reproductive health services. The project reached over 2 million people with education on reproductive health and HIV/AIDS. The nine youth centers provide multi-purpose recreational, educational, and health services to young people.

Opportunities Industrialization Centers/Ethiopia (OIC-E), an affiliate of Opportunities Industrialization Centers (OIC), is implementing an innovative program that integrates adolescent reproductive health education and services with training in marketable skills. The project established two training centers one in Kombolcha in the Amhara Region and one in Jimma in the Oromiya Region that provides diversified training to youths in adolescent reproductive health integrated with entrepreneurship, basic computer applications, masonry, carpentry, gardening, bakery, and other skills. The centers also help trainees secure jobs and/or apprenticeships. These centers trained around 1,000 youth in different entrepreneurial and life skills. Of these trainees, half of them were able to get apprenticeship or job placement

opportunities. OIC-E provided adolescent reproductive health education to more than 200,000 adolescents. Young people also get counseling and referral services.

Amhara Development Association (ADA)'s Packard-funded project has the objective of increasing access to family planning services; decreasing maternal and infant morbidity and mortality; and reducing the incidence of HIV/AIDS and STDs. ADA integrated reproductive health program as a major component of its development portfolio in the Amhara Region in 1999 with initial support from the Packard Foundation. During the past seven years the organization reached over 5 million people with information on reproductive health and HIV/AIDS and recruited more than 300,000 new family planning users. Contraceptives prevalence has increased from 5 per cent to 39 percent in most project areas. Currently ADA expands its reproductive health program to more than 80 woredas through the support of other donors.

Pathfinder International is the key implementer and manager of all USAID funded NGO projects in family planning and reproductive health in Ethiopia. Pathfinder's projects include private sector franchise initiative, adolescent reproductive health, and empowerment of Ethiopian women. In 2000, Pathfinder collaborated with the Packard Foundation to organize the first national adolescent reproductive health (ARH) conference in Bahir Dar which later played a key role in developing ARH policies and strategies in Ethiopia. Furthermore, Pathfinder has supported over 200 youth and girls clubs and 23 youth centers. The women's empowerment project has reached more than 3.5 million women, youth, men, religious, and community leaders and key decision makers to advocate for women's reproductive health rights.

Save the Children USA has implemented a school-based adolescent reproductive health program in 28 government high schools in Addis Ababa, including a youth-focused radio broadcast. Recently, SAVE expanded the program to elementary schools and out-of-school youth in selected districts of Oromiya Region. Strategies include peer counseling, weekly programs by students (such as drama and poetry) and professional counseling by nurses. During the past seven years, the program reached more than 84,000 youth with information on sexual reproductive health in Addis Ababa and Oromiya Region. The program trained more than 3,000 youth as peer educators and club members. SAVE incorporated youth-friendly services in 25 health centers in Addis Ababa and 14 health centers/clinics in the two intervention areas in Oromiya Region. The project broadcasted a popular radio program to raise awareness of young people's reproductive and sexual health needs at the national level.

Deutsche Stiftung Weltbevölkerung (DSW), the German Foundation for World Population, is one of the NGOs in Ethiopia that initiated popular youth-to-youth (Y2Y) programs. DSW's adolescent reproductive health program aims to improve the sexual and reproductive health of adolescents in Ethiopia by supporting and strengthening youth self-help initiatives (clubs) and related activities. The projects do not provide services, but they link with other service providers. DSW's Y2Y approach and manual has become a nationally accepted model. DSW's Y2Y approach is being replicated by different organizations in the country that are implementing adolescent reproductive health programs. DSW has empowered more than 200 youth clubs through the Y2Y Initiative.

Marie Stopes International-Ethiopia (MSI-E) is an affiliate of the UK-based, non-governmental organization which has been providing a wide range of family planning/reproductive health services in Ethiopia since 1990. MSI-E's Packard-funded project aims to increase the utilization of sexual and reproductive health services through establishment of clinic-based, community-based, work-based and school-

based service delivery outlets in seven towns of Amhara, Oromiya and Tigray regions. Through this project, MSI-E established seven clinics, two youth centers, and other satellite community-based service delivery points to provide comprehensive reproductive health services including post abortion care in the project areas. In the past six years, MSI-E served close to 240,000 clients with different reproductive health services. The project also enabled young people to get access to youth-friendly reproductive health services, library, in/out door games and other facilities.

PACT Ethiopia began its operations in Ethiopia in 1996 with the objective of building local NGOs' implementation capacity in the areas of primary and preventive health, HIV/AIDS, disadvantaged youth, rural development, food security, education, and governance. PACT's adolescent reproductive health project aims to increase the effectiveness of reproductive health services to youth/adolescents by building the capacities of NGOs and community-based services. PACT built the capacity of 19 youth-focused organizations/ associations and provided re-grants to implement adolescent reproductive health projects. These partner organizations established and strengthened 55 urban and rural clubs. The project reached more than 500,000 adolescents and youth with RH education and services. Contraceptive prevalence increased up to 15 percent in project areas. The project also established different income generating activities to foster sustainability of youth clubs and associations.

Christian Relief Development Association (CRDA) is the largest umbrella organization in Ethiopia with 210 member NGOs, including religious organizations. CRDA's Packard-funded project aims to promote comprehensive sexual and reproductive health and rights to youth and women. The project focuses on reducing harmful traditional practices and preventing sexually transmitted diseases and HIV/AIDS.

Guraghe People Self-Development Organization (GPSDO) is an indigenous non-governmental organization, serving the local community in areas of road construction and integrated rural development for more than 42 years. GPSDO has a good experience in mobilizing local community resources for social issues. With Packard funding, GPSDO implements community-based reproductive health/family planning services in eight woredas of the Guraghe zone focusing on young people and women.

Oromiya Development Association (ODA) is a membership, non-governmental association committed to furthering the social and economic development of Oromiya Region. ODA's reproductive health/family planning project is established to increase the availability and use of an acceptable standard of voluntary reproductive health/family planning services. It provides contraceptives through community based reproductive health agents and referrals and back-up support from health facilities. The project operates in 28 Woredas of East and West Wollega, Jimma and Illubabour zones of Oromiya. During the past seven years the organization has reached over 5 million people with information on reproductive health and HIV/AIDS and serves more than 200,000 active family planning users. Contraceptives prevalence has increased from 5 percent to 28 percent in most project areas. Today, ODA has expanded its reproductive health and HIV/AIDS prevention program to 62 woredas through the support of several donors.

Relief Society of Tigray (REST) is an indigenous grassroots NGO established in 1978 with a vision of combating poverty in Tigray region. Packard-funded program aims to improve adolescent reproductive health in the Tigray region. The program focuses on reduction of harmful practices like early marriage and abduction; reduction of early initiation of sexual activities; prevention of unsafe sex and its complications; and prevention of sexually transmitted infections and HIV. In the last two years, the program reached more than

30,000 in and out of school youth with information on family planning, sexually transmitted diseases, and HIV/AIDS. The project provided voluntary counseling and testing to over 2,000 youth and arranged referral services to health facilities for 3,500 adolescents.

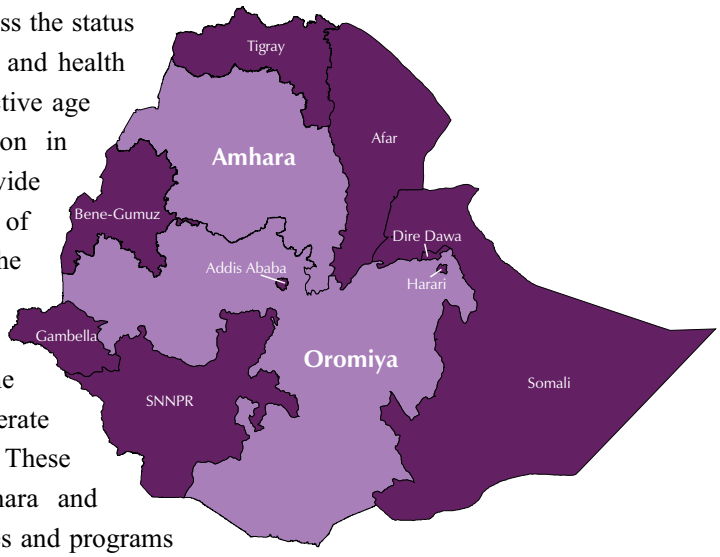
Africa Humanitarian Action (AHA) has a mandate to focus on reproductive health, family planning, maternal child health, STI/HIV prevention, and harmful traditional practices. The youth activities of AHA focus on distribution of family planning methods through CBRHAs, training of youth peer educators, and formation of anti-AIDS clubs/associations in Shashemane and its surrounding areas.

Ethiopian Youth Network was established in 2002 and is made up of a national network of youth, youth groups, and youth associations working on HIV/AIDS and reproductive and sexual health. Its overall aim is to complement the national effort to fight against HIV/AIDS and improve the reproductive and sexual health of youth through information exchange, advocacy, collaboration, coordination, and technical support.

The POLICY Project has been active in helping to write the reproductive health section of the national youth policy that was developed by the then MYSC. In addition, the POLICY Project has focused its efforts to serve youth around three specific areas: (1) advocacy, (2) inter-agency collaboration, and (3) contraceptive security.

In addition, there are a number of NGOs and faith-based organizations in Ethiopia that are dedicated to reducing the spread of HIV/AIDS and providing care and support for those affected by HIV/AIDS. The supporting, and promoting of adolescent sexual and reproductive health initiatives is part of their agenda. These organizations include: ***Organization for Social Services for AIDS (OSSA), Family Health International (FHI), Ethiopian Kale Hiwot Church (EKHC), Ethiopian Evangelical Church Mekane Yesus (EECMY), Ethiopian Muslim Development Agency (EDMA), Ethiopian Orthodox Church (EOC),*** **and** ***CARE/Ethiopia***.

1.4 Data Sources and Purpose of this Report



The objective of this report is to assess the status of and changes in fertility, family planning, and health behavior of women and men in the reproductive age group in general and the youth population in particular, in Ethiopia, in order to provide decision-makers with a clearer understanding of the experiences and needs of people in the country, and help them design programs that can focus on these needs. In addition, this report compares data on the areas of the country where Packard-funded programs operate to those areas where Packard is not active. These latter analyses are restricted to the Amhara and Oromiya regions, because Packard's activities and programs are mostly focused and have been active longest in these two regions—long enough to allow observation of changes, if any, in reproductive health. Amhara is in the northwestern part of the country, while Oromiya is located in the southern and western central part of the country and is the largest region in terms of both

population and surface area. Together these two regions account for about three-fifths of the population of Ethiopia. Both areas are largely rural, more so than the country as a whole.

The data for this study come from the 2000 and 2005 Ethiopia Demographic and Health Surveys (EDHS). The 2000 EDHS was the first comprehensive nationally representative population and health survey in Ethiopia. It was conducted under the worldwide Demographic and Health Surveys (DHS) project and surveyed 14,072 households and interviewed 15,367 women age 15-49 and 2,607 men age 15-59. The 2005 EDHS covered 13,721 households, 14,070 women age 15-49 in these households, and 6,033 men age 15-59. The 2005 EDHS collected information similar to that collected in the 2000 EDHS. In addition, the 2005 EDHS included HIV testing among men, HIV and anemia testing among women, and anemia testing among children age 6-59 months in half of the surveyed households. In selecting the sample for the EDHS, smaller regions were over sampled, so that analyses could be done at the regional level. All statistics presented here have been weighted and hence are nationally representative.

It is important to note here that the analysis on the impact of the Packard-sponsored programs is restricted to data collected in those clusters sampled in the EDHS that are in the Packard areas and is therefore not representative of all Packard-supported areas in Amhara and Oromiya, nor are they representative of all women who participate in the programs. Nevertheless, since EDHS clusters that have the Packard programs comprise about 25 percent of all the sampled EDHS clusters in the two regions, they should provide a meaningful insight into the impact of Packard-funded programs on reproductive health in general in these regions and monitor changes over the five years between 2000 and 2005. In addition, by restricting the analysis of the EDHS sample in the Packard and non-Packard areas to Amhara and Oromiya we hope to minimize the confounding effects of regional differences. Moreover, since Packard programs focus primarily on the youth population, comparisons are drawn for the youth population.

This report presents descriptive statistics that illustrate differences among population subgroups. Multivariate analyses have also been conducted to examine these relationships, and these are mentioned where relevant and particularly noteworthy.

This report complements four other reports based on EDHS data, which should be consulted for additional information:

1. *Ethiopia Demographic and Health Survey 2000* (CSA and ORC Macro, 2001) reports the key findings from the 2000 EDHS;

2. *Ethiopia Demographic and Health Survey 2005* (CSA and ORC Macro, 2006) reports the key findings from the 2005 EDHS;

3. *Youth Reproductive Health in Ethiopia* (Govindasamy, Kidanu and Banteyerga, 2002) presents data from the 2000 EDHS on women and men age 15-24, with particular attention to their sexual experience, knowledge and use of family planning, fertility and childbearing patterns, maternal and child health and knowledge of HIV/AIDS. The report was published in 2002 and widely disseminated in Ethiopia and elsewhere;

4. *Trends in Demographic and Reproductive Health Indicators in Ethiopia: Further Analysis of the 2000 and 2005 Demographic and Health Surveys* (Macro International Inc., 2007) examines changes between 2000 and 2005 in key demographic and health indicators.

This report focuses on the youth population age 15-24, and discusses how women and men age 15-19 and 20-24 differ from each other and from the older population of reproductive age (25-49). The report also examines changes between the 2000 and 2005 EDHS data for youth age 15-24 in general and among youth in the Packard and non-Packard areas of Amhara and Oromiya. Topics include: profile of youth, marriage and sexual activity, knowledge and use of contraception, childbearing and fertility preferences, maternal and child health, and knowledge about HIV/AIDS. The report concludes with a summary of the main findings and discusses their implication for policymakers and program planners.

Chapter 2

Profile of Youth

KEY FINDINGS

- The majority of young male and female respondents, about eight in ten, live in rural areas.
- Half of young women and one-fourth of young men have no education.
- At all levels, young men are more educated than young women.
- Literacy levels among youth increased dramatically between 2000 and 2005; however, literacy among female youth continues to be substantially lower than literacy among male youth.
- Young women are less likely to be employed than young men; seven in ten young men are currently employed, but only about three in ten young women are.
- Seven in ten youth age 15-24 were not exposed to any form of mass media on a weekly basis.

2.1 BACKGROUND CHARACTERISTICS

This chapter provides a demographic and socioeconomic profile of respondents interviewed in the 2000 and 2005 EDHS. Such background information provides a context for interpreting the results presented later in this report. Basic characteristics documented in the EDHS include age, marital status, residence, level of education and literacy status, religion, ethnicity, employment, and wealth status. Exposure to mass media is also examined.

Tables 2.1.1 and 2.1.2 show characteristics of the female and male youth population age 15-24 interviewed in the 2005 and 2000 EDHS surveys. Data are presented on the number of cases in each group—both the actual number of cases (unweighted) and the effective weighted number of cases—so that readers are informed about the sizes of the samples for statistics presented later in this report and can exercise caution in interpreting comparisons of groups with small numbers of unweighted cases.

Table 2.1.1 Background characteristics of respondents, Ethiopia 2005

Percent distribution of women and men age 15-24 by selected background characteristics, Ethiopia 2005

Background characteristic	Women			Men		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Age						
15-19	56.2	3,266	3,252	55.7	1,335	1,278
20-24	43.8	2,547	2,617	44.3	1,064	1,039
Marital status						
Never married	54.5	3,165	3,283	86.7	2,081	2,014
Married	38.2	2,220	2,145	11.5	275	264
Living together	1.1	65	86	0.4	8	9
Divorced/separated	5.9	340	327	1.3	31	27
Widowed	0.4	23	28	0.1	3	3
Residence						
Urban	21.4	1,242	2,128	18.0	431	692
Rural	78.6	4,571	3,741	82.0	1,968	1,625
Region						
Tigray	6.7	387	519	6.0	145	196
Affar	0.9	54	281	0.8	18	85
Amhara	24.0	1,392	782	25.6	614	365
Oromiya	36.7	2,131	945	37.8	907	427
Somali	2.7	155	208	2.5	60	89
Benishangul-Gumuz	0.9	51	347	0.7	18	121
SNNP	20.6	1,197	844	20.5	491	345
Gambela	0.3	17	291	0.3	8	140
Harari	0.3	17	374	0.2	6	128
Addis Ababa	6.6	382	945	5.0	120	285
Dire Dawa	0.5	29	333	0.5	12	136

Continued…

Table 2.1.1—*Continued*

Background characteristic	Women			Men		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Education[1]						
No education	48.9	2,841	2,572	26.3	630	563
Primary	34.3	1,996	1,886	47.3	1,135	947
Secondary	15.6	906	1,277	24.8	595	745
Higher	1.2	70	134	1.6	39	62
Literacy						
Literate[2]	41.6	2,420	2,797	67.2	1,613	1,631
Not literate	55.7	3,236	2,940	29.8	715	635
No card or missing	2.7	158	132	3.0	71	51
Religion						
Orthodox	50.9	2,956	2,975	50.6	1,214	1,145
Catholic	1.4	79	64	1.1	26	25
Protestant	19.0	1,103	969	17.3	416	354
Muslim	27.1	1,573	1,769	28.0	673	734
Other	1.8	103	92	3.0	71	59
Ethnicity						
Affar	0.6	36	200	0.6	14	70
Amhara	31.3	1,820	1,768	30.9	740	658
Guragie	5.0	290	379	5.2	124	157
Oromo	33.2	1,930	1,481	33.5	803	584
Sidama	3.3	191	119	4.0	97	59
Somali	2.3	134	220	2.4	57	104
Tigraway	7.1	412	578	6.5	155	220
Welaita	2.8	160	117	2.2	52	42
Other	14.5	841	1,007	14.9	356	423
Wealth quintile						
Lowest	14.4	836	939	17.7	425	429
Second	18.0	1,045	807	17.5	421	327
Middle	19.5	1,135	843	16.3	391	314
Fourth	18.0	1,043	768	20.6	493	358
Highest	30.2	1,753	2,512	27.9	669	889
Total 15-24	100.0	5,813	5,869	100.0	2,399	2,317

[1] Education categories refer to the highest level of education attended, whether or not that level was completed.
[2] Refers to women and men who attended secondary school or higher and women and men who can read a whole sentence or part of a sentence from the literacy cards. The literacy cards contained simple sentences in five of the major languages.

Table 2.1.2 Background characteristics of respondents, Ethiopia 2000

Percent distribution of women and men age 15-24 by selected background characteristics, Ethiopia 2000

Background characteristic	Women			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

Continued…

Table 2.1.2 Background characteristics of respondents, Ethiopia 2000—*Continued*

Background characteristic	Women			Men		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Education[1]						
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[2]	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
Ethnicity						
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
Sidama	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 15-24	100.0	6,570	6,428	100.0	1,008	990

[1] Education categories refer to the highest level of education attended, whether or not that level was completed.
[2] Refers to women and men who attended secondary school or higher and women and men who can read a whole sentence or part of a sentence from the literacy cards. The literacy cards contained simple sentences in five of the major languages.

Data from both surveys show that proportionally, there are more women and men age 15-19 than age 20-24. The 2005 EDHS data show that young women are much more likely to be married than young men, because women in Ethiopia marry at younger ages than men (see Chapter 3). Nearly half (46 percent) of women age 15-24 are currently or formerly married, compared with only 13 percent of men.

The majority of young male and female respondents, about eight in ten, live in rural areas. About two in five respondents live in the Oromiya Region, about one in four live in the Amhara Region, and about one in five live in SNNP (the Southern Nations, Nationalities, and People's Region).

Half of young women have no education, one-third have primary education, and one-sixth have secondary education or higher. A significantly lower proportion of men than women have no education (26 percent of men versus 49 percent of women), and a higher proportion have primary education (47 percent of men versus 34 percent of women) or secondary or higher education (26 percent of men compared with 17 percent of women). Four in ten young women are literate compared with about seven in ten young men.

One in two youths are Orthodox Christians; about three in ten are Muslims; and one in five are Protestants. Ethnically, about a third of young women and men are Oromos and one-third are Amharas; about 7 percent are Tigraways.

Tables 2.2.1, 2.2.2, 2.3.1 and 2.3.2 present data on the background characteristics of the sampled populations of women and men in the Packard and non-Packard clusters of the Amhara and Oromiya Regions for 2000 and 2005. In the 2005 EDHS, 984 (unweighted) female respondents age 15-49 and 453 (unweighted) male respondents age 15-59 lived in the Packard areas. The numbers in the non-Packard areas were considerably larger (Tables 2.2.1 and 2.3.1). About two in five of all respondents in the two regions were age

15-24. The percentage representation of the youth population in these regions in the 2000 EDHS sample was similar.

Because the samples in the Packard areas are fairly small, differences between population subgroups are not analyzed; the lack of statistical precision would prevent conclusive results. Compared with women in the non-Packard areas, a larger proportion of women in the Packard areas live in the Amhara Region (48 percent versus 44 percent) while a smaller proportion live in Oromiya (47 percent versus 51 percent). Women in the Packard areas are less likely to be Orthodox (and more likely to be Protestant or Muslim) than those in the non-Packard areas. Apart from the difference in the regional representation of the population, the two samples are fairly similar in terms of background characteristics.

Table 2.2.1 Background characteristics of women, Amhara and Oromiya 2005

Percent distribution of women age 15-49 in Packard and non-Packard areas by background characteristics, Amhara and Oromiya 2005

Background characteristic	Packard			Non-Packard			Total		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Age									
15-19	23.6	456	227	23.8	1,560	764	23.7	2,017	991
20-24	18.2	351	185	17.6	1,156	551	17.7	1,507	736
25-29	18.6	359	183	16.9	1,108	532	17.3	1,468	715
30-34	10.2	198	101	13.1	861	419	12.5	1,058	520
35-39	10.3	200	103	11.7	768	378	11.4	969	481
40-44	10.0	193	98	8.2	538	262	8.6	731	360
45-49	9.1	176	87	8.6	566	283	8.7	743	370
Marital status									
Never married	24.2	467	232	21.5	1,408	670	22.1	1,875	902
Married	64.2	1,242	632	65.9	4,322	2,098	65.5	5,564	2,730
Living together	1.2	23	12	0.7	43	21	0.8	66	33
Divorced/separated	6.7	130	70	7.7	508	265	7.5	638	335
Widowed	3.7	72	38	4.2	277	135	4.1	349	173
Residence									
Urban	11.0	213	106	14.2	933	447	13.5	1,146	553
Rural	89.0	1,720	878	85.8	5,625	2,742	86.5	7,345	3,620
Region									
Amhara	47.9	927	508	39.0	2,555	1,435	41.0	3,482	1,943
Oromiya	52.1	1,007	476	61.0	4,002	1,754	59.0	5,010	2,230
Education[1]									
No education	68.1	1,317	668	69.3	4,542	2,240	69.0	5,859	2,908
Primary	21.1	408	209	21.7	1,426	663	21.6	1,834	872
Secondary	10.0	193	99	8.2	539	262	8.6	733	361
Higher	0.8	15	8	0.8	50	24	0.8	65	32
Literacy									
Literate[2]	28.3	547	282	27.5	1,802	864	27.7	2,349	1,146
Not literate	71.7	1,386	701	71.0	4,653	2,282	71.1	6,039	2,983
Missing	0.1	1	1	1.5	102	43	1.2	103	44
Religion									
Orthodox	38.8	750	400	59.3	3,888	2,007	54.6	4,638	2,407
Catholic	0.2	3	2	1.3	88	38	1.1	91	40
Protestant	13.8	266	127	8.9	585	253	10.0	851	380
Muslim	44.9	868	433	29.2	1,912	846	32.7	2,779	1,279
Other	2.4	46	22	1.3	85	45	1.5	132	67
Ethnicity									
Affar	0.1	2	1	0.0	0	0	0.0	2	1
Amhara	48.1	930	508	44.3	2,906	1,576	45.2	3,836	2,084
Guragie	0.5	10	5	0.7	46	20	0.7	55	25
Oromo	47.2	913	434	50.5	3,314	1,457	49.8	4,227	1,891
Sidama	0.2	3	2	0.0	0	0	0.0	3	2
Somali	0.0	0	0	0.1	4	2	0.1	4	2
Tigraway	0.2	5	3	0.5	31	16	0.4	35	19
Welaita	0.1	2	1	0.4	23	9	0.3	25	10
Other	3.6	69	30	3.6	233	109	3.6	302	139
Wealth quintile									
Lowest	16.3	316	156	16.8	1,103	532	16.7	1,419	688
Second	20.2	391	195	20.9	1,368	676	20.7	1,758	871
Middle	22.5	434	225	20.2	1,328	638	20.8	1,762	863
Fourth	22.4	434	220	19.3	1,266	628	20.0	1,700	848
Highest	18.6	359	188	22.8	1,493	715	21.8	1,852	903
Total	100.0	1,934	984	100.0	6,557	3,189	100.0	8,491	4,173

[1] Education categories refer to the highest level of education attended, whether or not that level was completed.
[2] Refers to women who attended secondary school or higher and women and men who can read a whole sentence or part of a sentence from the literacy cards. The literacy cards contained simple sentences in five of the major languages.

Table 2.2.2 Background characteristics of women, Amhara and Oromiya 2000

Percent distribution of women age 15-49 in Packard and non-Packard areas by background characteristics, Amhara and Oromiya 2000

Background characteristic	Packard			Non-Packard			Total		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Age									
15-19	22.3	488	244	25.7	1,948	841	25.0	2,436	1,085
20-24	18.2	398	198	18.9	1,429	625	18.7	1,827	823
25-29	15.4	337	174	16.4	1,244	560	16.2	1,581	734
30-34	12.8	280	144	11.6	878	397	11.9	1,158	541
35-39	12.0	263	138	10.8	815	363	11.1	1,078	501
40-44	11.1	242	125	8.3	629	287	8.9	871	412
45-49	8.3	182	95	8.2	624	296	8.3	806	391
Marital status									
Never married	22.4	490	241	21.4	1,620	680	21.6	2,110	921
Married	60.7	1,329	685	65.6	4,962	2,253	64.5	6,291	2,938
Living together	0.8	17	8	0.7	49	21	0.7	66	29
Divorced/separated	12.6	275	142	9.1	691	304	9.9	966	446
Widowed	3.7	80	42	3.2	244	111	3.3	324	153
Residence									
Urban	22.2	487	207	11.8	892	287	14.1	1,380	494
Rural	77.8	1,703	911	88.2	6,674	3,082	85.9	8,377	3,993
Region									
Amhara	47.0	1,030	564	36.9	2,790	1,345	39.2	3,820	1,909
Oromiya	53.0	1,161	554	63.1	4,776	2,024	60.8	5,937	2,578
Education[1]									
No education	75.8	1,660	871	79.7	6,032	2,752	78.8	7,693	3,623
Primary	13.5	295	142	14.3	1,085	459	14.1	1,380	601
Secondary	9.8	214	97	5.7	431	151	6.6	645	248
Higher	1.0	21	8	0.2	18	7	0.4	39	15
Literacy									
Literate[2]	26.4	577	274	20.4	1,544	626	21.7	2,121	900
Not literate	73.3	1,606	840	79.5	6,013	2,740	78.1	7,619	3,580
Missing	0.3	7	4	0.1	9	3	0.2	16	7
Religion									
Orthodox	38.2	837	426	58.0	4,388	2,015	53.6	5,225	2,441
Catholic	0.0	0	0	0.8	61	23	0.6	61	23
Protestant	5.6	123	58	8.7	655	275	8.0	778	333
Muslim	51.4	1,127	585	29.6	2,239	939	34.5	3,365	1,524
Other	4.7	104	49	3.0	224	117	3.4	328	166
Ethnicity									
Affar	0.2	5	2	0.0	0	0	0.1	5	2
Amhara	49.4	1,081	568	41.6	3,144	1,448	43.3	4,225	2,016
Guragie	1.6	34	14	1.0	77	26	1.1	111	40
Oromo	47.7	1,046	523	51.8	3,918	1,709	50.9	4,963	2,232
Sidama	0.0	0	0	0.5	36	8	0.4	36	8
Somali	0.0	0	0	0.5	36	17	0.4	36	17
Tigraway	0.4	8	4	0.2	18	6	0.3	27	10
Welaita	0.0	0	0	0.4	31	7	0.3	31	7
Other	0.7	16	7	4.0	306	148	3.3	323	155
Total	100.0	2,191	1,118	100.0	7,566	3,369	100.0	9,757	4,487

[1] Education categories refer to the highest level of education attended, whether or not that level was completed.
[2] Refers to women who attended secondary school or higher and women and men who can read a whole sentence or part of a sentence from the literacy cards. The literacy cards contained simple sentences in five of the major languages.

Table 2.3.1 Background characteristics of men, Amhara and Oromiya 2005

Percent distribution of men age 15-59 in Packard and non-Packard areas by background characteristics, Amhara and Oromiya 2005

Background characteristic	Packard			Non-Packard			Total		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Age									
15-19	22.2	186	101	23.2	676	351	23.0	861	452
20-24	17.1	143	77	17.8	517	263	17.6	660	340
25-29	11.2	94	52	11.6	336	166	11.5	430	218
30-34	11.3	95	53	12.6	366	187	12.3	460	240
35-39	12.5	104	55	10.3	299	152	10.8	403	207
40-44	6.9	58	31	8.5	247	123	8.1	305	154
45-49	8.1	67	35	6.9	201	102	7.2	269	137
50-54	6.5	55	30	5.0	145	76	5.3	200	106
55-59	4.1	35	19	4.1	120	65	4.1	155	84
Marital status									
Never married	41.2	344	187	39.2	1,140	580	39.7	1,484	767
Married	55.0	460	249	57.4	1,669	851	56.9	2,128	1,100
Living together	0.7	6	3	0.2	6	3	0.3	12	6
Divorced/separated	2.9	24	13	2.8	81	44	2.8	105	57
Widowed	0.2	2	1	0.4	12	7	0.4	13	8
Residence									
Urban	10.0	83	43	11.0	321	146	10.8	404	189
Rural	90.0	752	410	89.0	2,587	1,339	89.2	3,339	1,749
Region									
Amhara	51.9	433	251	37.4	1,088	646	40.6	1,521	897
Oromiya	48.1	402	202	62.6	1,820	839	59.4	2,222	1,041
Education[1]									
No education	49.2	411	226	45.6	1,325	710	46.4	1,736	936
Primary	33.9	283	151	37.2	1,082	537	36.5	1,364	688
Secondary	15.9	133	71	15.7	456	216	15.7	589	287
Higher	1.1	9	5	1.5	45	22	1.4	54	27
Literacy									
Literate[2]	56.1	468	254	59.2	1,720	865	58.5	2,189	1,119
Not literate	43.9	367	199	40.1	1,167	610	41.0	1,534	809
Missing	0.0	0	0	0.7	20	10	0.5	20	10
Religion									
Orthodox	41.5	346	199	59.1	1,719	930	55.2	2,066	1,129
Catholic	0.0	0	0	0.7	19	9	0.5	19	9
Protestant	10.3	86	42	9.4	272	123	9.6	358	165
Muslim	46.1	385	203	29.7	862	403	33.3	1,247	606
Other	2.2	18	9	1.2	35	20	1.4	53	29
Ethnicity									
Amhara	49.6	415	241	42.3	1,231	705	44.0	1,646	946
Guragie	0.8	6	3	1.3	37	16	1.2	43	19
Oromo	46.2	386	195	51.9	1,510	702	50.7	1,896	897
Somali	0.0	0	0	0.1	2	1	0.1	2	1
Tigraway	0.6	5	3	0.3	10	4	0.4	15	7
Welaita	0.0	0	0	0.1	2	1	0.1	2	1
Other	2.8	24	11	4.0	115	56	3.7	138	67
Wealth quintile									
Lowest	19.3	161	82	16.8	488	252	17.3	649	334
Second	18.3	153	83	20.6	600	310	20.1	753	393
Middle	21.0	176	97	18.7	544	279	19.2	720	376
Fourth	23.2	194	107	22.1	642	338	22.3	836	445
Highest	18.1	151	84	21.8	634	306	21.0	785	390
Total	100.0	835	453	100.0	2,908	1,485	100.0	3,743	1,938

[1] Education categories refer to the highest level of education attended, whether or not that level was completed.
[2] Refers to men who attended secondary school or higher and women and men who can read a whole sentence or part of a sentence from the literacy cards. The literacy cards contained simple sentences in five of the major languages.

Table 2.3.2 Background characteristics of men, Amhara and Oromiya 2000

Percent distribution of men age 15-59 in Packard and non-Packard areas by background characteristics, Amhara and Oromiya 2000

Background characteristic	Packard			Non-Packard			Amhara and Oromiya		
	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted	Weighted percent	Weighted	Unweighted
Age									
15-19	24.9	92	47	22.5	295	137	23.0	387	184
20-24	19.4	72	36	15.0	197	90	16.0	269	126
25-29	10.1	37	19	13.2	174	79	12.5	211	98
30-34	9.8	36	19	10.5	138	60	10.4	174	79
35-39	14.0	52	26	11.0	144	68	11.7	196	94
40-44	8.6	32	17	6.5	86	39	7.0	118	56
45-49	3.5	13	7	8.8	115	52	7.6	129	59
50-54	4.1	15	8	6.1	80	40	5.6	95	48
55-59	5.6	21	11	6.4	83	40	6.2	104	51
Marital status									
Never married	42.3	157	79	36.9	484	222	38.1	641	301
Married	54.8	204	105	57.4	753	347	56.8	956	452
Living together	0.5	2	1	0.2	2	1	0.3	4	2
Divorced/separated	1.9	7	4	5.3	70	33	4.5	76	37
Widowed	0.5	2	1	0.3	4	2	0.3	5	3
Residence									
Urban	18.2	68	28	6.6	87	31	9.2	154	59
Rural	81.8	304	162	93.4	1,225	574	90.8	1,529	736
Region									
Amhara	39.7	148	81	36.7	482	240	37.4	630	321
Oromiya	60.3	224	109	63.3	830	365	62.6	1,054	474
Education[1]									
No education	52.3	194	104	61.0	801	381	59.1	995	485
Primary	31.7	118	60	30.3	397	179	30.6	515	239
Secondary	11.8	44	20	7.6	100	40	8.6	144	60
Higher	4.2	16	6	1.1	14	5	1.8	30	11
Literacy									
Literate[2]	53.7	199	101	45.9	602	271	47.6	801	372
Not literate	45.8	170	88	54.1	710	334	52.3	880	422
Missing	0.5	2	1	0.0	0	0	0.1	2	1
Religion									
Orthodox	37.2	138	71	61.1	802	381	55.8	940	452
Protestant	9.9	37	18	6.6	86	40	7.3	123	58
Muslim	51.3	191	98	31.3	411	176	35.7	601	274
Other	1.6	6	3	1.0	13	8	1.1	19	11
Ethnicity									
Amhara	41.6	155	81	40.4	530	254	40.7	685	335
Guragie	0.6	2	1	0.3	4	1	0.4	6	2
Oromo	54.9	204	103	53.3	700	311	53.7	904	414
Sidama	0.0	0	0	0.2	2	1	0.1	2	1
Somali	0.0	0	0	1.3	17	8	1.0	17	8
Tigraway	2.3	8	4	0.2	2	1	0.6	11	5
Other	0.6	2	1	4.3	57	29	3.5	59	30
Total	100.0	371	190	100.0	1,312	605	100.0	1,683	795

[1] Education categories refer to the highest level of education attended, whether or not that level was completed.
[2] Refers to men who attended secondary school or higher and women and men who can read a whole sentence or part of a sentence from the literacy cards. The literacy cards contained simple sentences in five of the major languages.

2.2 EDUCATIONAL ATTAINMENT AND LITERACY

Education is an important factor influencing an individual's attitude and outlook on various aspects of life and his or her opportunities in the labor market. In general, the higher the level of education of a woman, the more knowledgeable she is about her health and the health of her family and children. Ethiopia's education system has been stable for a long time. It must be noted that recently, the government undertook a major restructuring and expansion program in the education sector opening it to private investment. The current system of formal education is based on a three-tier system: eight years of primary education, followed by four years each of secondary school and tertiary education. Prior to the change in the education policy, the

education system was based on six years of primary education, followed by two years of junior secondary and four years each of senior secondary education and tertiary education. Currently, several pre-university colleges and various institutions operated by the government and the private sector offer vocational, technical and professional training in different parts of the country. The number of government universities, and private universities and vocational and technical schools has increased substantially in various parts of the country (CSA and ORC Macro, 2006). The recent changes in the education system in Ethiopia must be kept in mind when interpreting time trends in educational attainment among youth.

The 2005 Ethiopia Demographic and Health Survey (EDHS) provided data on net attendance ratios (NARs) and gross attendance ratios (GARs) for the de facto household population in the country. The NAR indicates participation in primary schooling for the population age 7-12 and secondary schooling for the population age 13-18. The GAR measures participation at each level of schooling among those of any age. The survey results for NARs show that 42 percent of children who should be attending primary school are currently doing so and that only 16 percent of secondary-school-age youth are in school. The GAR at the primary-school level is 77 percent, but at secondary-school level it is only 24 percent. Generally, educational attainment in Ethiopia is significantly lower among women than among men (CSA and ORC Macro, 2006).

Figures 2.1, 2.2, 2.3.1 and 2.3.2 present data on the education of youth and of respondents age 25-49 in 2000 and 2005. Specifically, they show the percent distribution of respondents by highest level attended (but not necessarily completed) for each of the subsamples. Educational attainment among youth is low, with half of young women and one-fourth of young men having no education. At all levels, young men are more educated than young women. For example, in 2005, 47 percent of young men have at least some primary education compared with 34 percent of young women, and 25 percent of young men have at least some secondary education compared with 16 percent of young women (Figure 2.1).

Figure 2.1 Percent distribution of respondents age 15-24 and 25-49, by highest level of schooling attended, Ethiopia 2005

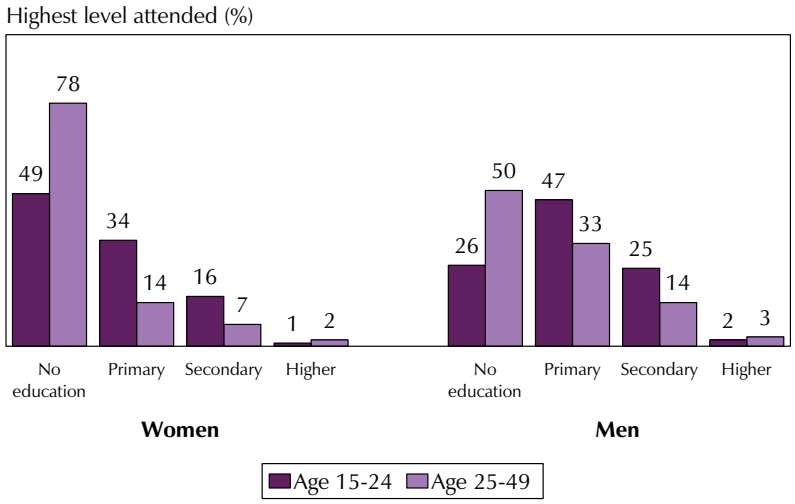
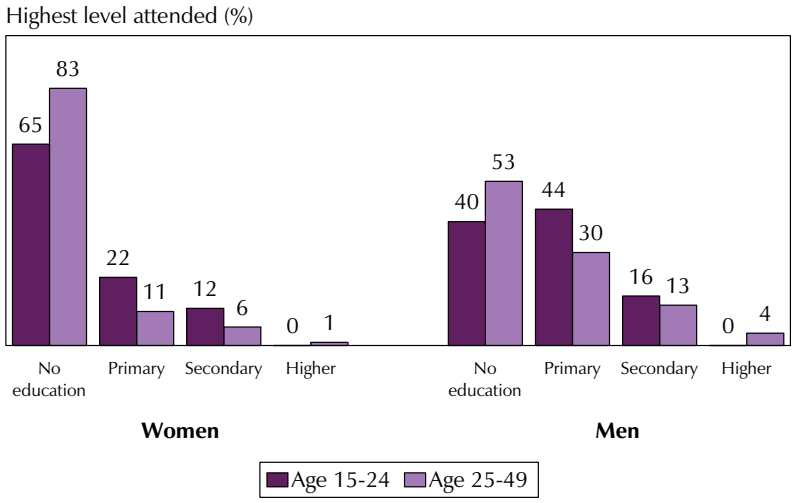


Figure 2.2 Percent distribution of respondents age 15-24 and 25-49 by highest level of schooling attended, Ethiopia 2000



In both the 2000 and 2005 EDHS surveys, young respondents age 15-24 are more likely to have primary or secondary education and are less likely to be uneducated compared with respondents age 25-49 (Figures 2.1 and 2.2). For example, in 2005, half as many men age 15-24 as men age 25-49 had no education (26 percent versus 50 percent). Similarly, 49 percent of women age 15-24 had no education compared with 78 percent of women age 25-49.

The proportion of young respondents with no education decreased between 2000 and 2005, from 65 percent to 49 percent for young women, and from 40 percent to 26 percent for young men (Figures 2.3.1 and 2.3.2). On the other hand, the proportion of youth attending all levels of education has increased since 2000. For example, the percentage of women age 15-24 who have some primary education increased from 22 percent in 2000 to 34 in 2005.

Figure 2.3.1 Trends in education among women age 15-24, Ethiopia 2000 and 2005

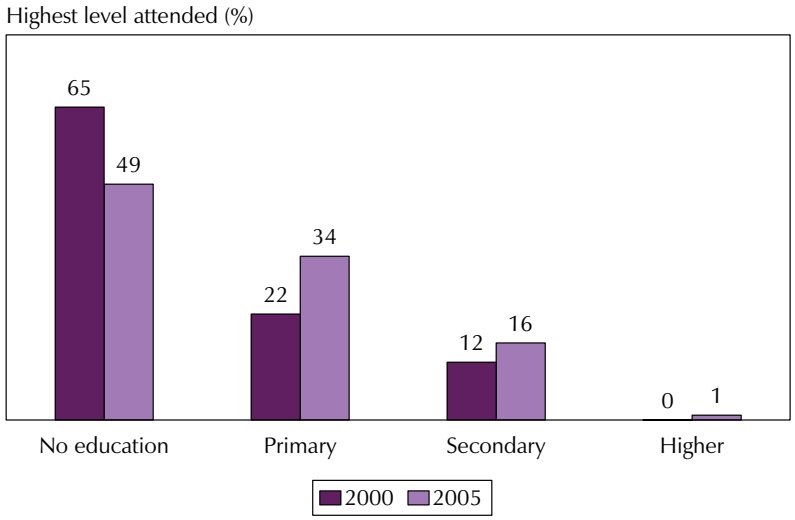
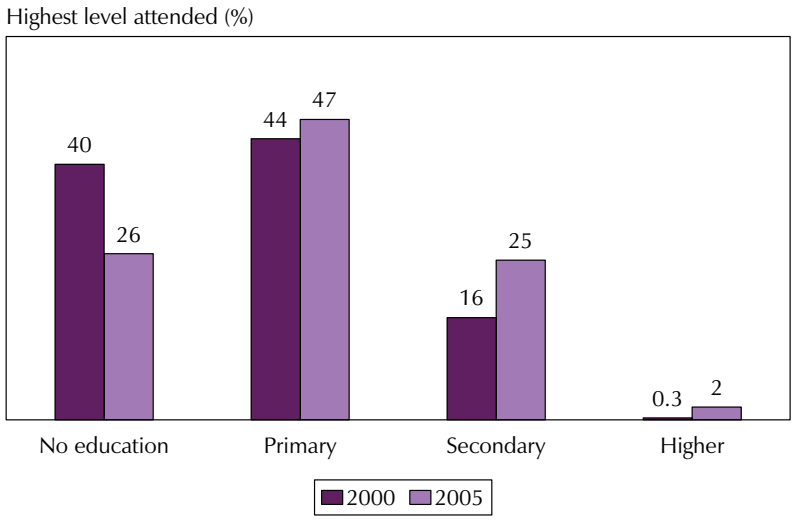


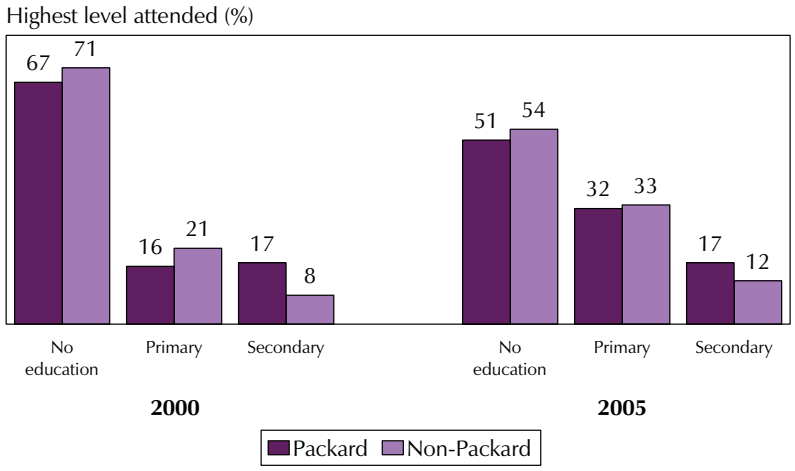
Figure 2.3.2 Trends in education among men age 15-24, Ethiopia 2000 and 2005



Figures 2.4 and 2.5 show data on educational attainment among youth in the Packard and non-Packard areas in 2000 and 2005. The proportion of young men and women with no education has decreased substantially over this period in both the Packard and non-Packard areas. However, while among young women the decline is almost the same in the Packard and non-Packard areas (16 and 17 percentage points, respectively), among young men the decline is more pronounced in the non-Packard areas than in the Packard areas (20 and 8 percentage points, respectively). The percentage of young men with at least some primary education has increased in the non-Packard areas but has decreased slightly among young men in the Packard areas. The proportion of young men with at least some secondary education increased substantially in both areas between 2000 and 2005, but the increase is much greater among those of the non-Packard areas. The proportion of young women with at least some primary education doubled in the Packard areas (from 16 percent to 32 percent), and increased one and a half times in the non-Packard areas, while the proportion with at least some secondary education increased among those in the non-Packard areas but remained the same among young women in the Packard areas.

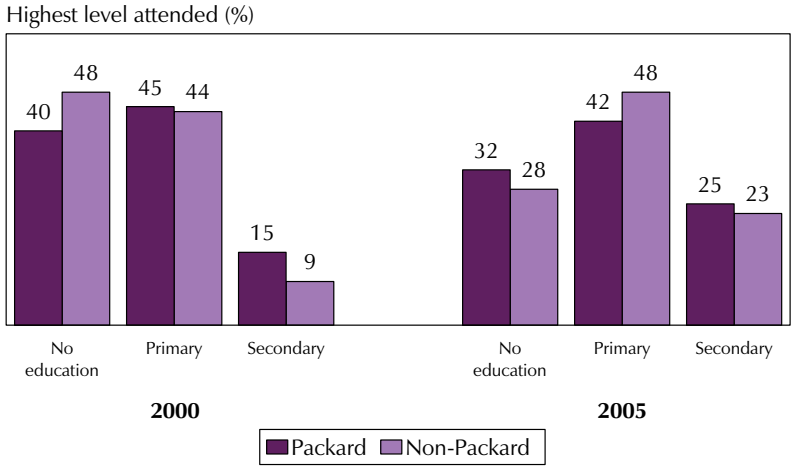
Literacy levels show similarly dramatic increases between 2000 and 2005. Literacy levels have increased from 30 percent to 42 percent among young women, and from 54 percent to 67 percent among young men (Tables 2.1.1 and 2.1.2). It is worth noting that despite the considerable improvement in literacy among female youth over the five-year period, the rate is still lower than that of male youth in 2000.

Figure 2.4 Education among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



Note: The category "Higher" (than Secondary) is not shown because there were fewer than 25 unweighted cases.

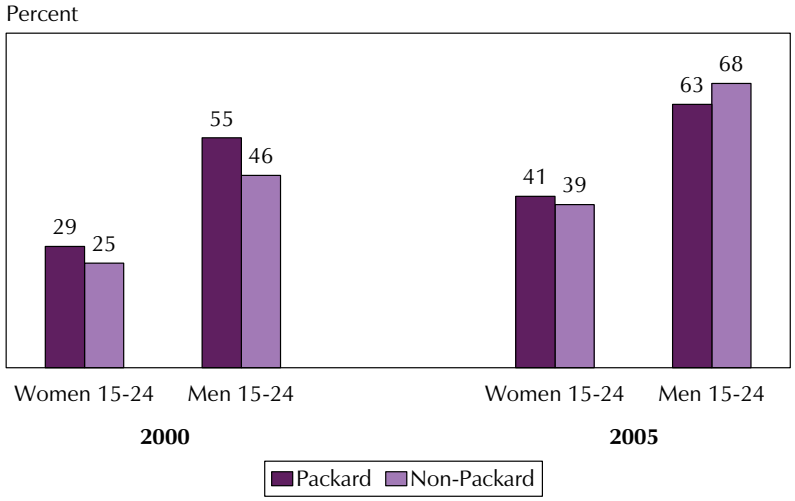
Figure 2.5 Education among men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



Note: The category "Higher" (than Secondary) is not shown because there were fewer than 25 unweighted cases.

When looking at changes in literacy among youth between 2000 and 2005 in the Packard and non-Packard areas (Figure 2.6), we see that the proportion of literate youth has increased in both areas and for both sexes. Literacy among women is higher in the Packard than in the non-Packard areas, with little change between 2000 and 2005. However, a higher proportion of male youth in the non-Packard areas than in the Packard areas were literate in 2005 compared with 2000.

Figure 2.6 Literacy among women and men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



2.3 EMPLOYMENT STATUS

Data on employment status indicate the extent to which people are involved in the labor market and contributing to the national economy. Figures 2.7 and 2.8 compare employment status and changes between 2000 and 2005 among youth and older respondents age 25-49 in 2000 and 2005. Seventy percent of young men in Ethiopia were currently employed at the time of the 2005 EDHS, but only 27 percent of young women were (Figure 2.7). Both young women and young men are less likely to be employed than their older counterparts, but the gap is much larger among men than women. For both young and older respondents, women are much less likely to be employed than men.

Figure 2.7 Employment status among women and men age 15-24 compared with women and men age 25-49, Ethiopia 2005

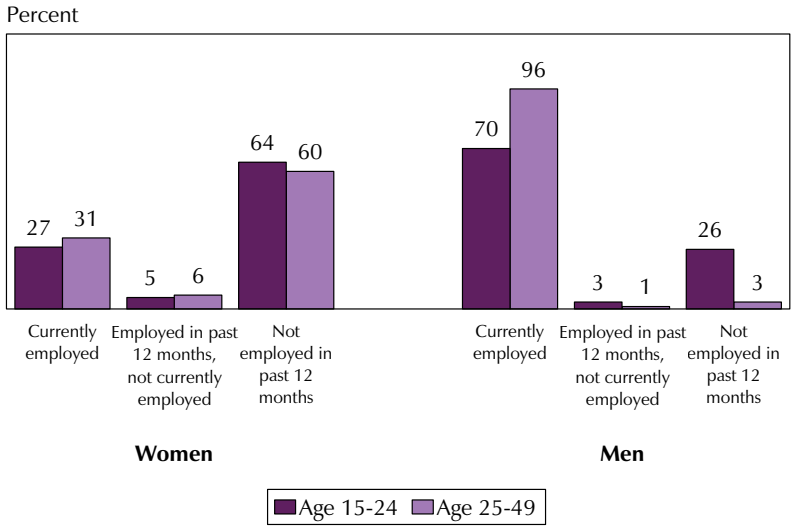
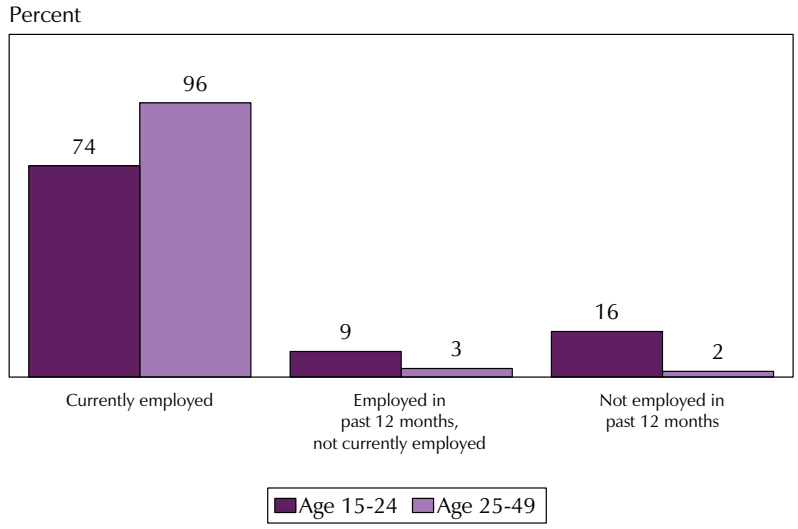


Figure 2.8 Employment status among men age 15-24 compared with men age 25-49, Ethiopia 2000



The percentage of young men currently employed decreased between 2000 and 2005, from 74 percent to 70 percent. The percentage not employed in the past 12 months also declined (Figures 2.7 and 2.8). The latter may reflect the increase in school attendance discussed earlier. The percentage of young men employed in the 12 months before the survey but not at the time of the survey decreased between 2000 and 2005. Data are not presented on the employment status of women for the year 2000 because the questions in 2000 and 2005 were not comparable.

Figures 2.9 and 2.10 show employment status among youth in the Packard and non-Packard areas in 2005 (men and women) and in 2000 (men only). In all cases, youth in the Packard areas were more likely to be currently employed than those in the non-Packard areas. Between 2000 and 2005, the percentage of young men who were currently employed decreased slightly in both areas, and the percentage not employed in the past 12 months increased in both areas.

Figure 2.9 Employment status among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005

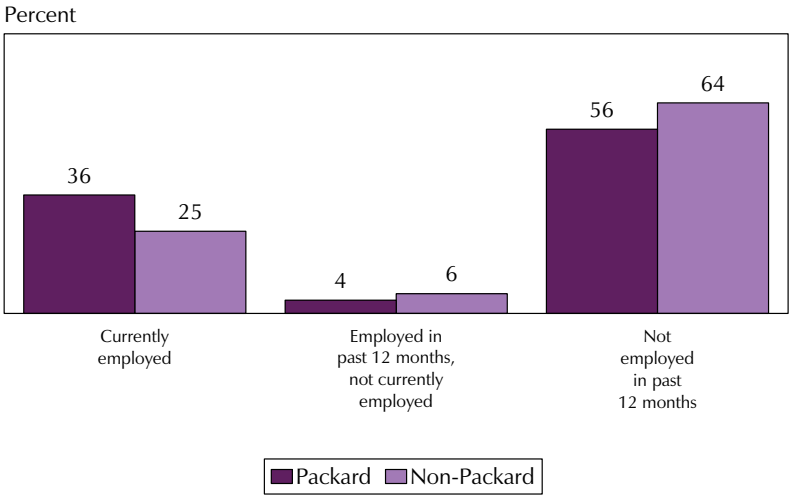
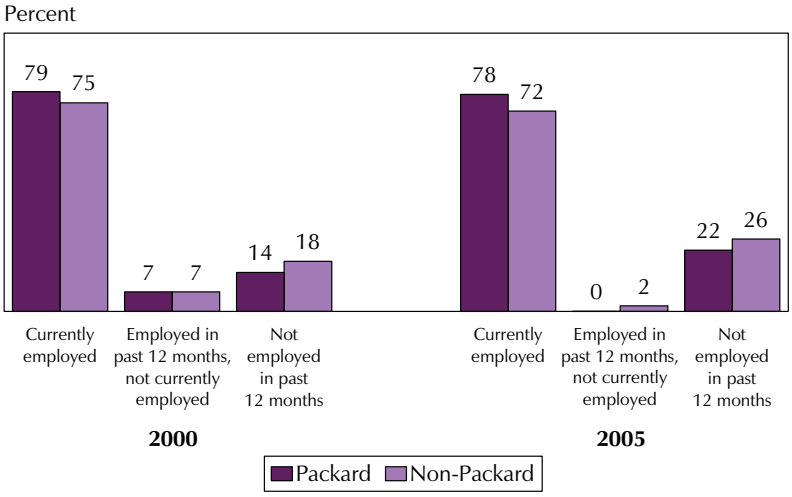


Figure 2.10 Employment status among men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



2.4 EXPOSURE TO MASS MEDIA

Mass media is an important means of reaching audiences with new ideas and knowledge that are useful in everyday life. In both the 2000 and 2005 EDHS, exposure to the media was assessed by asking respondents how often they listened to the radio, watched television, or read newspapers or magazines. This information is useful in determining which media sources are likely to be most effective in disseminating health information to targeted audiences.

According to the 2005 EDHS, a large majority of young respondents age 15-24, seven in ten, have no regular exposure to any of the specified media. Looking at specific types of media, 23 percent of youth listen to the radio at least once a week, 12 percent watch television at least once a week, and 6 percent read a newspaper once a week (Table 2.4). Exposure to mass media varies strikingly by residence, education, and wealth. For example, four in five rural youth lacked exposure to some form of weekly media, compared with one-third of urban youth. Ninety percent of youth with no education have no weekly media exposure, compared with 32 percent of youth with secondary or higher education. Three-quarters of youth in Addis Ababa have weekly media exposure, but only one in ten in the Somali Region does. Finally, youth in the highest wealth quintile are nearly ten times more likely to be exposed to mass media than those in the lowest quintile (60 percent versus 6 percent).

Table 2.4 Exposure to mass media, Ethiopia 2005

Percentage of youth age 15-24 who are exposed to specific media on a weekly basis, according to background characteristics, Ethiopia 2005, and percentage of youth age 15-24 who are exposed to specific media on a weekly basis in Packard and non-Packard areas, Amhara and Oromiya 2005

Background characteristic	Reads newspaper at least once a week	Watches television at least once a week	Listens to the radio at least once a week	All three media at least once a week	No media at least once a week	Number
ETHIOPIA						
Age						
15-19	6.3	11.7	21.8	1.8	70.6	4,601
20-24	4.9	11.7	24.7	2.0	70.6	3,611
Sex						
Women	4.2	10.7	19.7	1.2	74.2	5,813
Men	9.2	14.0	31.2	3.4	61.8	2,399
Residence						
Urban	14.1	46.6	47.5	8.1	32.8	1,674
Rural	3.5	2.7	16.8	0.3	80.3	6,538
Region						
Tigray	7.9	14.7	22.5	2.5	68.9	532
Affar	0.6	9.0	15.8	0.0	78.0	73
Amhara	3.6	7.0	19.8	1.1	76.1	2,006
Oromiya	5.8	10.3	25.3	1.6	68.9	3,038
Somali	0.0	4.8	7.1	0.0	89.5	214
Benishangul-Gumuz	3.1	4.3	23.3	0.2	74.0	69
SNNP	3.3	4.9	16.6	0.5	79.5	1,688
Gambela	3.3	7.9	14.9	0.5	78.8	25
Harari	12.0	46.0	51.4	6.1	34.7	23
Addis Ababa	21.3	58.9	50.0	11.5	24.7	502
Dire Dawa	8.5	41.0	44.7	5.2	42.8	41
Education						
No education	0.1	1.9	8.6	0.0	90.2	3,472
Primary	5.1	8.6	24.0	0.5	68.9	3,130
Secondary and higher	18.7	38.6	52.5	8.6	31.6	1,610
Wealth quintile						
Lowest	1.9	0.8	5.0	0.2	93.6	1,261
Second	1.5	1.8	11.7	0.3	86.5	1,466
Middle	5.0	1.6	15.4	0.2	81.1	1,526
Fourth	3.8	3.0	23.1	0.1	73.4	1,537
Highest	11.6	35.2	44.2	5.9	40.5	2,422
Total 15-24	5.6	11.7	23.1	1.9	70.6	8,212
AMHARA AND OROMIYA						
Women 15-24						
Packard	4.1	8.1	17.3	0.6	77.6	807
Non-Packard	3.6	7.8	20.1	1.0	75.2	2,716
Men 15-24						
Packard	8.9	13.9	25.3	2.3	67.9	329
Non-Packard	7.3	10.8	33.3	2.5	61.0	1,192

Figures 2.11, 2.12 and 2.13 compare exposure to mass media among youth age 15-24 and among respondents age 25-49 in 2000 and 2005. Overall, young men are somewhat more likely to be exposed to specific media than young women (Figure 2.11). For example, in 2005, 31 percent of young men listened to the radio at least once a week, compared with 20 percent of young women, and, although the percentages are low, young men are more likely than young women to read a newspaper at least once a week (9 percent versus 4 percent). The same pattern was observed in 2000 (Figure 2.12).

Figure 2.11 Exposure to specific types of mass media on a weekly basis among women and men age 15-24, Ethiopia 2005

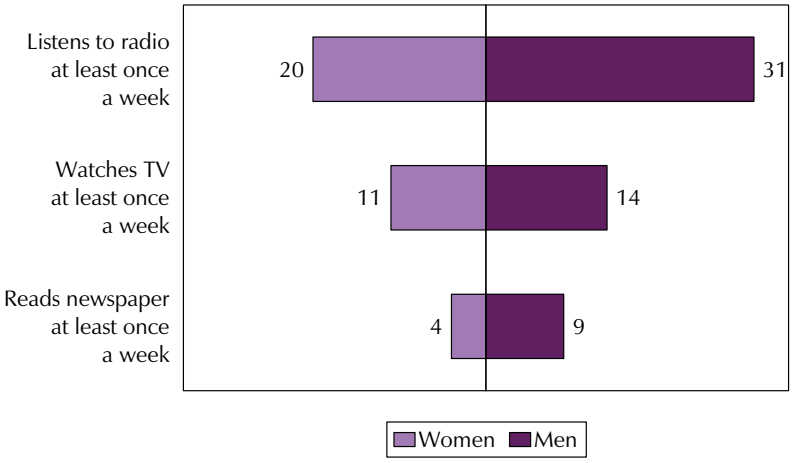
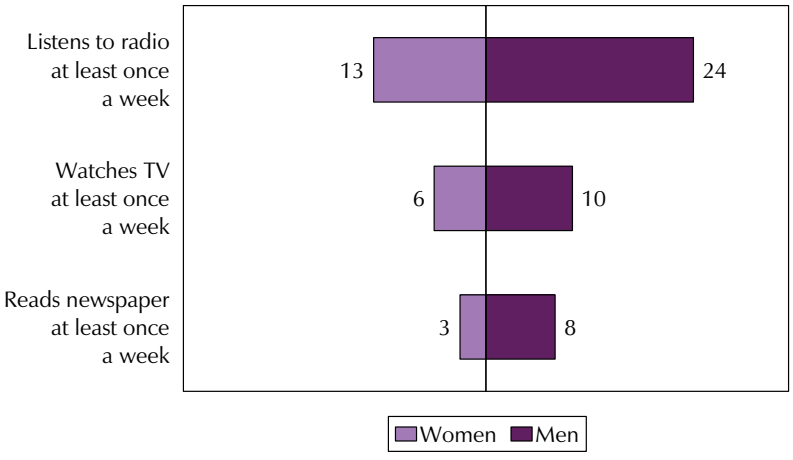
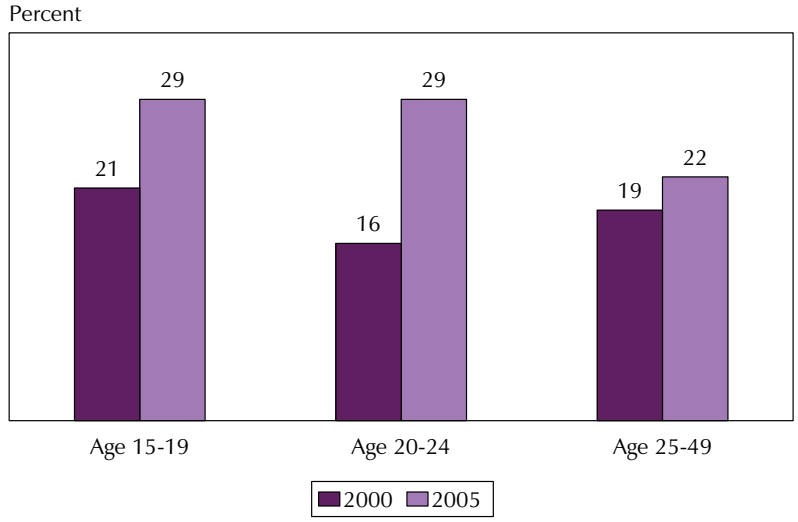


Figure 2.12 Exposure to specific types of mass media on a weekly basis among women and men age 15-24, Ethiopia 2000



Young respondents age 15-24 have greater exposure to all types of mass media than older respondents age 25-49 (Figure 2.13). The multivariate analyses reveal that this is due to the higher levels of education of the younger respondents. For all age groups, media exposure increased substantially between 2000 and 2005, with the largest change observed among youth age 20-24.

Figure 2.13 Exposure to at least one type of mass media on a weekly basis, by age group, Ethiopia 2000 and 2005



Female youth in the non-Packard areas are somewhat more likely than those in the Packard areas to listen to the radio weekly, but there are no differences among female youth by residence with regard to watching television or reading the newspaper (Figure 2.14). In 2005, male youth in the Packard areas were slightly more likely than those in the non-Packard areas to read the newspaper and watch television at least once a week but considerably less likely to listen to the radio once a week. Media exposure among both female and male youth increased between 2000 and 2005, but, for men, the extent of increase was generally larger among youth in the non-Packard than Packard areas (Figures 2.14 and 2.15). This is primarily because although exposure to television and radio nearly doubled over the five-year period among female youth in both areas, exposure to the print media doubled in the non-Packard areas but declined in the Packard areas. Similarly, the increase in media exposure is more marked among male youth in the non-Packard areas than in the Packard areas. This is primarily because of the larger increases in exposure to the radio in the non-Packard areas. On the other hand, exposure to newspapers more than doubled over the five-year period among male youth in the Packard areas but remained the same among male youth in the non-Packard areas.

Figure 2.14 Exposure to specific types of mass media on a weekly basis among women and men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005

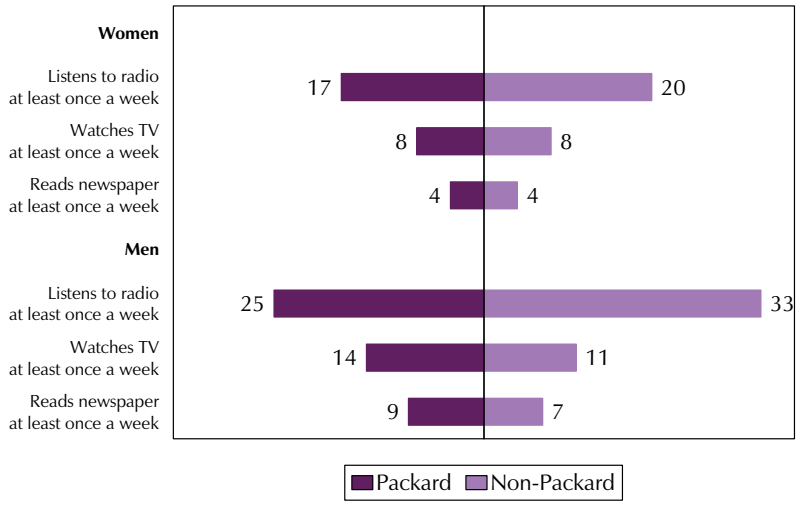
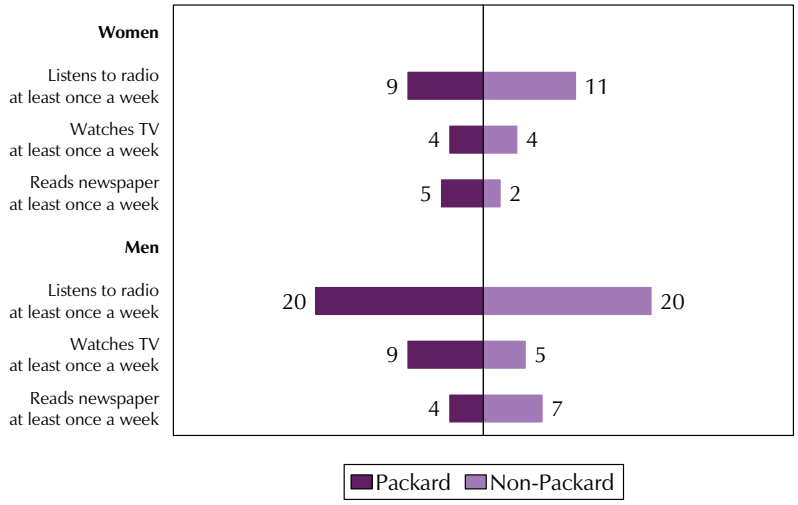


Figure 2.15 Exposure to specific types of mass media on a weekly basis among women and men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000



Chapter 3

Sexual Experience and Marriage

KEY FINDINGS

- Fewer women and men age 15-24 had ever had sexual intercourse by the time of the 2005 survey, compared with the 2000 survey.
- Women in Ethiopia marry at much younger ages than men. The male-female gap in the proportion ever married narrows with age, and is much smaller for the 25-49 age group compared with the 15-24 age group.
- The percentage of young women age 15-24 who have ever been married is slightly lower than the percentage who have ever had sexual intercourse, while the percentage of young men age 15-24 ever married is considerably lower than the percentage who have ever had sexual intercourse, suggesting that sexual intercourse prior to marriage is much more common among men than women.
- At each age between 15 and 24, young women are much more likely to have been sexually active in the four weeks preceding the survey than young men, because women in this age group are much more likely to be currently married than men.

Adolescent sexual behavior is an area of great interest because the period between sexual initiation and marriage is for many young people a time of sexual experimentation that may involve high-risk behaviors associated with sexually transmitted infections and HIV/AIDS. Furthermore, in Ethiopia, marriage marks the point in a woman's life when childbearing becomes socially acceptable. Age at first marriage has a major effect on childbearing because women who marry early have, on average, a longer period of exposure to pregnancy and a greater number of lifetime births. This chapter presents data on adolescent sexual experience, age at sexual debut, and age at first marriage.

3.1 SEXUAL EXPERIENCE

Figures 3.1.1 and 3.1.2 show that, at each age, young women are much more likely to have ever had sexual intercourse than young men. For example, in 2005, women age 20 were twice as likely to have ever had sexual intercourse (71 percent) as men (35 percent). The percentage of youth who have ever had sexual intercourse increases significantly with age for both sexes. Sexual experience is almost universal among both male and female respondents age 25-49. A similar pattern is seen in the 2000 EDHS data.

Figure 3.1.1 Sexual experience among women by age, Ethiopia 2000 and 2005

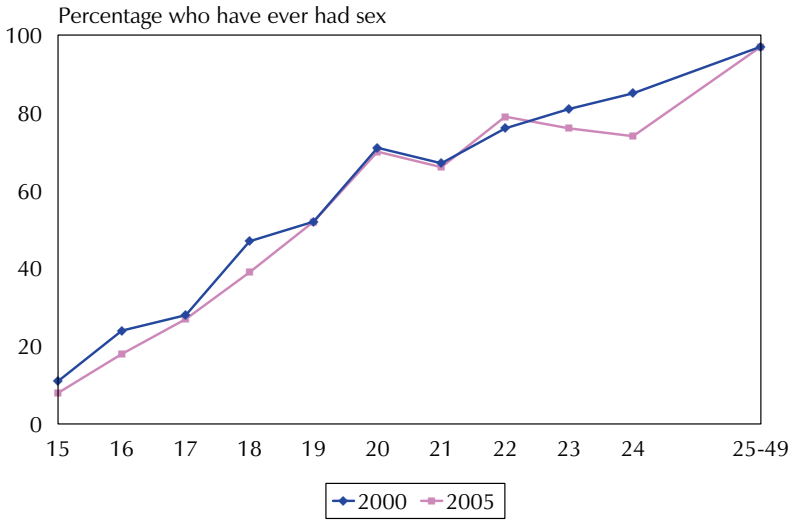
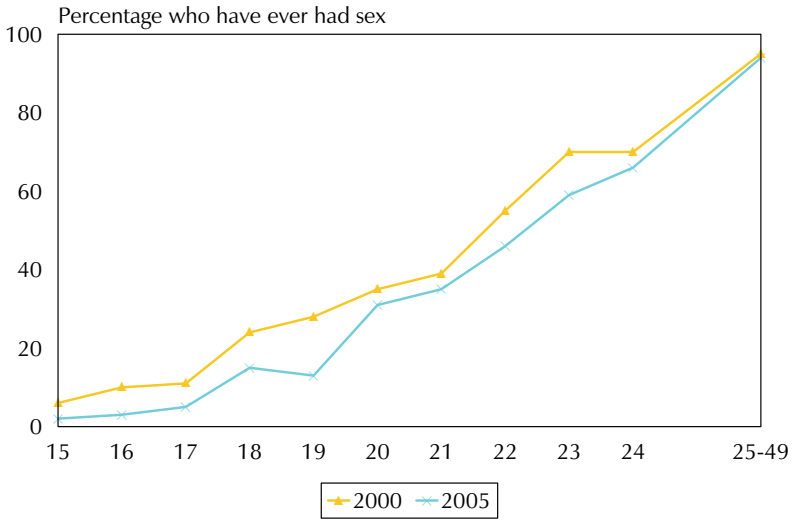


Figure 3.1.2 Sexual experience among men by age, Ethiopia 2000 and 2005



Fewer women age 15-24 had [ever] had sexual intercourse by the time of the 2005 survey compared with the same age group in the 2000 survey; the difference is small, but it is statistically significant, even when other covariates are controlled. Forty-seven percent of women age 15-24 had [ever] had sexual intercourse by 2005, compared with 50 percent in 2000. The difference is even greater for young men: in 2000, 31 percent of men age 15-24 had [ever] had sexual intercourse; by 2005, this decreased to 24 percent.

With the exception of women age 15 years, sexual experience is universal among ever-married women irrespective of their age and rises to nearly 100 percent among men after age 18 years (Figures 3.2.1 and 3.2.2). On the other hand, sexual experience among unmarried women and men varies markedly by age.

Figure 3.2.1 Sexual experience among women by marital status and age, Ethiopia 2005

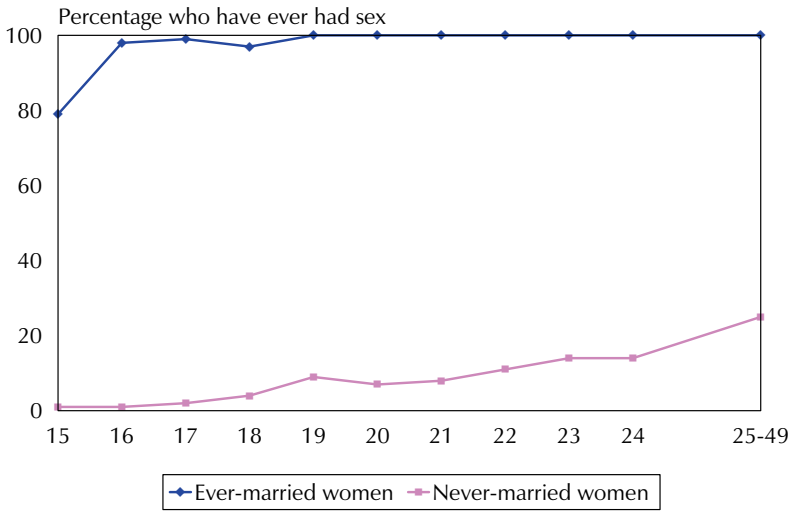
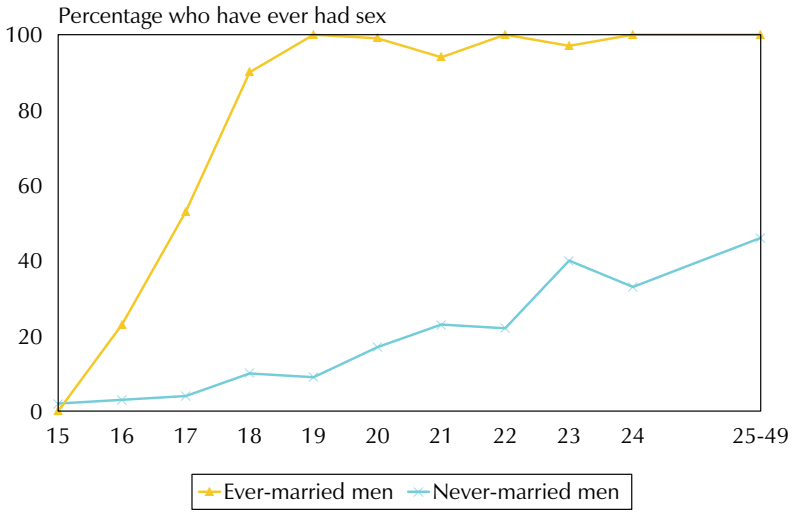


Figure 3.2.2 Sexual experience among men by marital status and age, Ethiopia 2005



Never-married women age 25-49 are six times more likely to have sexual experience as women age 15-24 (25 percent versus 4 percent). Similarly, older never-married men are more than four times as likely to have had sexual intercourse as never-married male youth (50 percent versus 12 percent). While ever-married women are slightly more likely to have had sexual intercourse than ever-married men at all ages, never-married women are less likely to have ever had sexual intercourse than never-married men at all ages.

Figures 3.3.1, 3.3.2, 3.4.1, and 3.4.2 show for 2000 and 2005 the percentage of young women and young men in the Packard and non-Packard areas who have ever had sexual intercourse. Overall, the percentage of women and men age 15-24 who have ever had sexual intercourse is lower in the Packard than in the non-Packard areas. This difference is much more pronounced among young women than young men.

Overall, in 2005, 47 percent of women age 15-24 in the Packard areas had [ever] had sexual intercourse compared with 54 percent of young women in the non-Packard areas. A similar pattern was seen in 2000 among women in the Packard and non-Packard areas. However, in 2000, more young men in the Packard areas had [ever] had sexual intercourse compared with young men in the non-Packard areas. Between the two surveys, the proportion of young women and young men who had [ever] had sexual intercourse generally decreased in both the Packard and non-Packard areas. This decline was more pronounced in the Packard areas, particularly among young men. For example, in the Packard areas, the proportion of men age 15-24 who had [ever] had sexual intercourse decreased from 44 percent in 2000 to 23 percent in 2005, while in the non-Packard areas it decreased from 30 percent to 24 percent.

Figure 3.3.1 Trends in sexual experience among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000

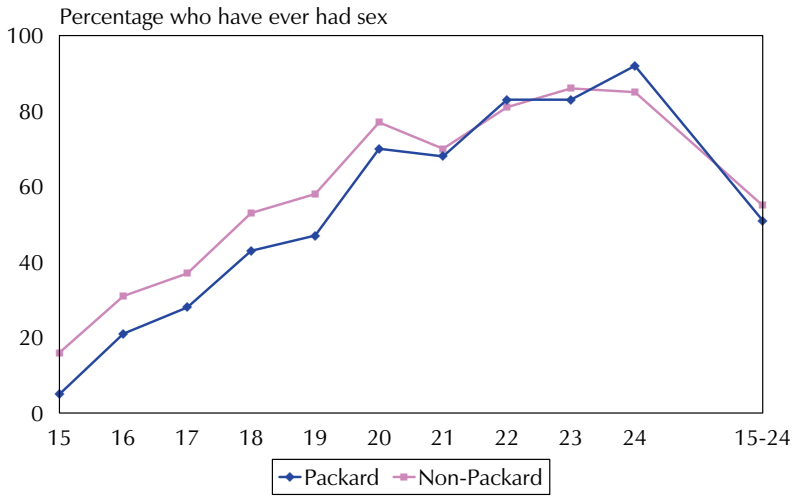


Figure 3.3.2 Trends in sexual experience among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005

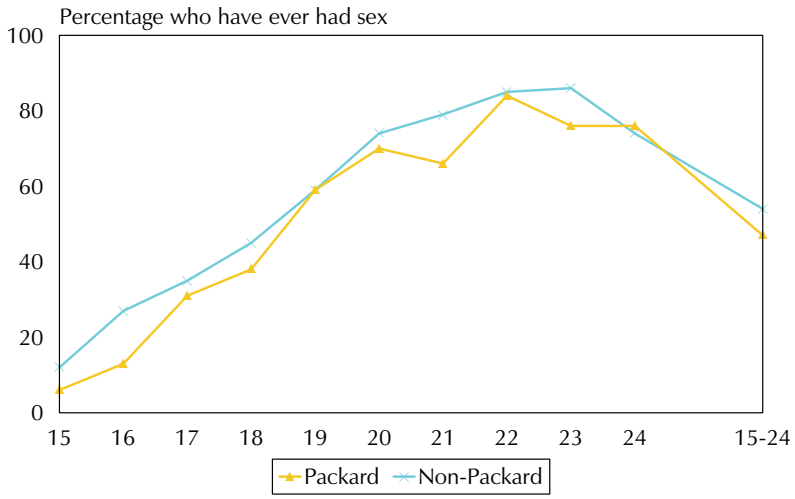


Figure 3.4.1 Trends in sexual experience among men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000

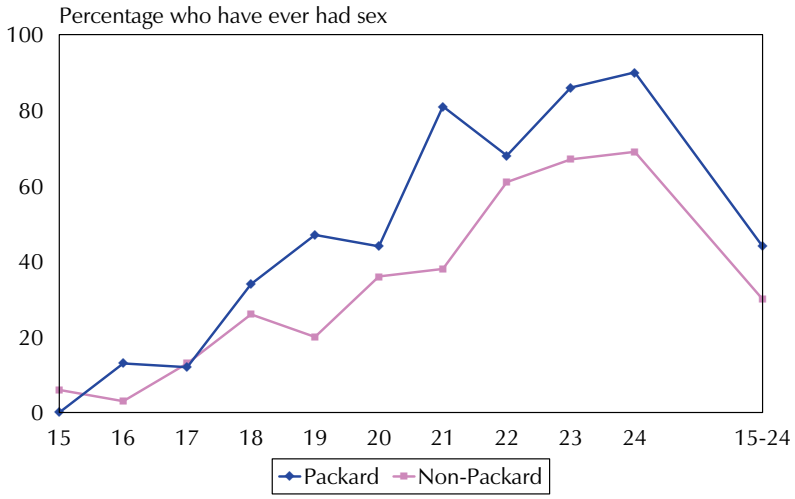
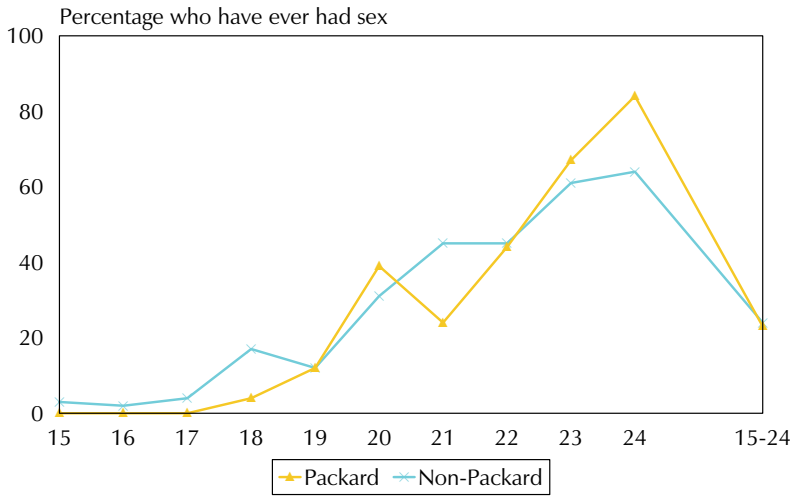


Figure 3.4.2 Trends in sexual experience among men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005



3.2 MARRIAGE

The 2005 EDHS data show that women in Ethiopia marry at much younger ages than men. Men are much less likely to have married by a particular age than women (Figures 3.5.1 and 3.5.2). However, the male-female gap in the proportion ever married becomes narrower with age and is much smaller for the 25-49 age group, where 96 percent of women and 89 percent of men are ever married.

Figure 3.5.1 Trends in age at first marriage, women, Ethiopia 2000 and 2005

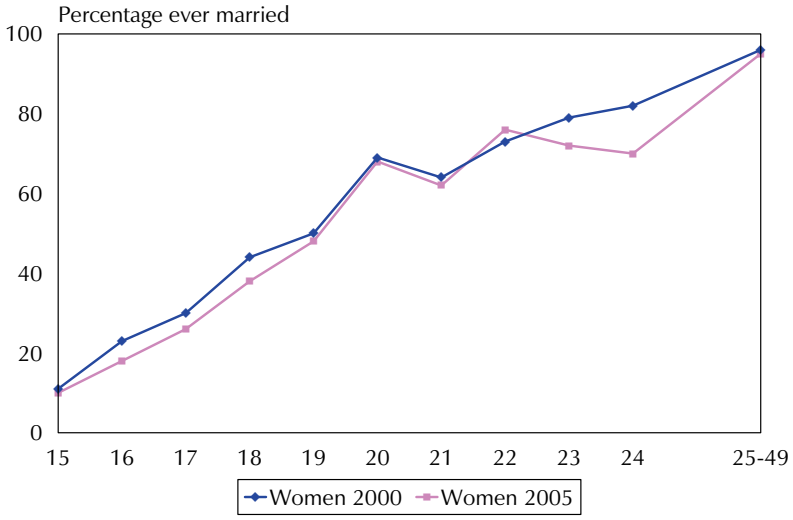
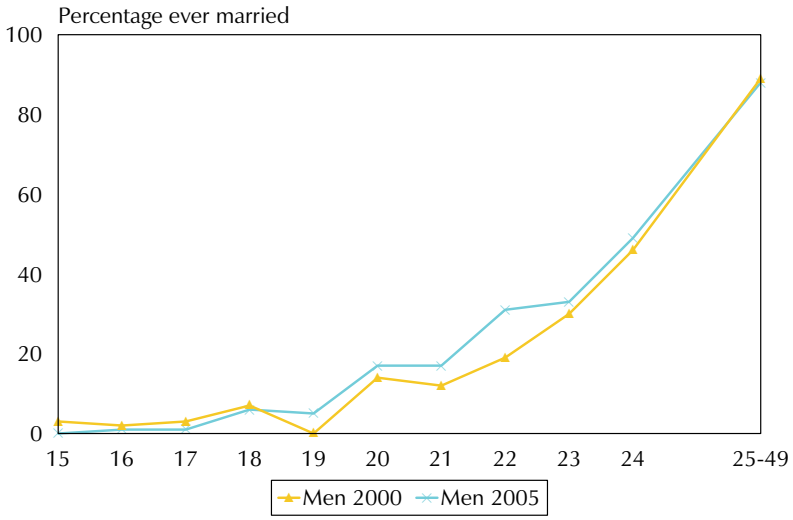


Figure 3.5.2 Trends in age at first marriage, men, Ethiopia 2000 and 2005



The percentage of young women who have ever married decreased at all ages except age 22 in the period between the 2000 and 2005 surveys. For men, the percentage ever married decreased slightly between 2000 and 2005 for those age 15-18, but it increased somewhat for older men age 19-24.

For each age, the percentage of women who have ever been married is similar to, but typically lower than, the percentage who have ever had sexual intercourse (Figures 3.1.1 and 3.5.1). In contrast, at each age the percentage of men ever married is considerably lower than the percentage who have ever had sexual intercourse (Figures 3.1.2 and 3.5.2), suggesting that sexual intercourse prior to marriage is much more common among men than women. Indeed, the data show that 13 percent of men age 15-24 have ever married,

whereas 24 percent have had sexual intercourse. In contrast, 46 percent of young women in the same age group have ever married and an almost identical proportion, 47 percent, has ever had sexual intercourse.

When comparing trends in age at first marriage among young women in the Packard and non-Packard areas, it can be seen that the patterns are identical to those observed for sexual experience (Figures 3.3.1 and 3.3.2) because, for most Ethiopian women, sexual intercourse occurs in the context of marriage.

3.3 TIMING OF SEXUAL ACTIVITY

Timing of the most recent sexual encounter provides insight into sexual behavior in general and exposure to the risk of pregnancy and sexually transmitted infections (STIs) in particular. The 2005 EDHS data show that, at each age between 15 and 24, women are much more likely to have been sexually active in the four weeks preceding the survey than men (Figures 3.6.1 and 3.6.2), presumably because, as was seen earlier, women in this age group are much more likely to be currently married than men. Overall, 32 percent of young women age 15-24 were sexually active in the last 4 weeks compared with 11 percent of young men in the same age group. However, among respondents age 25-49 in 2005, men are more likely to have been sexually active in the four weeks before the survey than women (71 percent versus 64 percent).

Figure 3.6.1 Trends in recent sexual activity among women, Ethiopia 2000 and 2005

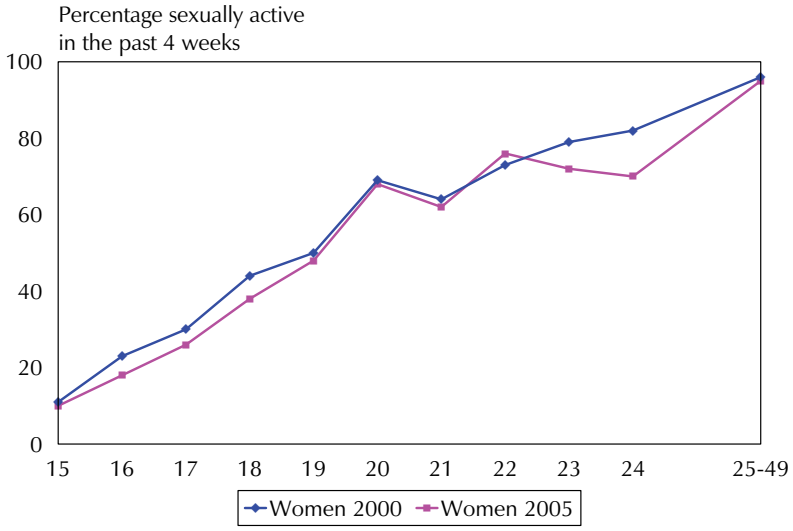
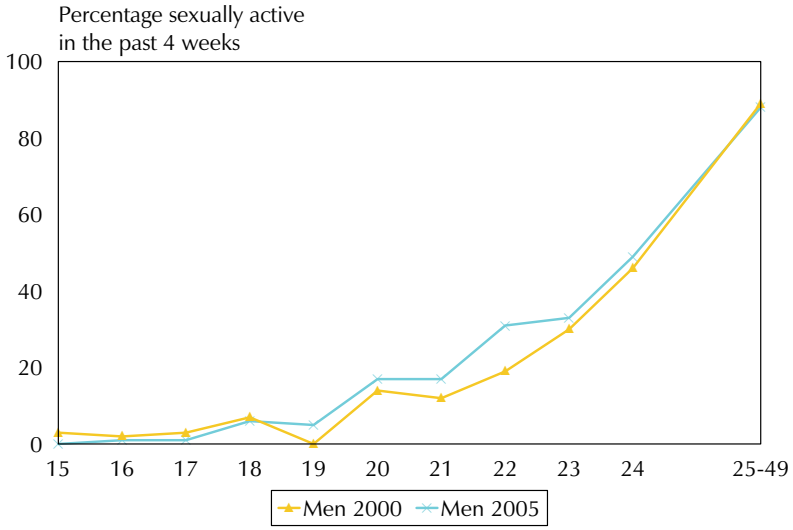


Figure 3.6.2 Trends in recent sexual activity among men, Ethiopia 2000 and 2005



The overall percentage with recent sexual exposure decreased slightly between 2000 and 2005 for young women, but not for young men.

Figures 3.7.1, 3.7.2, 3.8.1, and 3.8.2 show that in 2005 and 2000, sexual activity in the four weeks before the survey was slightly lower among young women and men age 15-24 in the Packard areas than among those in the non-Packard areas. Between 2000 and 2005 the proportion of men who have been sexually active in the four weeks prior to the survey decreased in the Packard areas but changed little in the non-Packard areas. However, this pattern is reversed for women: the percentage with recent sexual activity changed little in the Packard areas, while it decreased in the non-Packard areas. The differences and changes are very small, and, given the small sample sizes, are not statistically significant.

Figure 3.7.1 Trends in recent sexual activity among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000

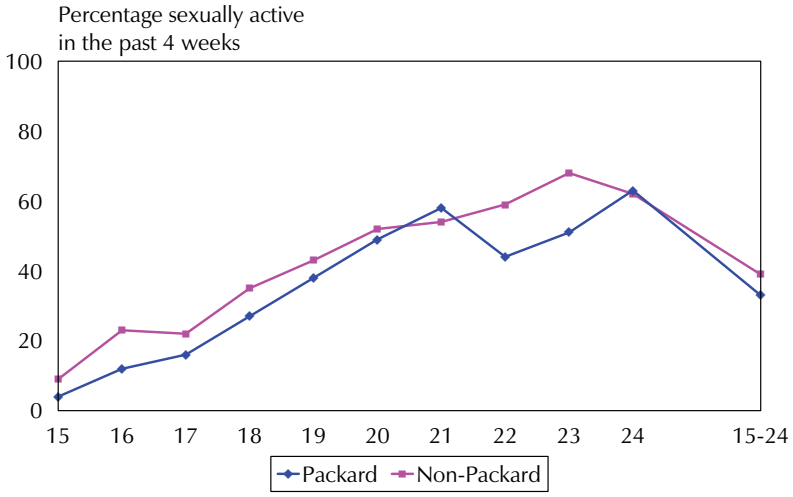


Figure 3.7.2 Trends in recent sexual activity among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005

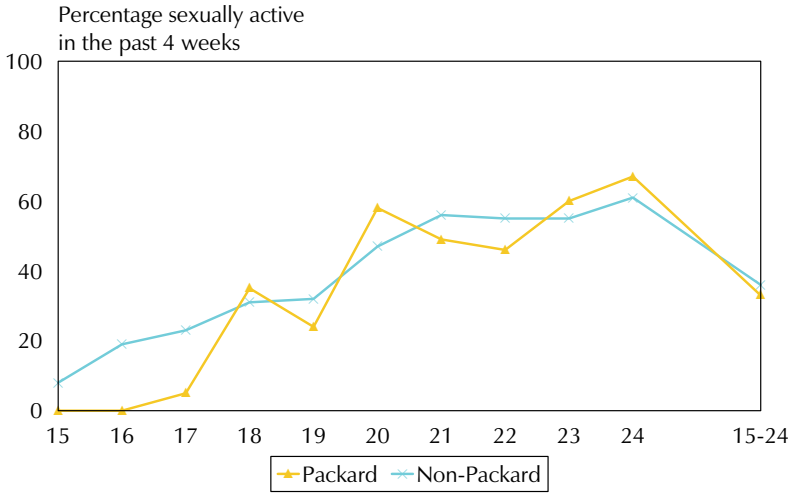


Figure 3.8.1 Trends in recent sexual activity among men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000

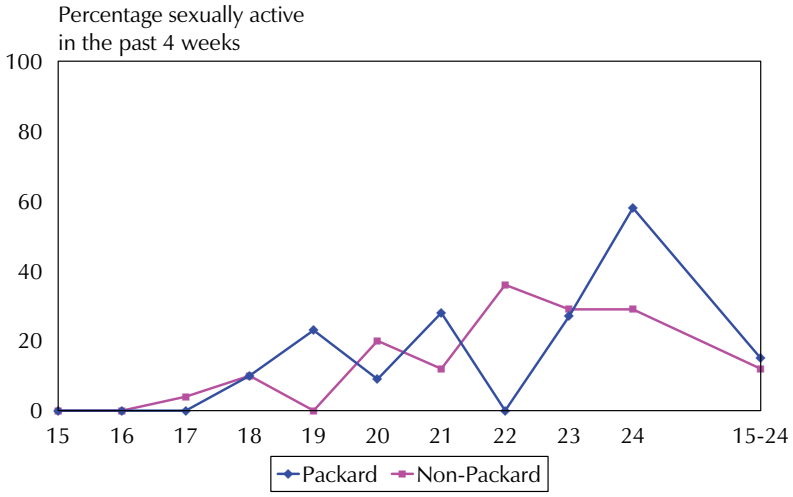
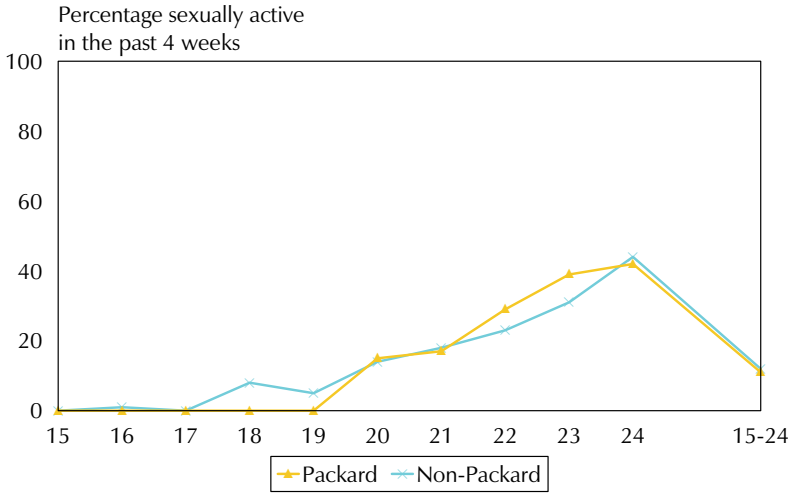


Figure 3.8.2 Trends in recent sexual activity among men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005



Chapter 4

Knowledge and Use of Contraception

KEY FINDINGS

- Most young women and men of reproductive age know about contraception. Knowledge of modern methods of family planning is substantially higher than knowledge of traditional methods among both women and men.
- Contraceptive knowledge increased markedly between 2000 and 2005 among youth, especially among those age 15-19 and those who had never had sexual intercourse.
- Among sexually experienced youth, the percentage using a method of contraception at the time of the survey doubled between 2000 and 2005.
- Over three-quarters of sexually experienced women age 15-24 have never used a contraceptive method.
- Over half of all women and men age 15-24 had been exposed to a message about family planning in the 12 months preceding the survey. Women are most likely to receive these messages at community events, while men are most likely to receive them over the radio.

This chapter presents data on knowledge about contraceptive methods, current and ever use of contraception, and exposure to family planning messages through the media and community events for youth.

Knowledge about family planning is an important step towards gaining access to and using a suitable contraceptive method in a timely and effective manner. Individuals who have adequate information about the available methods of contraception are better able to make choices about planning their pregnancies. Survey respondents were first asked to mention spontaneously all the methods of contraception that they had heard of. For methods not mentioned spontaneously, the interviewer described the methods and probed for whether the respondent recognized it. It must be noted that knowledge about family planning is measured in terms of awareness about each method and not specifically about its correct use.

Ever use of contraception provides a measure of the cumulative experience of a population with family planning. The 2005 EDHS collected data on ever use of family planning methods from women by asking respondents whether they had ever used each of the methods that they have heard about. The current level of contraceptive use is a measure of actual contraceptive practice at the time of the survey. It takes into account all use of contraception, whether the concern of the user is permanent cessation of childbearing or a desire to space births. Current use of family planning services provides insight into one of the principal determinants of fertility. It also serves to assess the success of family planning programs.

Measuring the extent of exposure to information about family planning helps program managers and planners to effectively target population subgroups for information, education, and communication (IEC) activities.

4.1 KNOWLEDGE ABOUT FAMILY PLANNING

The 2005 EDHS data show that most young women and men of reproductive age know about contraception. For example, 84 percent of women and 89 percent of men age 15-24 know of at least one method of contraception, and the same percentages know of at least one modern method (Table 4.1). Young women, on average, knew 3.3 contraceptive methods, and young men knew 3.9 methods. The pill is the best known method (80 percent of women and 77 percent of men age 15-24), followed closely by injectables

(known by 79 percent of women and 74 percent of men age 15-24) and male condoms (known by 52 percent of women and 85 percent of men age 15-24). Young men are more knowledgeable than young women about most methods of contraception, such as the male condom and male sterilization, as well as about traditional methods. Young women are somewhat more knowledgeable than young men only about the female methods of the pill and injectables. Young respondents age 15-19 are generally less knowledgeable about contraception than are respondents age 20 or older. Overall, respondents age 15-24 are somewhat less likely to know of any family planning method or of any modern method than their older counterparts age 25-49.

Table 4.1 Knowledge of contraceptive methods

Percentage of respondents who know any contraceptive method, by specific method, according to age, Ethiopia 2005

	Women				Men			
Method	15-19	20-24	15-24	25-49	15-19	20-24	15-24	25-49
Any method	81.1	87.9	84.1	87.6	86.1	92.8	89.1	92.9
Any modern method	81.1	87.6	84.0	87.5	86.0	92.7	88.9	92.5
Pill	76.7	84.9	80.3	84.3	71.5	82.8	76.5	84.9
IUD	13.3	18.8	15.7	14.2	13.5	18.0	15.5	14.5
Injectables	75.1	83.1	78.6	82.5	68.6	80.0	73.7	83.0
Diaphragm/foam/jelly	6.5	7.3	6.8	5.2	9.8	13.3	11.3	7.6
Condom	51.4	53.2	52.2	41.8	81.1	89.1	84.6	85.7
Female sterilization	16.2	19.1	17.5	19.0	18.2	27.6	22.4	29.5
Male sterilization	6.6	8.4	7.4	6.1	13.3	19.5	16.0	15.3
Implants	20.4	26.1	22.9	22.0	18.9	26.1	22.1	25.4
Standard days method	5.4	4.9	5.2	3.7	5.2	9.2	7.0	6.3
Lactational amenorrhea method (LAM)	6.3	9.5	7.7	10.2	5.9	8.8	7.2	9.0
Any traditional method	22.2	25.0	23.5	18.6	31.8	42.5	36.5	42.4
Rhythm/periodic abstinence	20.1	21.8	20.8	16.1	28.5	39.5	33.4	37.6
Withdrawal	12.9	14.0	13.4	10.6	17.3	26.7	21.5	22.2
Folk method/Other method	0.3	0.7	0.5	0.7	1.2	1.0	1.1	1.7
Mean number of methods known	3.1	3.5	3.3	3.2	3.5	4.4	3.9	4.2
Number of respondents	3,266	2,547	5,813	8,257	1,335	1,064	2,399	3,064

Contraceptive knowledge among youth increased between the 2000 and 2005 surveys (Figures 4.1.1 and 4.1.2). For example, for women age 15-24 knowledge of any contraceptive method increased from 75 percent to 84 percent, while knowledge of any modern method increased from 74 percent to 84 percent. Similar patterns are observed for men age 15-24. For both young women and men, large increases in knowledge over the five-year period are observed for the pill, injectables, and the male condom.

Figure 4.1.1 Family planning knowledge among women age 15-24, by method, Ethiopia 2000 and 2005

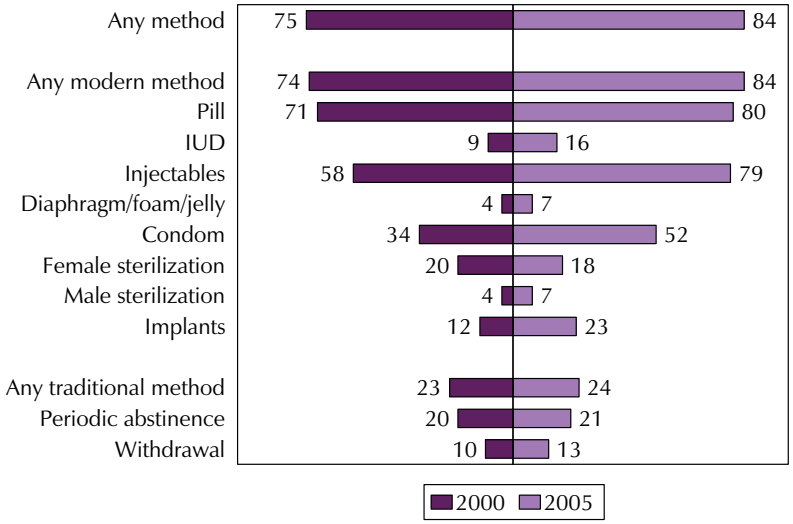


Figure 4.1.2 Family planning knowledge among men age 15-24, by method, Ethiopia 2000 and 2005

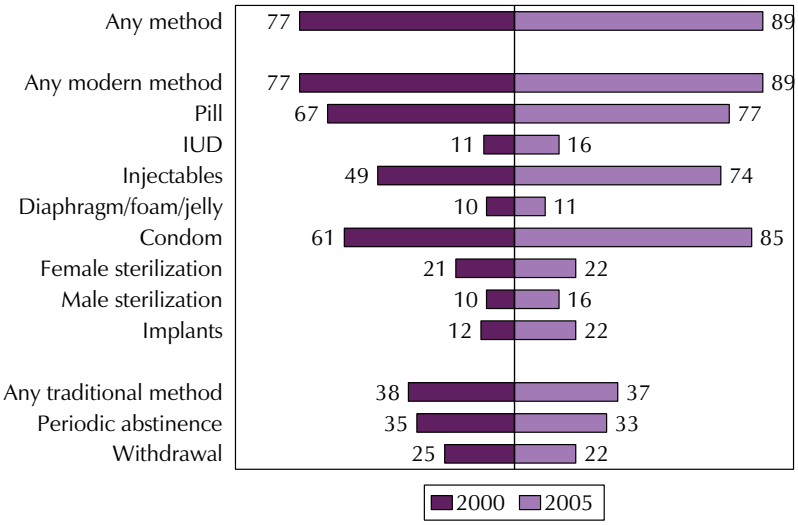


Figure 4.2 shows how knowledge of any modern method of contraception among men and women age 15-24 differs by their sexual experience and how this changed between 2000 and 2005. In both 2000 and 2005, sexually experienced young women and men are more knowledgeable of a modern method of contraception than are those who have never had sex. Contraceptive knowledge among men and women increased in the five years between 2000 and 2005 among both sexually experienced and those who have never had sexual intercourse. The increase in knowledge of modern contraceptive methods over this period is more pronounced among respondents who have never had sexual intercourse than among those who have ever had sexual intercourse.

Figure 4.2 Knowledge of any modern contraceptive method among women and men age 15-24, by sexual experience, Ethiopia 2000 and 2005

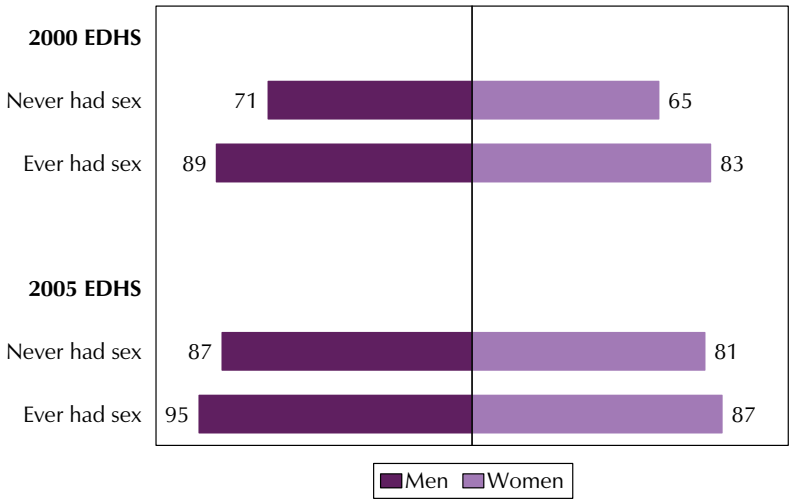


Table 4.2 shows how the knowledge of specific contraceptive methods among young women and men differed between the Packard and non-Packard areas in 2005. There is no difference between the areas in the average number of methods known. Women in each area know about 3.3 methods on average, and men in each know about 4.0 methods. Women in the Packard areas are more likely than those in the non-Packard areas to know about IUDs and implants and are less likely to know about the standard days methods and

Table 4.2 Knowledge of contraceptive methods among youth in Packard and non-Packard areas

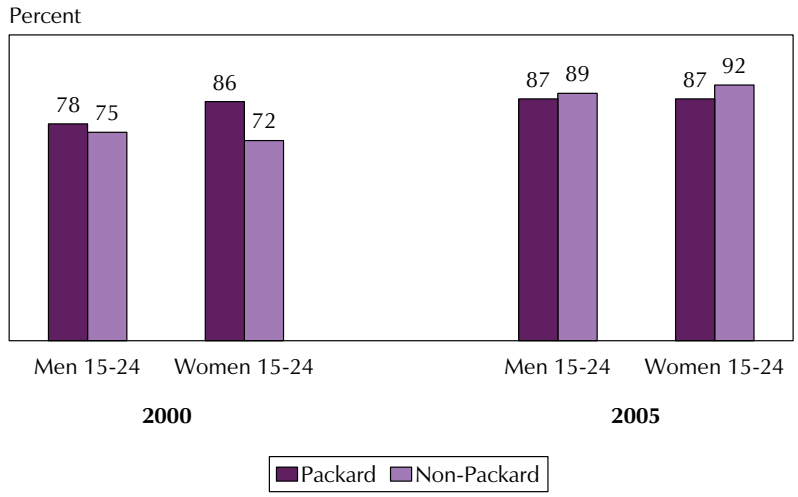
Percentage of women and men age 15-24 who know a contraceptive method by specific method, for Packard and non-Packard areas, Amhara and Oromiya 2005

	Packard		Non-Packard	
Method	Women	Men	Women	Men
Any method	87.3	88.6	88.7	91.7
Any modern method	87.3	88.1	88.5	91.7
Pill	84.4	77.8	84.8	78.7
IUD	17.2	17.8	12.6	14.1
Injectables	81.3	73.7	83.5	76.5
Diagphragm/foam/jelly	6.9	11.0	6.1	11.4
Condom	48.0	83.1	49.6	87.0
Female sterilization	17.6	22.9	17.8	24.6
Male sterilization	5.7	14.5	6.9	16.8
Implants	24.2	25.5	20.0	21.2
Standard days method	3.3	8.0	5.8	6.7
Lactational amenorrhea (LAM)	6.2	3.4	7.5	8.9
Any traditional method	21.7	43.3	22.1	36.5
Rhythm/periodic abstinence	18.2	40.9	19.8	32.6
Withdrawal	12.7	21.4	12.4	21.3
Folk method/Other method	0.0	0.4	0.6	0.8
Mean number of methods known	3.3	4.0	3.3	4.0
Number	807	329	2,716	1,192

LAM. Otherwise, there is very little difference between the areas in the percentages knowing about various methods for women. The differences are greater for men. Like women, men in the Packard areas are more likely than those in the non-Packard areas to know about IUDs and implants, and they are also more likely to know about rhythm/periodic abstinence, but they are less likely to know about many other modern methods or any modern method.

Figure 4.3 shows how the knowledge of modern contraceptive methods among youth changed between 2000 and 2005 in the Packard and non-Packard areas. In 2000, knowledge was considerably greater in the Packard than the non-Packard areas for women (86 percent of women age 15-24 in the Packard areas knew of a modern method of contraception compared with 72 percent in the non-Packard areas), and to a lesser extent for men, but the area differences had reversed by 2005. Knowledge of modern contraceptive methods increased for both men and women and in both areas, but to a greater extent in the non-Packard areas.

Figure 4.3 Knowledge of contraceptive methods among women and men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



4.2 Ever Use and Current Use of Contraception

The analyses here of ever use and current use of contraception consider only respondents who have ever had sex. Twenty-three percent of sexually experienced women age 15-24 have used a method of family planning at some point, with 21 percent having used a modern method (Table 4.3). Overall and for each method, ever use is higher among young respondents age 20-24 than among those age 15-19 and slightly higher than for those age 25-49. For example, 24 percent of women age 20-24 have ever used a modern method compared with 15 percent of women age 15-19 and 23 percent for those age 25-49. For every age group the most popular method is injectables.

Table 4.3 Ever use of contraception: women

Percentage of sexually experienced women who have ever used a method of contraception, by specific age groups, Ethiopia 2005

Method	Age group			
	15-19	20-24	15-24	25-49
Any method	16.3	26.0	22.8	24.1
Any modern method	15.4	24.4	21.4	23.1
Pill	4.7	12.8	10.1	12.2
Injectables	11.1	18.2	15.8	16.8
Condom	2.3	2.0	2.1	0.9
Any traditional method	1.7	3.7	3.0	2.3
Rhythm/periodic abstinence	1.4	3.3	2.7	1.7
Withdrawal	0.3	0.8	0.7	0.8
Number	932	1,851	2,783	7,994

Table 4.4 shows the percentage of sexually experienced women currently using a contraceptive method. In 2005, 14 percent of young women age 15-24, were using some method of family planning, with 12 percent using a modern method. The patterns for current use are similar to those observed for ever use. Current use of contraception is considerably higher among women age 20-24 than among those age 15-19 and somewhat higher than those age 25-49. Current use of family planning among women age 15-24 is identical to current use among their older counterparts (13.5 percent).

Table 4.4 Current use of contraception: women

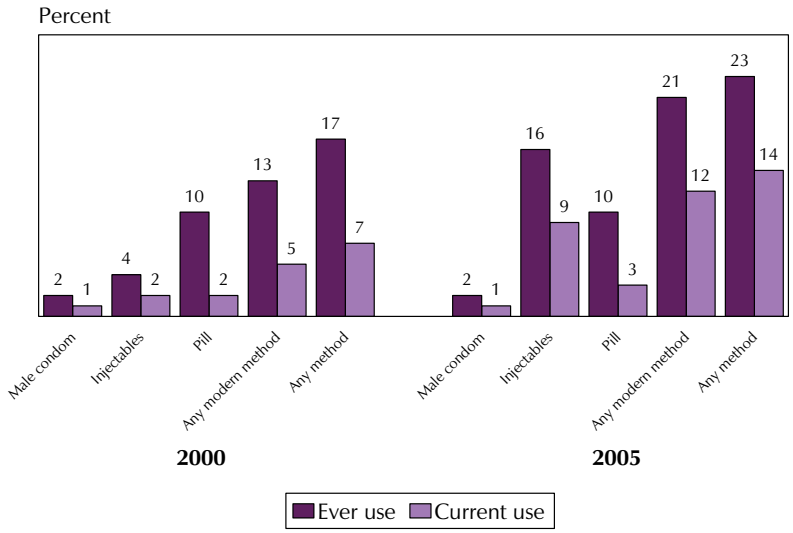
Percent distribution of sexually experienced women who are currently using a method of contraception, by specific age groups, Ethiopia 2005

Method	Age group			
	15-19	20-24	15-24	25-49
Any method	8.9	15.7	13.5	13.5
Any modern method	8.6	14.3	12.4	12.7
Pill	1.0	3.2	2.5	2.8
Injectables	6.4	10.1	8.9	8.8
Condom	1.2	0.7	0.8	0.2
Any traditional method	0.3	1.5	1.1	0.8
Rhythm	0.1	1.2	0.8	0.6
Withdrawal	0.2	0.3	0.3	0.2
Number	932	1,851	2,783	7,994

Note: If more than one method is used, only the most effective method is considered in this tabulation.

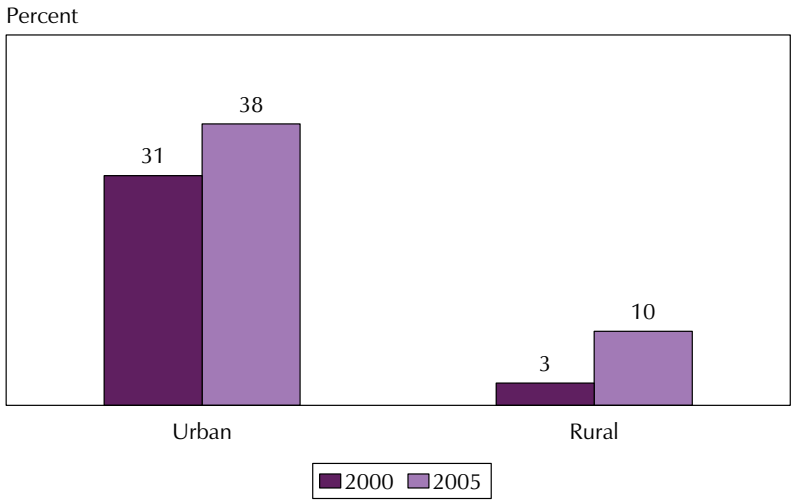
Ever use and current use of contraception among young women age 15-24 increased substantially between 2000 and 2005, particularly for current use of modern contraception (from 5 percent in 2000 to 12 percent in 2005) (Figure 4.4). Looking at specific methods, the largest increase occurred for injectables, for which ever use increased from 4 percent to 16 percent and current use increased from 2 percent to 9 percent between 2000 and 2005. Survey data show that current and ever use of traditional methods decreased somewhat between the two surveys, with the most significant change observed for periodic abstinence or rhythm method.

Figure 4.4 Ever use and current use of contraception among sexually experienced women age 15-24, Ethiopia 2000 and 2005



Current use of any contraceptive method in 2005 was much higher among sexually experienced young women living in urban areas (38 percent) than among those living in rural areas (10 percent) (Figure 4.5). The same pattern is seen for the year 2000, where 31 percent of young women living in urban areas used some form of contraception compared with only 3 percent of rural young women. Current use of any method of family planning increased between 2000 and 2005 in both urban and rural areas, but the relative increase was much greater in rural areas, where the current contraceptive use rate more than tripled during this period (from 3 percent to 10 percent).

Figure 4.5 Current use of any method of contraception among sexually experienced women age 15-24, by urban-rural residence, Ethiopia 2000 and 2005



Current use of contraception increases substantially with women's education. For example, Figure 4.6 shows that, in 2005, sexually experienced young women with secondary or higher education are more than five times as likely to be using contraception as those with no education (45 percent versus 8 percent). Current use between 2000 and 2005 increased for all education categories. The largest absolute increase over that five-year period occurred for women with secondary or higher education (from 35 percent to 45 percent), but in relative terms the increase was greatest for those with no education (from 3 percent to 8 percent).

Figure 4.6 Current use of contraception among sexually experienced women age 15-24, by education, Ethiopia 2000 and 2005

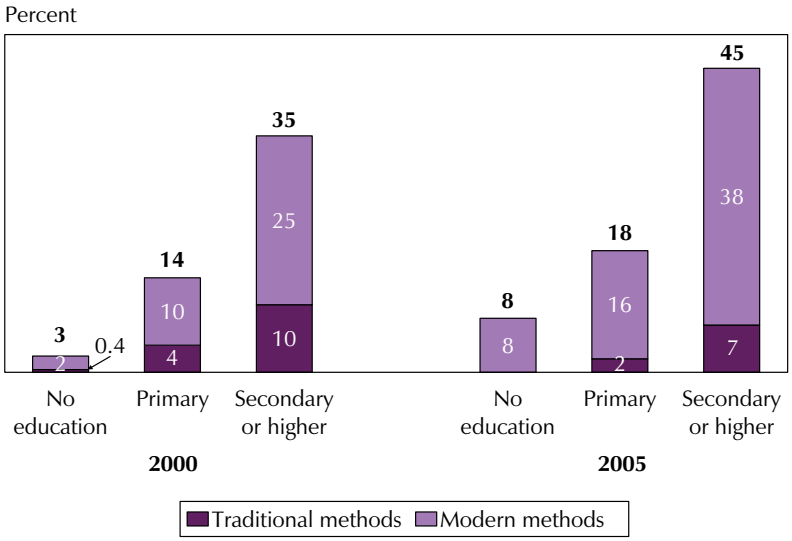
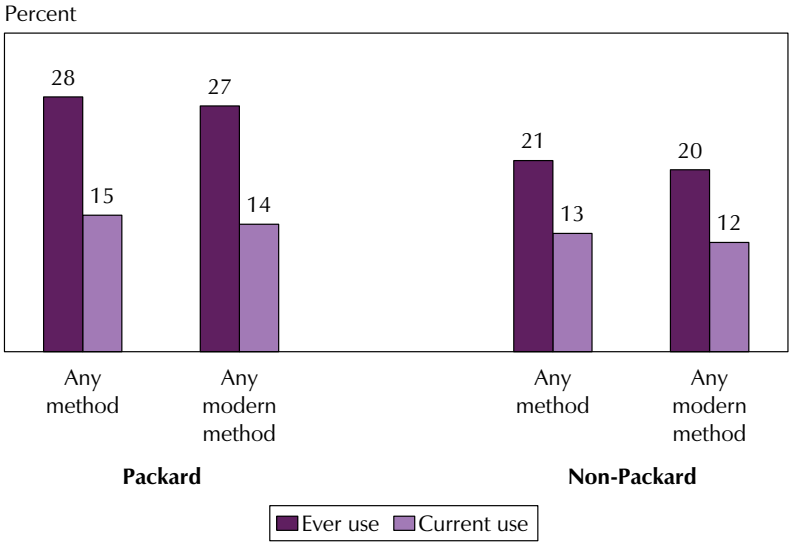


Figure 4.7 shows contraceptive use among women age 15-24 in the Packard and non-Packard areas in 2005. Sexually experienced women age 15-24 in the Packard areas are more likely to have ever used a contraceptive method than those in the non-Packard areas (28 percent versus 21 percent) and to have ever used a modern method (27 percent versus 20 percent), and they are also more likely to be currently using, though the difference in current use between these two areas is smaller than that in ever use. As seen in Table 4.5, the difference is mainly due to the greater use of injectables and the pill by women in the Packard areas (19 percent and 14 percent, respectively) compared with those in the non-Packard areas (15 percent and 9 percent, respectively).

Figure 4.7 Contraceptive use among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005



Data in Table 4.5 for young men show that men in the Packard areas are three times as likely to have ever used contraception, particularly condoms when compared with men in the non-Packard areas (34 percent ever use of condoms in the Packard areas versus 11 percent in the non-Packard areas).

Table 4.5 Ever use of contraception among youth in Packard and non-Packard areas

Percentage of sexually experienced women and men age 15-24 who have ever used a method of contraception, Packard and Non-Packard areas, Amhara and Oromiya 2005

	Packard		Non-Packard	
Method	Women	Men	Women	Men
Any method	28.0	37.7	21.0	19.3
Any modern method	27.0	33.7	19.6	10.7
Pill	13.7	0.0	8.9	0.0
Injectables	19.3	0.0	15.4	0.0
Condom	2.4	33.7	1.3	10.7
Any traditional method	2.3	13.2	3.1	12.4
Rhythm/periodic abstinence	1.8	5.8	3.0	10.9
Withdrawal	0.8	9.5	0.5	2.2
Number	379	75	1,481	291

Table 4.6 shows that, among women age 15-24 who have ever had sexual intercourse, there is little difference between the Packard and non-Packard areas in the current use of contraception, though women in the Packard areas were somewhat more likely to be using pills and condoms and less likely to be using injectables than those in the non-Packard areas. Figure 4.8 shows that contraceptive use increased in both areas between 2000 and 2005, and that the increase in the non-Packard areas was proportionately higher, resulting in a narrowing of the gap in contraceptive use among young women in the Packard and non-Packard areas. Data not presented here show that in both areas the greatest increase occurred in the use of injectables.

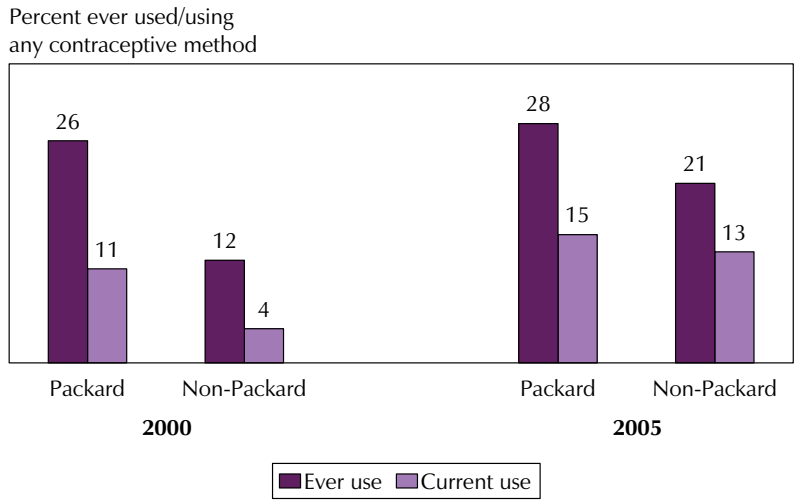
Table 4.6 Current use of contraception among youth in Packard and Non-Packard areas

Percentage of sexually experienced women 15-24 who are currently using a method by specific method, for Packard and Non-Packard areas, Amhara and Oromiya 2005

Method	Packard	Non-Packard
Any method	14.6	12.9
Any modern method	13.8	11.6
Pill	4.6	1.9
Injectables	7.3	9.1
Condom	1.9	0.3
Any traditional method	0.8	1.4
Rhythm/periodic abstinence	0.5	1.0
Withdrawal	0.3	0.4
Number of respondents	379	1,481

Note: If more than one method is used, only the most effective method is considered in this tabulation.

Figure 4.8 Use of any contraceptive method among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



4.3 EXPOSURE TO FAMILY PLANNING MESSAGES

Over half of all women and men age 15-24 had been exposed to a family planning message in the few months before the 2005 EDHS (Figure 4.9). In general, young men are more likely than young women to be exposed to messages about family planning through the radio, television, and print media, which is consistent with their greater exposure to these types of media that we saw earlier, while young women are more likely than young men to be exposed to such messages through community events. In fact, community events are the main source of information on family planning among women (44 percent), whereas men get their information mainly from the radio (37 percent). Both young men and women were more likely to have been exposed to information about family planning in 2005 than in 2000. The increase in exposure to family planning messages between the two surveys is greater among women than men for all media sources.

Figure 4.9 Trends in exposure to family planning messages among respondents age 15-24, Ethiopia 2000 and 2005

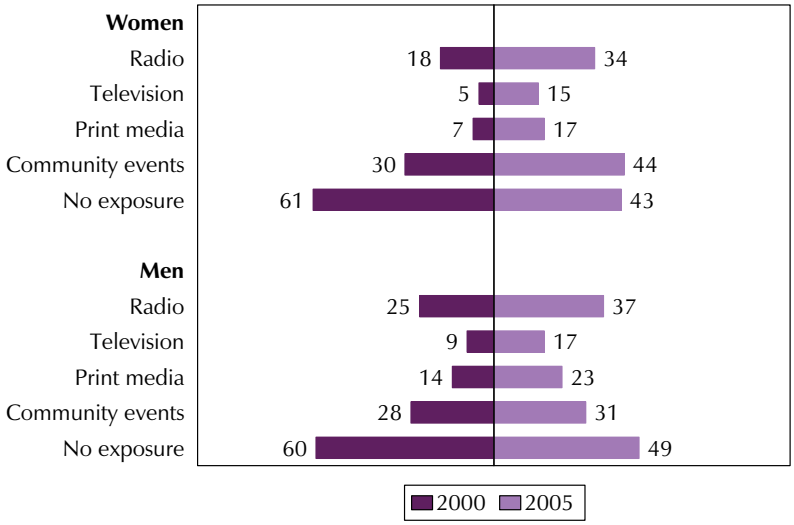
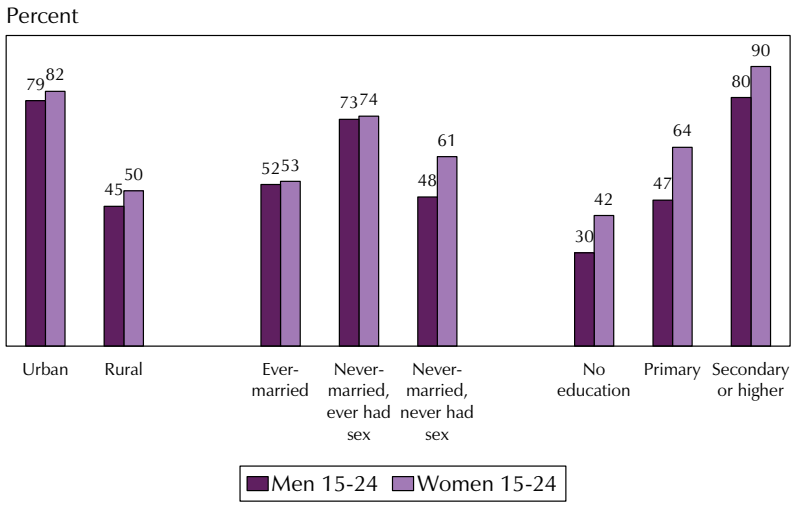


Figure 4.10 shows exposure to family planning messages in 2005, among male and female youth age 15-24, by urban-rural residence, marital status/sexual experience, and education. Young women are more likely than young men to report having been exposed to family planning messages regardless of their background characteristics. Urban youth are much more likely to report being exposed to family planning messages than rural youth. Reported exposure to family planning messages is greater among sexually experienced youth who are not married than among the ever-married or never-married who do not have sexual experience. The data are based on respondents' reports of whether they have been exposed to messages about family planning. It is possible that those with less "need to know" are less likely to remember having heard or seen such messages. Surprisingly, however, never-married young women who have never had sexual intercourse are more likely to report having been exposed to family planning messages than their ever-married

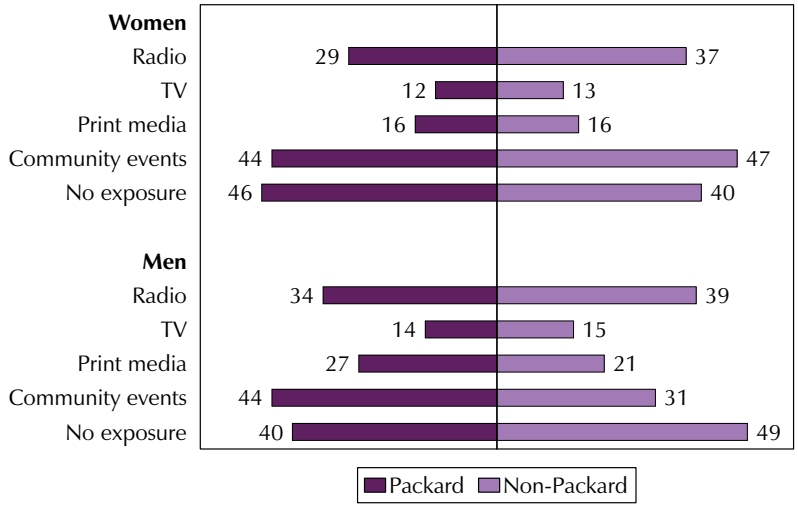
Figure 4.10 Exposure to family planning messages among women and men age 15-24 by selected background characteristics, Ethiopia 2005



counterparts (61 percent versus 53 percent). The level of reported exposure to family planning messages increases steadily with respondent's education, from 30 percent of young men and 42 percent of young women with no education, to 80 percent of young men and 90 percent and young women with secondary or higher education.

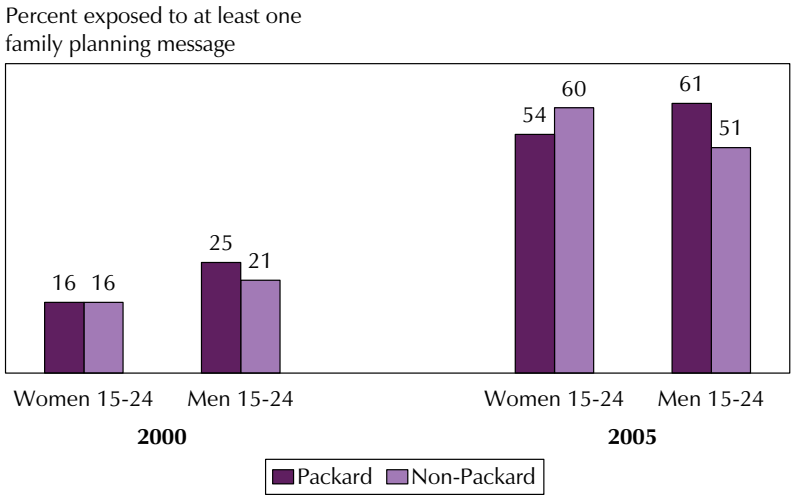
Figures 4.11 and 4.12 show the exposure to family planning messages among women and men age 15-24 in the Packard and non-Packard areas. Figure 4.12 shows that in 2005, young men in the Packard areas are more likely to report being exposed to at least one family planning message than those in the non-Packard areas (61 percent versus 51 percent). The Packard/non-Packard difference among young men is primarily a result of the greater exposure of those in the Packard areas to community events and the print media (Figure 4.11). On the other hand, Figures 4.11 and 4.12 show that young women in the Packard areas are less likely to report exposure to family planning messages than their counterparts in the non-Packard areas, irrespective of the type of media (54 percent versus 60 percent).

Figure 4.11 Exposure to family planning messages among women and men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005



There have been substantial improvements in exposure to family planning messages over the five years between 2000 and 2005 in both Packard and non-Packard areas (Figure 4.12). Media exposure among young women increased more than three times over the five years, with the increase slightly higher among women in the non-Packard than Packard areas. Media exposure among young men more than doubled over the five years, with little difference in the increase between Packard and non-Packard areas.

Figure 4.12 Exposure to at least one family planning message among women and men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



Chapter 5

Fertility and Childbearing

KEY FINDINGS

- More than one-third of young women age 15-24 in Ethiopia have begun childbearing.
- The number of children that young people in Ethiopia consider to be ideal is much smaller than the number considered ideal by older Ethiopians.
- Unmet need for family planning among young women age 15-24 in rural areas is nearly three times greater than that among women in urban areas.

This chapter presents data on fertility and fertility preferences among youth in Ethiopia. Fertility is one of the principal components in population dynamics that determine the size and structure of the population of a country. The 2005 EDHS data on fertility derive from birth history information collected from women age 15-49 interviewed during the survey. The birth history information is used to assess current and completed fertility and factors related to fertility such as age at first birth, birth intervals, and adolescent childbearing. Information on fertility preferences provides insight into a couple's attitude towards future childbearing, desired completed family size, the extent of unwanted and mistimed pregnancies, and the prevailing demand for contraception.

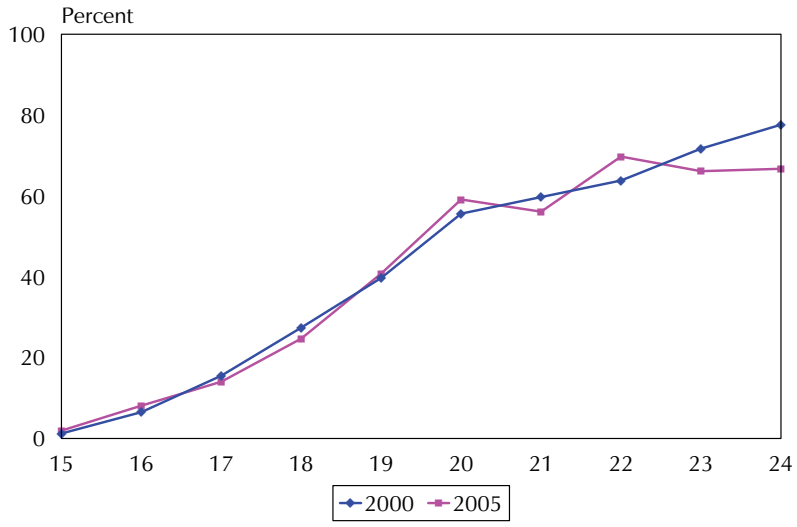
5.1 FERTILITY

Between the 2000 and 2005 EDHS surveys, the TFR among women age 15-49 in urban areas declined from 3.0 to 2.4 children per woman, whereas it remained constant in rural areas, at 6 children per woman. Since Ethiopia is predominantly rural (over 80 percent of people of reproductive age lived in rural areas in 2005), the national TFR changed very little over the five-year period, declining from 5.5 to 5.4 children per woman (CSA and ORC Macro, 2006).

5.2 BEGINNING OF CHILDBEARING

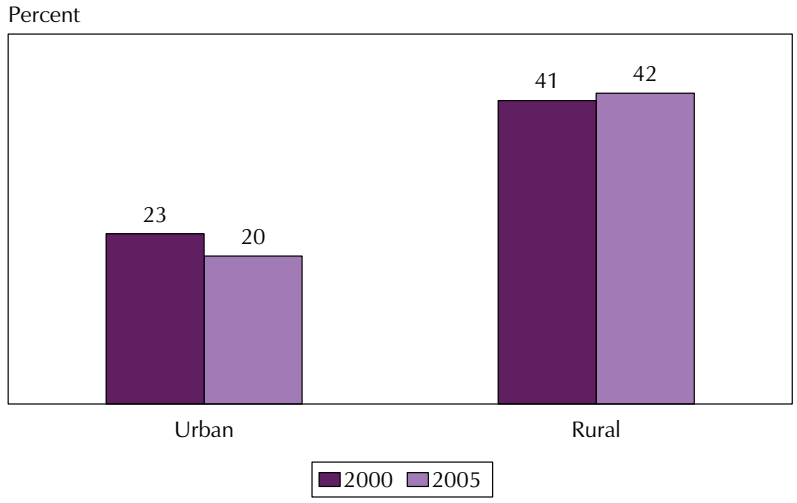
Data from the 2005 EDHS show that 37 percent of women age 15-24 have begun childbearing, i.e., have already given birth or are pregnant with their first child. The proportion of young women who have begun childbearing was the same in 2000. As shown in Figure 5.1, the largest changes in the proportion who have begun childbearing occurred for women age 22 (increased from 64 percent in 2000 to 70 percent in 2005), those age 23 (decreased from 72 percent in 2000 to 66 percent in 2005), and women age 24 (decreased from 78 percent in 2000 to 68 percent in 2005).

Figure 5.1 Percentage of women age 15-24 who have begun childbearing, Ethiopia 2000 and 2005



Rural women age 15-24 were twice as likely to have begun childbearing as urban women (42 percent versus 20 percent) (Figure 5.2). The difference was nearly as large in 2000. Between the two surveys, the percentage of women who had begun childbearing fell from 23 percent to 20 percent in urban areas, but it increased slightly from 41 percent to 42 percent in rural areas.

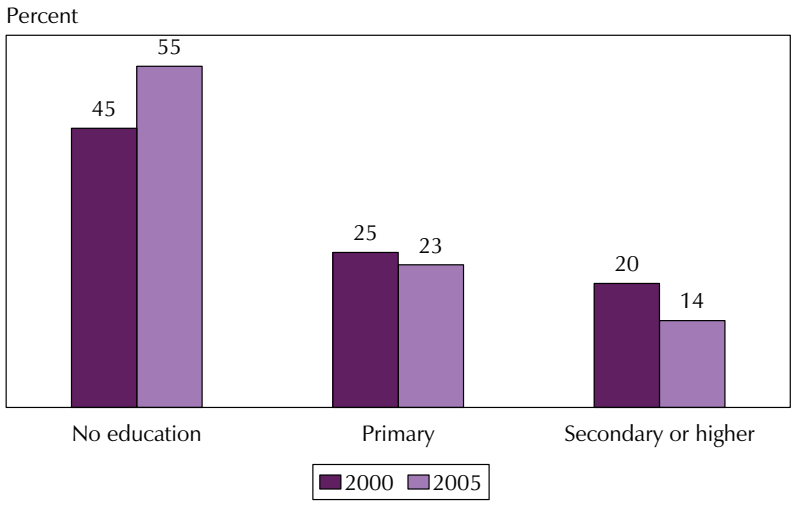
Figure 5.2 Trends in the percentage of women age 15-24 who have begun childbearing by urban-rural residence, Ethiopia 2000 and 2005



The beginning of childbearing varies with level of education. In 2005, over half of young women age 15-24 with no education (55 percent) had begun childbearing, compared with about one-fourth (23 percent) of those with primary education and one-seventh (14 percent) of those with secondary or higher education (Figure 5.3). The percentage of young women with no education who had begun childbearing increased between 2000 and 2005 (from 45 percent to 55 percent), while the percentage of young women who had

begun childbearing among those with secondary or higher education decreased over the same period (from 20 percent to 14 percent). The educational difference in childbearing patterns among young women is more marked in 2005 than in 2000.

Figure 5.3 Trends in the percentage of women age 15-24 who have begun childbearing by education, Ethiopia 2000 and 2005

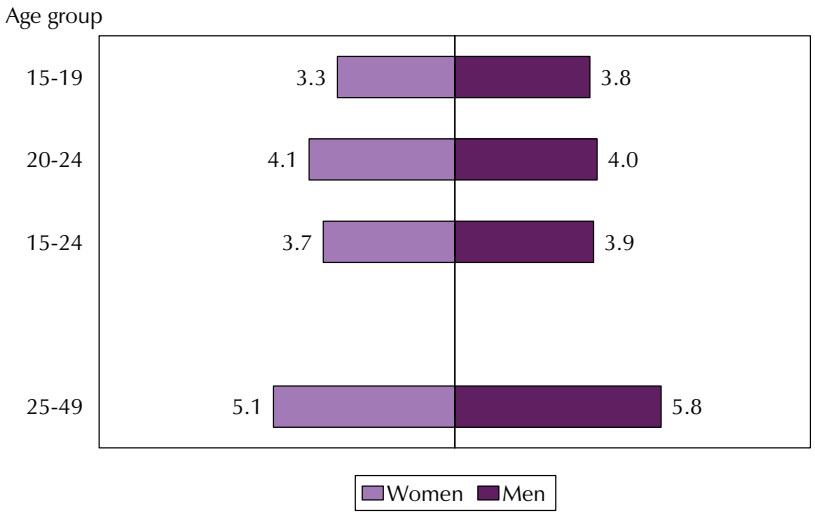


5.3 FERTILITY PREFERENCES

Ideal Number of Children

For both women and men, the younger the respondent, the fewer the number of children she or he considers to be ideal (Figure 5.4). For example, in 2005, the ideal family size for women age 15-19 was 3.3 children, considerably lower than the 4.1 children for those age 20-24 and the 5.1 children for those age 25-49. The age differences remain highly significant statistically when other variables are controlled in multivariate analyses. Similar age differences are seen for men, although the difference in the ideal number of children is somewhat smaller between ages 15-19 (3.8 children) and 20-24 (4 children) than it is for women. The ideal family size of men age 25-49 is large—5.8 children. At ages 15-19 and 25-49 the ideal of family size of men is considerably larger than that of women.

Figure 5.4 Mean ideal number of children among women and men by specific age groups, Ethiopia 2005



Ideal family size has decreased since 2000 for both women and men age 15-24, each by 0.8 children. These changes remain highly significant statistically when other variables are controlled. Substantial decreases between 2000 and 2005 in ideal family size are seen for the currently married as well (Figure 5.5). Ideal family size is larger among currently married youth than all respondents age 15-24. For example, currently married young men report 4.9 children as the ideal number, while the corresponding number for all men is 3.9 children. This suggests that earlier marriage is selective of those who desire larger families.

Figure 5.5 Trends in mean ideal number of children among all women and men age 15-24 and among currently married women and men age 15-24, Ethiopia 2000 and 2005

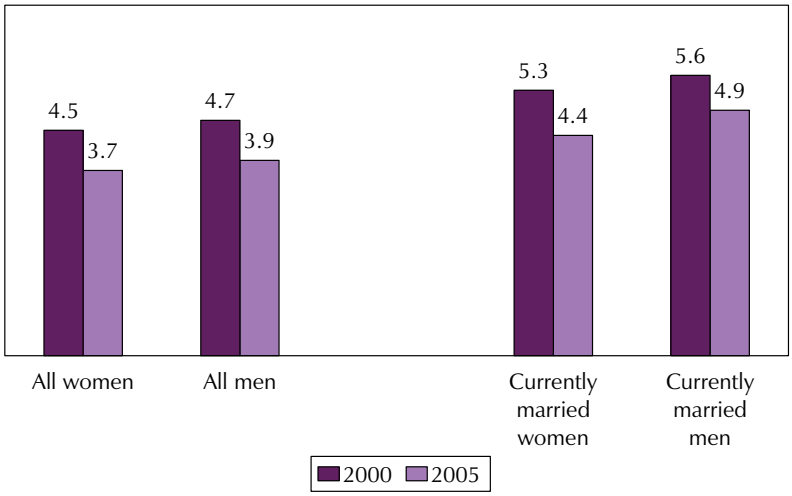
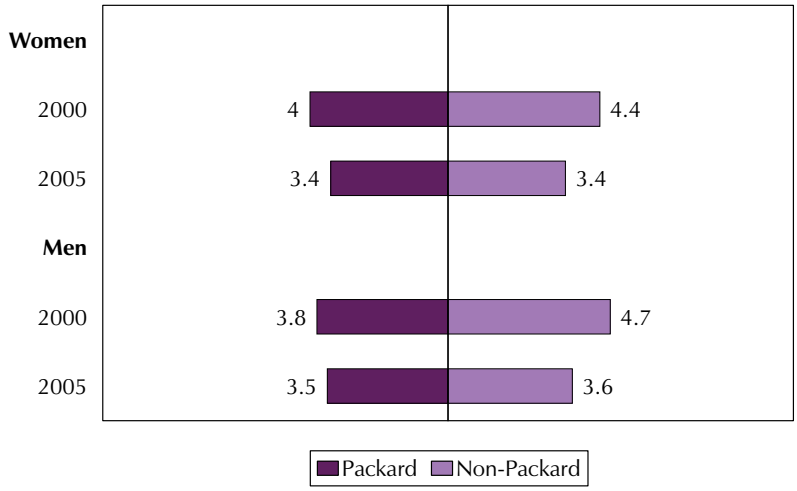


Figure 5.6 shows the ideal family size among youth in the Packard and non-Packard areas in 2000 and 2005. In 2005, the mean ideal number of children varies little by place of residence and, as in the total sample, is slightly higher among young men than that among young women. In contrast, in 2000, the mean ideal number of children among young men and young women in the Packard areas was noticeably lower than among those in the non-Packard areas. Over the five-year period there was a sizeable decline in the mean ideal number of children expressed by both young men and young women, irrespective of place of residence. The decline was more pronounced among residents of non-Packard areas than Packard areas, resulting in a narrowing of the gap in the mean ideal number of children by residence.

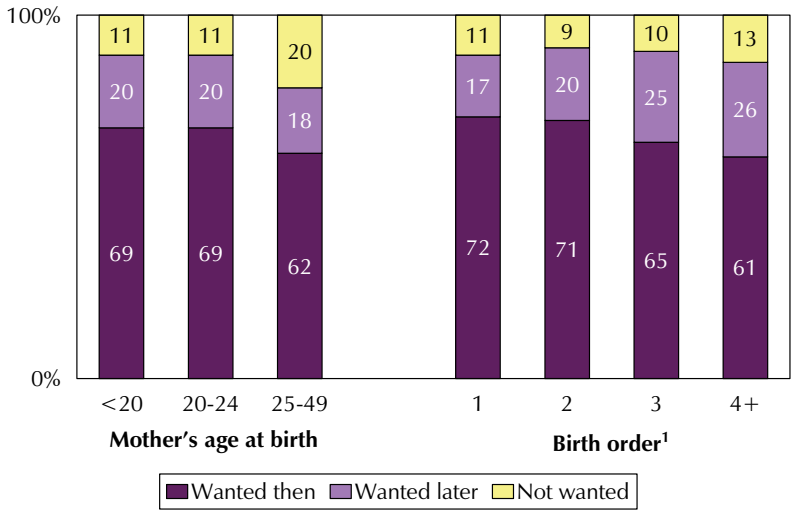
Figure 5.6 Mean ideal number of children among all women and men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



Planning Status of Births

According to the 2005 EDHS survey, nearly seven in ten births to young women under age 25 were wanted at the time they occurred, two in ten were wanted but at a later time, and one in ten were not wanted at all (CSA and ORC Macro, 2006). Figure 5.7 shows that, overall, births to women under age 25 are more likely to be wanted than those to women age 25-49 (89 percent versus 80 percent). Eleven percent of births to women under age 25 at the time of the pregnancy were not wanted at all, compared with 20 percent of births to women age 25-49. There are no differences in the planning status of births to women younger than age 20 and those age 20-24.

Figure 5.7 Planning status of births by mother's age and parity, Ethiopia 2005

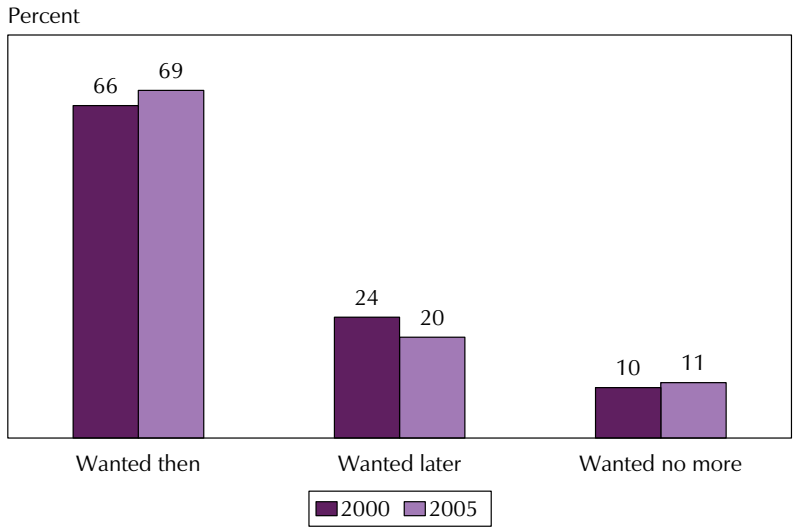


[1] Women <25 years

Figure 5.7 also shows that, for women under age 25, the higher the birth order of the pregnancy, the less likely the pregnancy was wanted at the time, and the more likely it was wanted later. The proportion of unwanted births does not vary much by parity for young women under age 25.

Between 2000 and 2005 there was a small decrease in the percentage of births to women under age 25 that were wanted later and small increases in the percentages wanted at the time or not wanted at all (Figure 5.8).

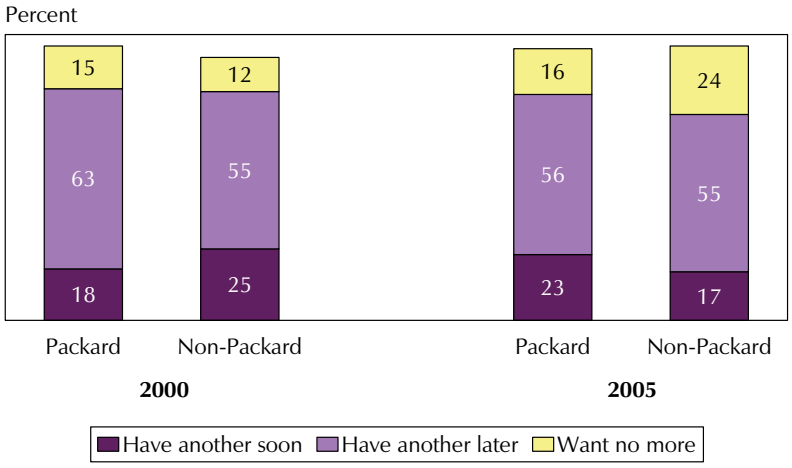
Figure 5.8 Trends in planning status of births among women <25 years, Ethiopia 2000 and 2005



In the 2005 EDHS, the desire to have another child soon (within two years) was slightly higher among currently married young women age 15-25 in the Packard areas than in the non-Packard areas (Figure 5.9). At the same time, the women in the Packard areas were slightly less likely than those in the non-Packard areas to

want no more children. There is very little difference in the percentage of women age 15-24 who want another child later (after two years), by place of residence. These differences between the areas are not statistically significant, perhaps because of some small sample sizes.

Figure 5.9 Fertility preferences among currently married women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



Note: Numbers may not add up to 100 percent due to rounding.

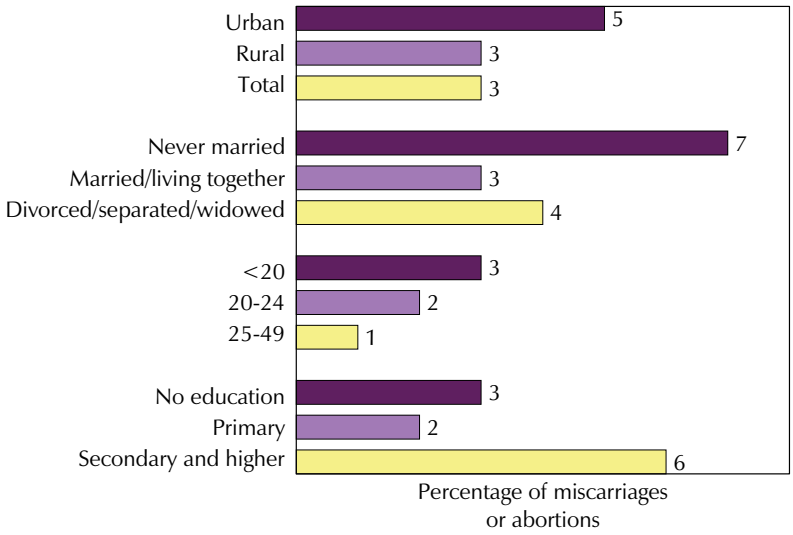
Between 2000 and 2005, there were changes in the fertility preference of currently married young women in the Packard and non-Packard areas. For example, in 2000, 15 percent of young women in the Packard areas wanted to limit the number of children they had, compared with 12 percent of women in the non-Packard areas. In 2005, the percentages were 16 percent and 24 percent, respectively, indicating a sizeable increase in the proportion of young women in the non-Packard areas who want no more children, compared with a very small increase among women in the Packard areas.

Pregnancy Terminations

The 2005 EDHS collected information on miscarriages and abortions, providing some indication of the potential health risks faced by young adults. It is important to note that, because of the sensitive nature of the questions, information on pregnancy loss is subject to substantial underestimation, particularly in the case of pregnancies that were terminated by abortion.

Overall, 3 percent of pregnancies to young women ended in a miscarriage or abortion (Figure 5.10). Such pregnancy outcomes are more likely in urban areas than in rural areas (5 percent versus 3 percent). The percentage of pregnancies ending in miscarriage or induced abortion varies by demographic and background characteristics. It is inversely related to age: such outcomes are more likely for women under age 20 and least likely for those age 25-49. Young women who have never been married are about twice as likely to have had a miscarriage or abortion as currently married or formerly married women. Pregnancy terminations are highest among young women with at least a secondary level of education.

Figure 5.10 Pregnancy terminations (miscarriage or abortion) among women age 15-24, Ethiopia 2005

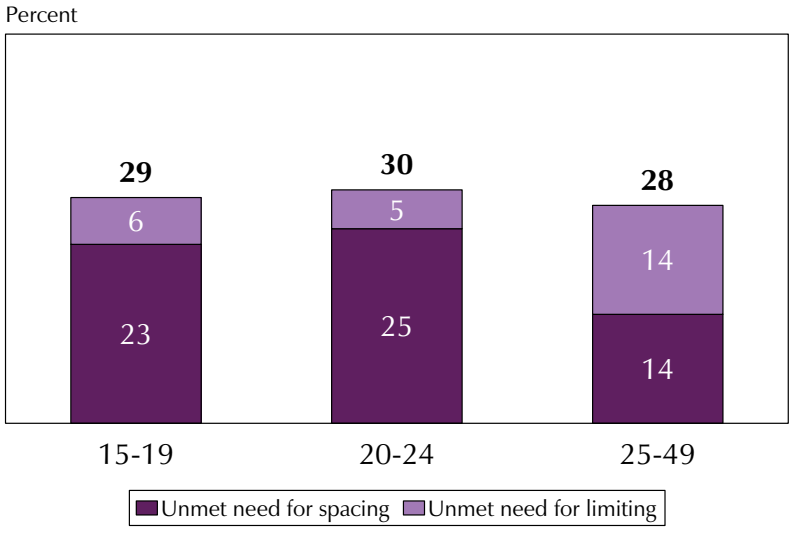


Unmet Need for Family Planning

Family planning programs are particularly interested in the "unmet need" for contraception. This is measured here as the percentage of sexually experienced women who want no more children or want another child later but are not using contraception.

In 2005 nearly 30 percent of all sexually experienced women had an unmet need for family planning, with little overall difference in unmet need among the age groups (Figure 5.11). The majority of women age

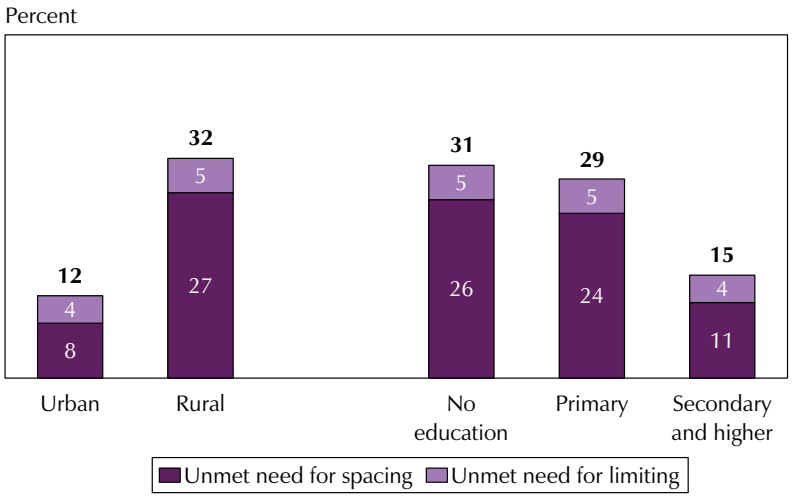
Figure 5.11 Unmet need for family planning among sexually experienced women by age, Ethiopia 2005



15-19 and 20-24 have an unmet need for spacing (23 percent and 25 percent, respectively), that is, they want to have another child later but are not using a method of contraception. Women age 25-49 are equally likely to want to space as to limit (14 percent each).

Unmet need is nearly three times higher among women age 15-24 who live in rural areas than in urban areas (Figure 5.12). The rural-urban difference in unmet need is much greater for spacing (27 percent versus 8 percent) than for limiting (5 percent versus 4 percent).

Figure 5.12 Unmet need for family planning among sexually experienced women age 15-24 by urban-rural residence and education, Ethiopia 2005



Unmet need varies with women's education. Young women with secondary or higher education have much less unmet need (15 percent) than those with primary or no education (29 percent and 31 percent respectively). The differences in unmet need by education are mostly due to the large differences in the unmet need for spacing. Only 11 percent of women with secondary or higher education have an unmet need for spacing, compared with 26 percent of women with no education.

Between 2000 and 2005, overall unmet need among young women 15-24 decreased somewhat from 31 percent to 29 percent, brought on by the slight decrease in the unmet need for spacing (from 26 percent to 24 percent) over the same period (Figure 5.13). The unmet need for limiting did not change between 2000 and 2005.

Figure 5.13 Trends in unmet need for family planning among sexually experienced women age 15-24, Ethiopia 2000 and 2005

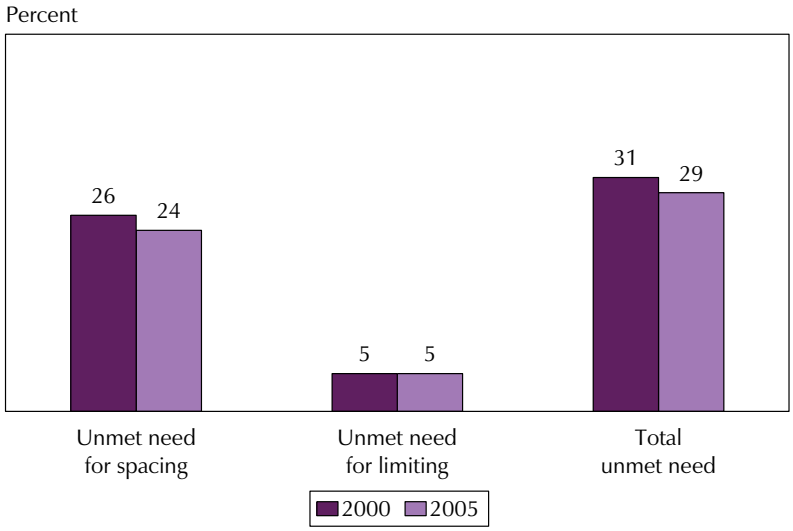
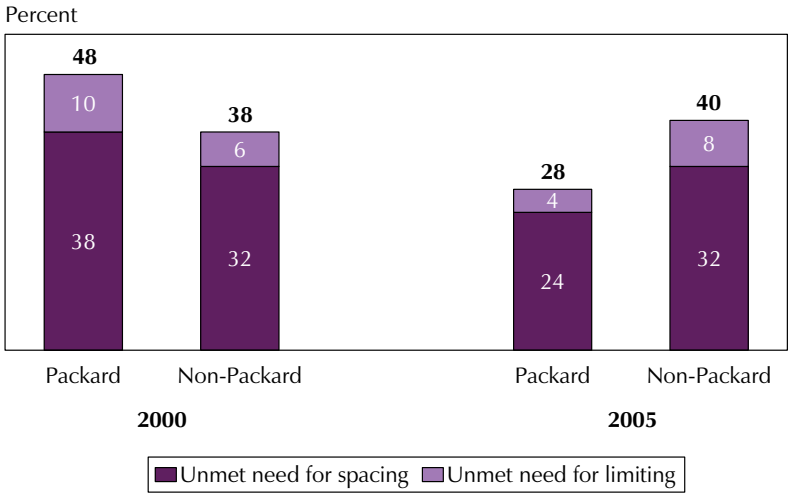


Figure 5.14 shows the trends in the unmet need for family planning among currently married women age 15-24 in the Packard and non-Packard areas between the two surveys. In 2005, unmet need among

Figure 5.14 Unmet need for family planning among currently married women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



currently married women age 15-24 in the Packard areas is lower than among those in the non-Packard areas (28 percent versus 40 percent). This is true for both unmet need for spacing and unmet need for limiting. In contrast, in 2000, young women in the Packard areas had a higher need for both spacing and limiting than women in the non-Packard areas. Unmet need among young women declined in the Packard areas between 2000 and 2005, (Figure 5.14), due to declines in both components of unmet need. By contrast, the unmet need for limiting among young women in the non-Packard areas increased slightly between the two surveys, while the unmet need for spacing remained the same.

Chapter 6

Maternal and Child Health

KEY FINDINGS

- Seven in ten young mothers in Ethiopia do not receive antenatal care during pregnancy.
- Less than one in ten (7 percent) young mothers receive delivery assistance from a health professional, and only 6 percent receive postnatal care services within two days of birth.
- Children born to women under age 20 have much higher rates of neonatal, postneonatal, infant, child, and under-five mortality than children born to older mothers.
- Between 2000 and 2005, there was substantial improvement in the health care of sick children of women age 15-24. This was especially true for children under 5 with fever who were taken to a health provider for treatment; the percentage doubled over the five-year period.

6.1 MATERNAL HEALTH

This chapter presents findings on several areas of importance to maternal health: antenatal, delivery, and postnatal care. The health care that a mother receives during pregnancy, at the time of delivery and soon after delivery is important for the survival and well-being of both the mother and the child. As seen in Chapter 5, a high proportion of Ethiopian women start childbearing in their teens. The 2005 EDHS data show that four in ten women age 19 and six in ten women age 20 have already begun childbearing. In addition to the relatively high level of pregnancy complications among young mothers because of physiological immaturity, inexperience associated with child care practices also influences maternal and infant health. Moreover, an early start to childbearing greatly reduces the educational and employment opportunities of women and is associated with higher levels of ultimate fertility.

Findings from this chapter are important to policymakers and program implementers in formulating programs and policies and in designing appropriate strategies and interventions to improve maternal and child health care services among young adults.

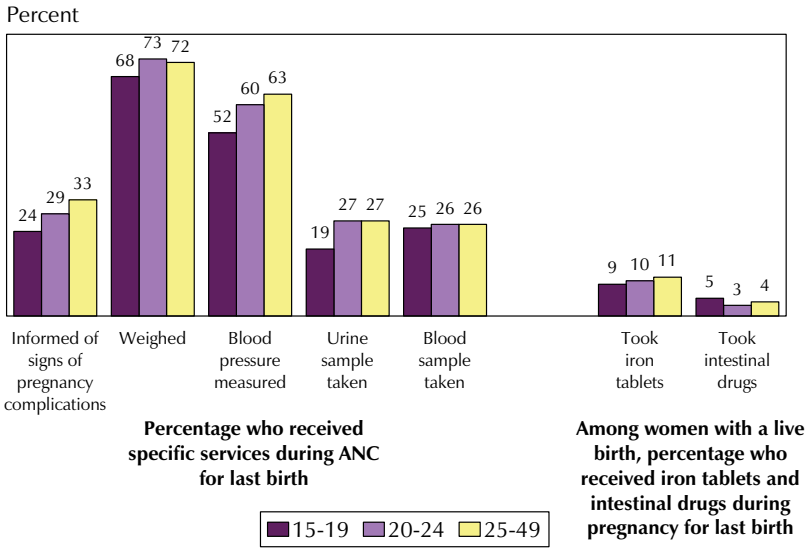
Antenatal Care

The content of antenatal care is important in assessing the quality of antenatal care services. Pregnancy complications are an important source of maternal and child morbidity and mortality, and thus teaching pregnant women about the danger signs associated with pregnancy and the appropriate action to take are essential components of antenatal care. EDHS data show that, overall, only three-tenths of Ethiopian mothers age 15-24 receive antenatal care from a health professional though they are significantly more likely to receive such care than older women (and this difference remains even when other covariates such as education are controlled).

Figure 6.1 presents information on the percentage of women, by age, who were informed about the signs of pregnancy complications and the percentage who received routine antenatal care services, among women receiving antenatal care (ANC). The figure also shows the percentage of women who took iron tablets and intestinal parasitic drugs during their last pregnancy in the five years preceding the survey. The quality of antenatal care varies by women's age. Of those who receive ANC, younger women less likely to be informed about pregnancy complications than are older women. One-third of women age 25-49 who received antenatal care reported that they were informed about pregnancy complications during their visits, compared with three-

tenths of women age 20-24 and one-fourth of those age 15-19. In addition, very young women are least likely of the age groups to have been weighed, to have their blood pressure measured, to have had urine or blood samples taken, and to have taken iron tablets during pregnancy, though some of the age differences are fairly small. The relative age difference is largest for urine tests. In contrast, however, the youngest women are slightly more likely than those age 20-24 and 25-49 to have taken intestinal parasitic drugs.

Figure 6.1 Quality of antenatal care by woman's age, Ethiopia 2005

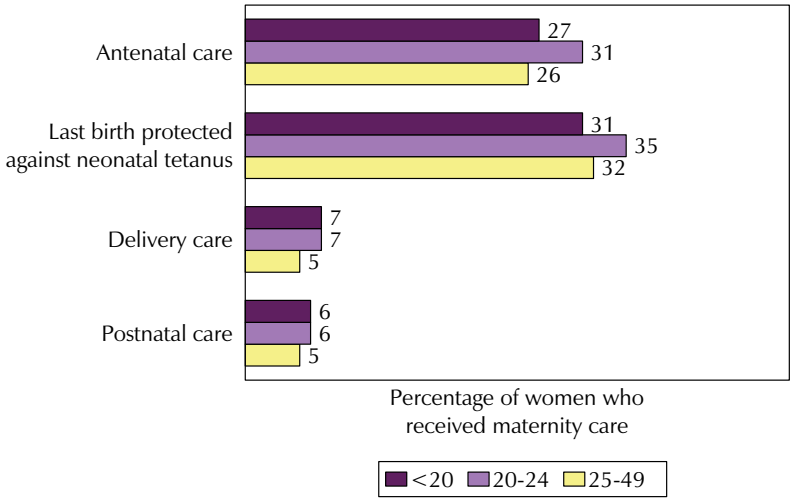


Maternity Care

Relatively few young women get professional maternity care in Ethiopia. EDHS data show that, overall (as noted above), three in ten women under age 25 at the time of birth received antenatal care from a health professional for their last live birth in the preceding five years, and just one-third had received tetanus toxoid injections to protect their last birth. Furthermore, postnatal care and professional delivery care were received for only 6 and 7 percent, respectively, of recent births to women under age 25. Though the rates are low for all age groups, women age 15-24 are significantly more likely to receive postnatal care than those age 25-49, even when other covariates are controlled.

Women under the age of 20 at the time of birth and those age 25-49 are less likely to have had their last birth protected against neonatal tetanus or to have gotten antenatal care than women age 20-24 (Figure 6.2). It is possible that these differentials by age may reflect parity differences. The 2000 and 2005 EDHS data show that women are more likely to get care for their first births (CSA and ORC Macro, 2001; CSA and ORC Macro, 2006). The lower rates of care observed here among older mothers in the total sample largely reflect the fact that fewer of their births are first births. There are relatively few differences across age groups for births of the second or higher order. However, for first births, the likelihood of getting maternity care is positively associated with mother's age at the time of birth, perhaps because, as we have seen, women who wait longer to have their first child are more educated, and therefore, more likely to seek maternity care.

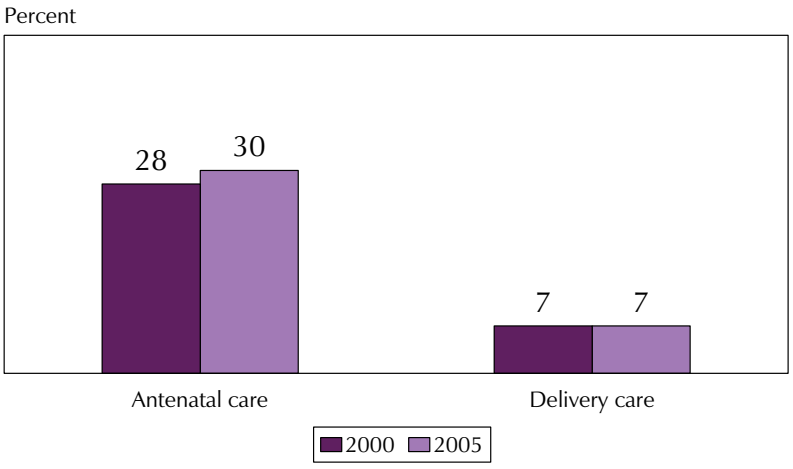
Figure 6.2 Maternity care by mother's age, Ethiopia 2005



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

Between 2000 and 2005, there has not been much change in the percentage of young women who received antenatal and delivery care for their most recent birth in the preceding five years. Antenatal care increased from 28 percent to 30 percent, while delivery care remained constant at 7 percent (Figure 6.3). Data on postnatal care cannot be compared over time because of different methodologies in data collection. (In the 2000 survey, only women who delivered at home were asked about whether they received postnatal care, since it was assumed that all women who gave birth in health care settings received postnatal care; in 2005 all women were asked about postnatal care irrespective of the place of delivery.)

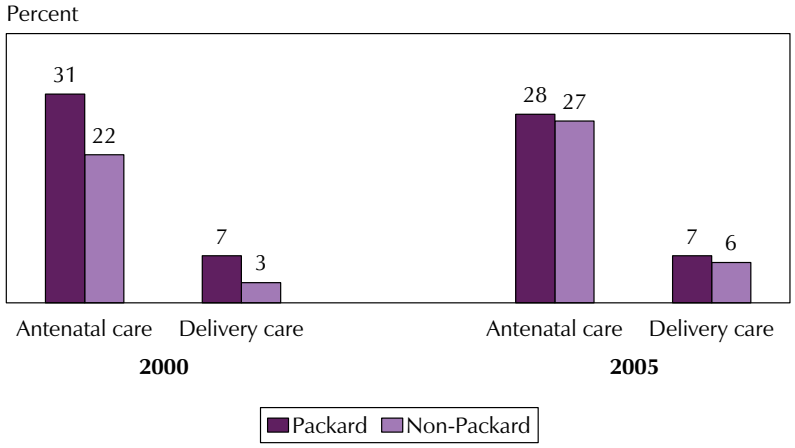
Figure 6.3 Trends in maternity care among women <25 years, Ethiopia 2000 and 2005



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

Figure 6.4 shows data on maternity care among young women in the Packard and non-Packard areas in 2000 and 2005. In both 2000 and 2005 women in the Packard areas are more likely to receive ANC and postnatal care than those in the non-Packard areas. The differences are considerably larger in 2000 than in 2005. Between the two surveys, the proportion of young women in the Packard areas receiving antenatal care decreased slightly, and the proportion receiving delivery care remained constant. In the non-Packard areas, on the other hand, there has been an increase in the percentage of young women receiving antenatal or delivery care over the same period of time.

Figure 6.4 Maternity care among women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



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

6.2 CHILDREN'S HEALTH AND SURVIVAL

In addition to maternal health, this chapter also presents data on several areas of importance to child health and survival, such as early childhood mortality rates, vaccination status of children, important childhood illnesses and their treatment, and children's nutritional status in relation to mother's age.

Childhood Mortality

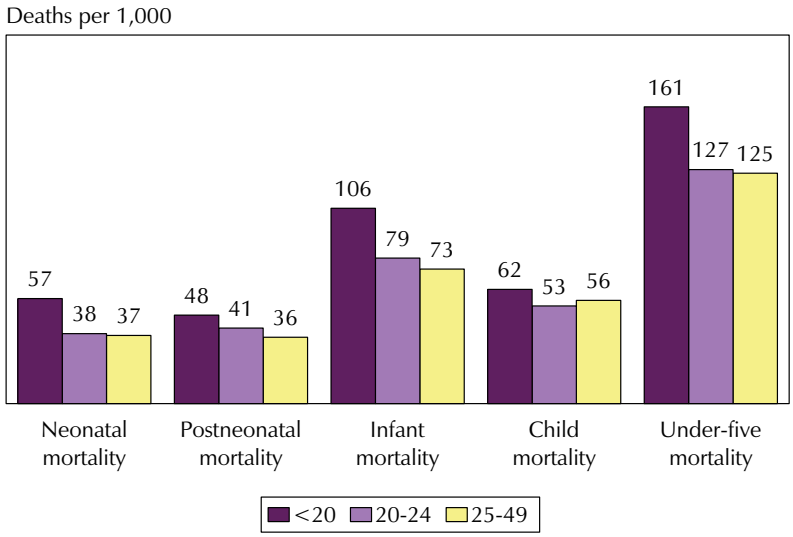
This section describes levels, trends, and differentials in infant and childhood mortality. Childhood mortality in general and infant mortality in particular are often used as broad indicators of social development or as specific indicators of health status. Hence, information on infant and child mortality contributes to a better understanding of a country's socioeconomic situation and sheds light on the quality of life of the population. We consider how childhood mortality varies by mother's age and birth parity, which helps identify subgroups that are at high risk.

Infant and child mortality rates are high in Ethiopia. According to the 2005 EDHS, one in every eight children do not survive to their fifth birthday (CSA and ORC Macro, 2006). In general, all early childhood mortality rates are inversely related to the mother's age at the time of the child's birth (Figure 6.5). Children born to women under age 20 have higher rates of neonatal, postneonatal, infant, child, and under-five mortality than children born to older mothers. For example, infant mortality among children of women under

age 20 is 106 deaths per 1,000 live births compared with 79 deaths and 73 deaths per 1,000 live births for children of women age 20-24 and women age 25-49, respectively. Similarly, under-five mortality rate is much higher for children of teenage mothers (161 deaths per 1,000 live births) than for children of mothers in their early twenties (127 deaths per 1,000 live births) and those age 25-49 (125 deaths per 1,000 live births).

Early childhood mortality rates declined between 2000 and 2005 (Macro International Inc., 2007). For example, infant mortality in the five years preceding the survey declined from 97 deaths to 77 deaths per 1,000 live births between the 2000 EDHS and the 2005 EDHS, while under-five mortality declined from 166 deaths to 123 deaths per 1000 live births over the same period. The same patterns observed for children of all women age 15-49 are also true for children of young mothers age 20-24.

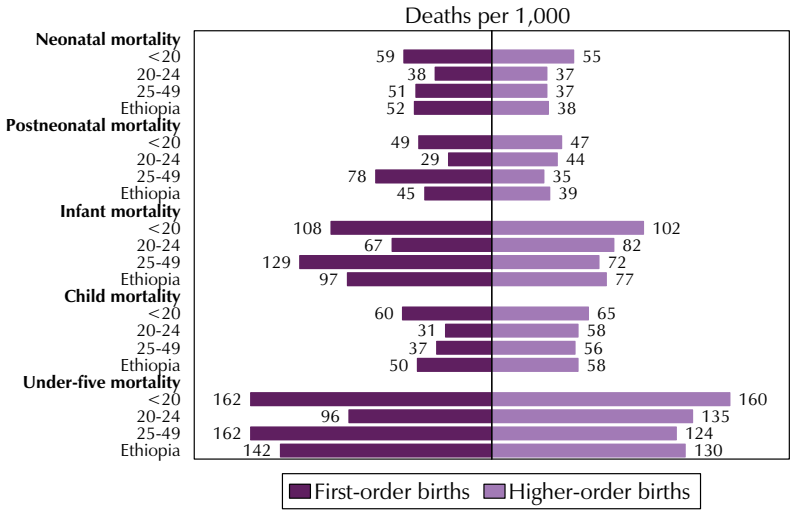
Figure 6.5 Childhood mortality by mother's age, Ethiopia 2005



Note: Rates are for the 10-year period before the survey.

It is widely reported in the literature that infant mortality rates are higher for first-order births than higher-order births (Bongaarts, 1987). Because the younger the mother, the more likely she is to be giving birth for the first time, this could contribute to the negative relationship shown in Figure 6.5 between childhood mortality and mother's age at the time of birth. To investigate this, the relationship between childhood mortality rates and birth parity were examined within age groups. Figure 6.6 shows that, first births have higher rates than higher-order births of infant, postneonatal, neonatal, and under-five mortality, but not child mortality. For example, overall infant mortality is 97 deaths per 1,000 live births for first births compared with 77 deaths per 1,000 live births for higher-order births, while under-five mortality is 142 deaths and 130 deaths per 1,000 live births, respectively. When examining the breakdown of childhood mortality by mother's age, however, it is clear that the higher mortality rates associated with first parity are mainly observed for older women age 25-49. Similar patterns were observed in the 2000 survey. These findings indicate that children of women age 25 or older who are becoming mothers for the first time merit particular attention. At the same time it is important to note that younger mothers (under age 25 at the time of birth) and especially mothers who give birth in their teens, experience relatively higher mortality for their children irrespective of parity, for two and higher-order births their mortality rates are always higher than those of older mothers (Figure 6.6).

Figure 6.6 Childhood mortality by parity according to mother's age, Ethiopia 2005



Note: Rates are for the 10-year period before the survey.

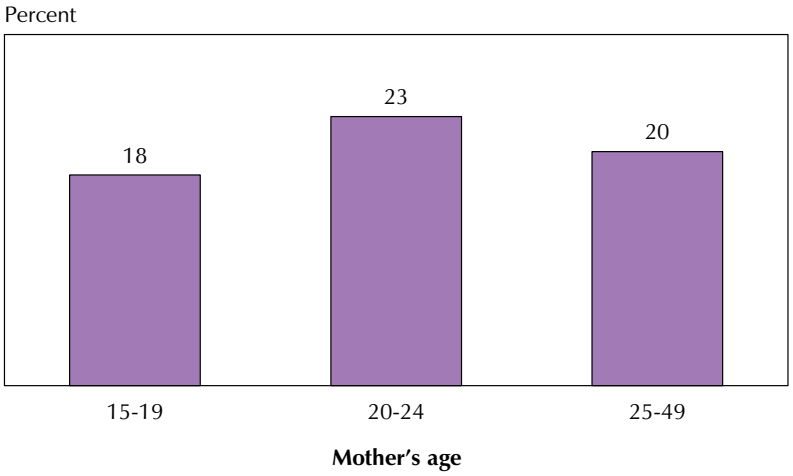
Immunization

Universal immunization of children against the six vaccine-preventable diseases (namely, tuberculosis, diphtheria, whooping cough, tetanus, polio, and measles) is crucial to reducing infant and child mortality. According to the guidelines developed by the World Health Organization, children are considered fully vaccinated when they have received a vaccination against tuberculosis (BCG), three doses each of the DPT and polio vaccines, and a measles vaccination by the age of 12 months. BCG should be given at birth or at first clinical contact, DPT and polio require three vaccinations at approximately 4, 8, and 12 weeks of age, and measles should be given at or soon after reaching 9 months of age. Information on immunization coverage is important for the monitoring and evaluation of the Expanded Programs on Immunization (EPI) and is useful for health program design and planning. The 2000 and 2005 EDHS surveys collected information on vaccination coverage for all living children born in the five years preceding the survey. Information on vaccination coverage presented here focuses on the age group 12-23 months. Overall coverage levels and trends over time are shown for children of mothers age 15-24.

Only about one in five Ethiopian children age 12-23 months are fully immunized. Children of teenage mothers are somewhat less likely to be fully vaccinated (18 percent) than children of mothers in their early twenties (23 percent) and those age 25-49 (20 percent) (Figure 6.7). Immunization coverage increased between 2000 and 2005 for all children age 12-23 months old of women age 15-24 (Figure 6.8). The increase was considerably larger among children of mothers age 20-24 (from 11 percent in 2000 to 23 percent in 2005) than for those with younger mothers.

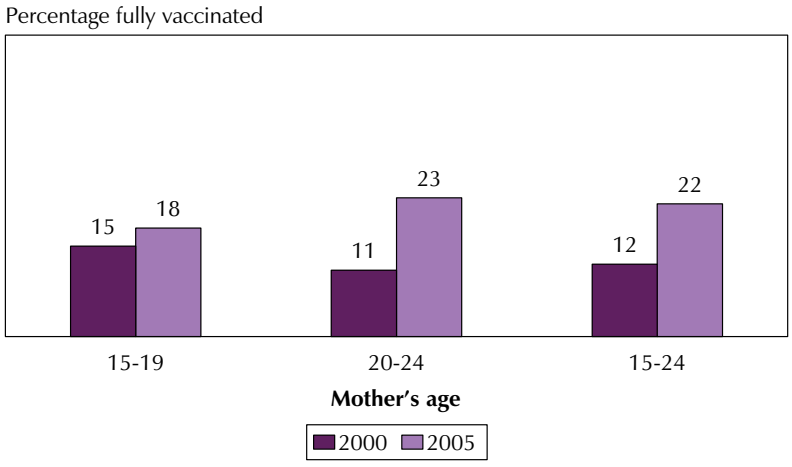
The proportion of children of young mothers who are fully vaccinated increased between 2000 and 2005 in both the Packard and non-Packard areas (Figure 6.9). The increase in vaccination coverage is more pronounced among children of young mothers in the non-Packard areas (from 9 percent to 22 percent) when compared with those in the Packard areas (from 14 percent to 22 percent), resulting in no difference between the areas in the latter year.

Figure 6.7 Percentage of children age 12-23 months fully vaccinated by mother's age, Ethiopia 2005



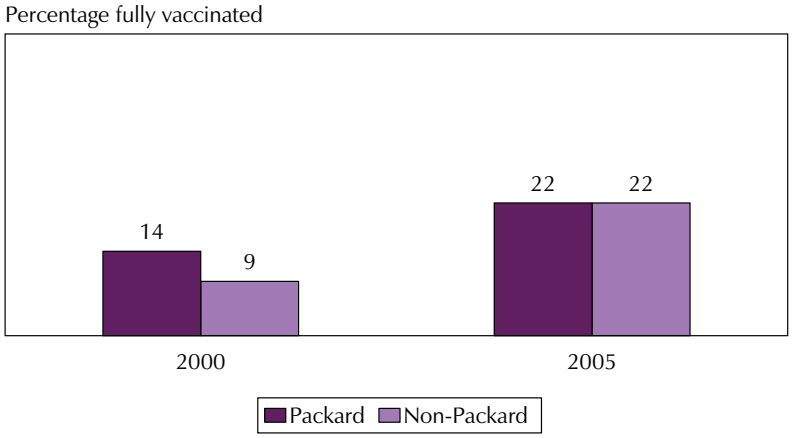
Note: Children are fully vaccinated if they received BCG, measles, and three doses each of DPT and polio vaccine (excluding polio 0)

Figure 6.8 Trends in vaccination of children age 12-23 months by mother's age, Ethiopia 2000 and 2005



Note: Children are fully vaccinated if they received BCG, measles, and three doses each of DPT and polio vaccine (excluding polio 0)

Figure 6.9 Vaccination coverage among children age 12-23 months of mothers age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



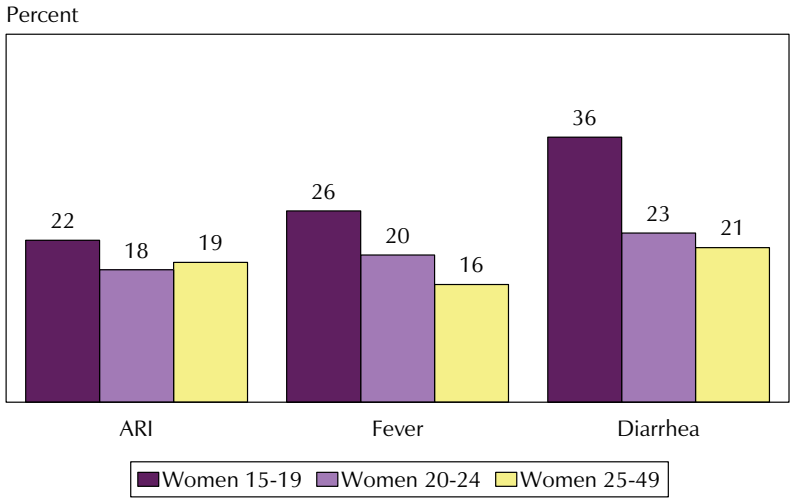
Note: Children are fully vaccinated if they received BCG, measles, and three doses each of DPT and polio vaccine (excluding polio 0)

Treatment of Childhood Illnesses

Acute respiratory infection (ARI), fever, and diarrhea are common childhood illnesses. ARI is among the leading causes of childhood morbidity and mortality throughout the world. Early diagnosis and proper treatment can prevent a large proportion of child deaths caused by ARI. Fever is a major manifestation of malaria and other acute infections in children. Malaria and fever contribute to high levels of malnutrition and mortality. Since malaria is a major contributory cause of death in infancy and childhood in many developing countries, presumptive treatment of fever with anti-malarial medication is advocated in many countries where malaria is endemic. Dehydration caused by severe diarrhea is a major cause of morbidity and mortality among young children although the condition can be easily treated with oral rehydration therapy (ORT). Exposure to diarrhea-causing agents is frequently related to the use of contaminated water and to unhygienic practices in food preparation and disposal of excreta. The information presented in this section on treatment practices and contact with health services among children with ARI, fever, and diarrhea is of importance in the assessment of national programs aimed at reducing the mortality impact of these illnesses.

Figure 6.10 shows the percentage of children under five with an ARI, fever, or diarrhea in the two weeks preceding the survey who were taken to a health provider for treatment by mother's age. Overall, a relatively low proportion of Ethiopian children who get sick are taken to a health provider for treatment. The proportion of children taken for treatment is somewhat higher when they have diarrhea than when they have ARI or fever. For each of these conditions, children of teenage mothers are more likely than children of mothers in their early twenties or older mothers to be taken to a health provider when they are sick. For example, more than one-third of children of teenage mothers (36 percent) were taken to a health facility when they had diarrhea compared with about one-fifth of children of older mothers.

Figure 6.10 Percentage of children under five years with ARI, fever, or diarrhea taken to a health provider for treatment by mother's age, Ethiopia 2005



Over the five years between the surveys, there was substantial improvement in the care for sick children born to women age 15-24 (Figure 6.11). This is true for all three childhood illnesses, especially for fever, for which the percentage of children taken to a health provider doubled over the five-year period.

Figure 6.11 Percentage of children under five years (of mothers age 15-24) with ARI, fever, or diarrhea taken to a health provider for treatment, Ethiopia 2000 and 2005

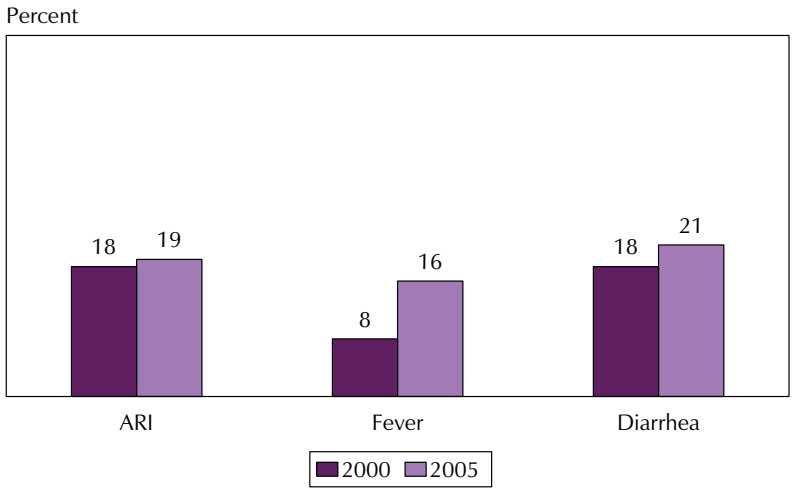
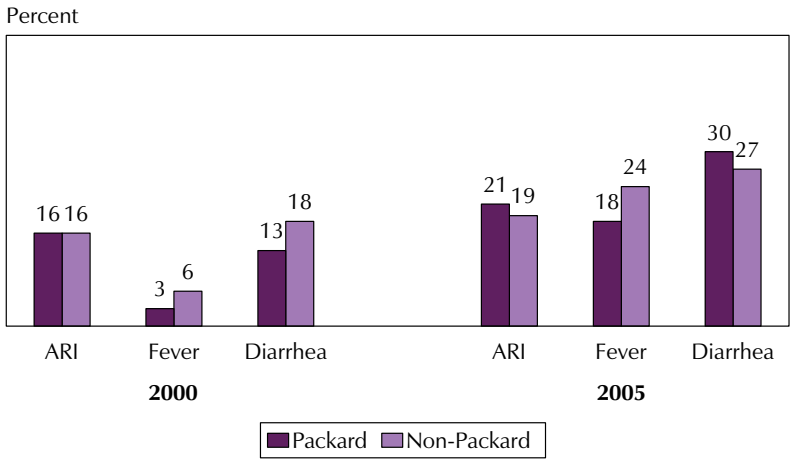


Figure 6.12 shows data on treatment of childhood illnesses among children of young mothers for the Packard and non-Packard areas in 2000 and 2005. In 2000, children of young mothers in the Packard areas were generally less likely than children of young mothers in the non-Packard areas to be taken to a provider for treatment. However, over the five years between the surveys, not only has there has been a noticeable improvement in both areas in the treatment of sick children of women age 15-24, but children in the Packard

Figure 6.12 Percentage of children under five years (of mothers age 15-24) with ARI, fever, or diarrhea taken to a health provider for treatment, in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



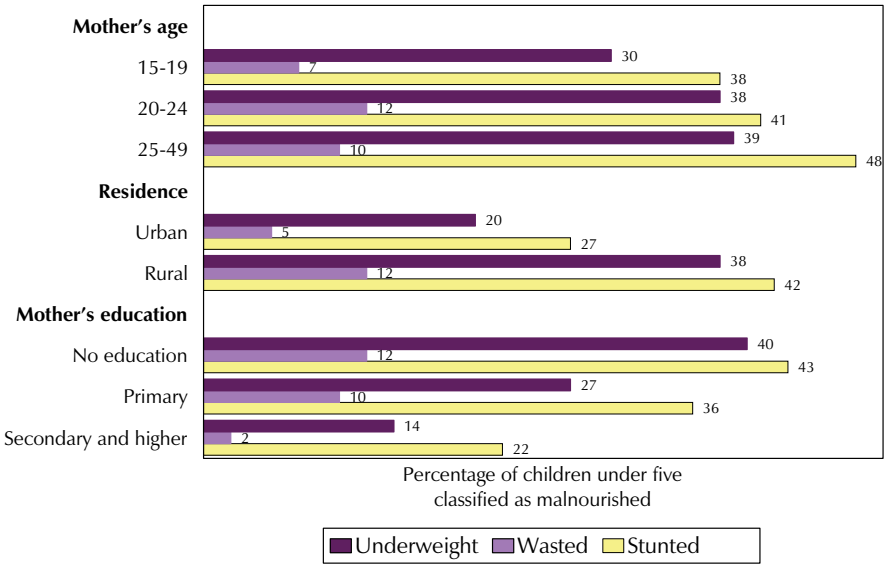
areas who were sick with ARI or diarrhea were more likely to be taken to a provider for treatment than children in the non-Packard areas. On the other hand, the increase in the percentage of children of young mothers who were taken to a health provider for the treatment of fever was greater in the non-Packard than in the Packard areas.

Children's Nutritional Status

The period from birth to two years of age is important for optimal growth, health, and development, especially since it is during this period that children are particularly vulnerable to growth retardation, micronutrient deficiencies, and common childhood illnesses such as diarrhea and ARI. Adequate nutrition is critical to child development, especially during the early years of life. The 2005 EDHS included information on the nutritional status of children under five years of age for three indices, namely, height-for-age (stunting), weight-for-height (wasting), and weight-for-age (underweight) taking age and sex into consideration.

Overall, nearly half of all Ethiopian children under the age of five (46 percent) are stunted, about four-tenths (39 percent) are underweight, and about one-tenth (11 percent) are wasted (CSA and ORC Macro, 2006). When we consider differentials by age (Figure 6.13), we see that children of teenage mothers are somewhat less likely to be stunted, wasted, or underweight than those of older mothers. Because the incidence of malnutrition, particularly stunting and underweight, increases with the child's age (see Figure 6.14), especially after the age of 9 months, it is possible that the lower rates of malnutrition observed for children of mothers age 15-19 compared with older mothers may reflect the fact that children of younger women are younger on average. When looking separately at the nutritional status of children under age 9 months and those age 9 months and older, younger children have much lower rates of malnutrition than older children (Figure 6.14). For example, 17 percent of children under age 9 months are stunted compared with 47 percent of children 9 months and older, while the proportions of underweight children are 11 percent and 43 percent, respectively. This may be because of inappropriate and/or inadequate feeding practices because increasing proportions of children underweight by age coincides with the age at which normal complementary feeding

Figure 6.13 Nutritional status of children under five years, Ethiopia 2005



starts. Nonetheless, when age of child (and mother's education) are controlled in multivariate analyses, we continue to see that the children of teenage mothers are significantly less likely to be malnourished than those of older mothers.

Figure 6.14 Nutritional status of children under five years of mothers age 15-24 by child's age, Ethiopia 2005

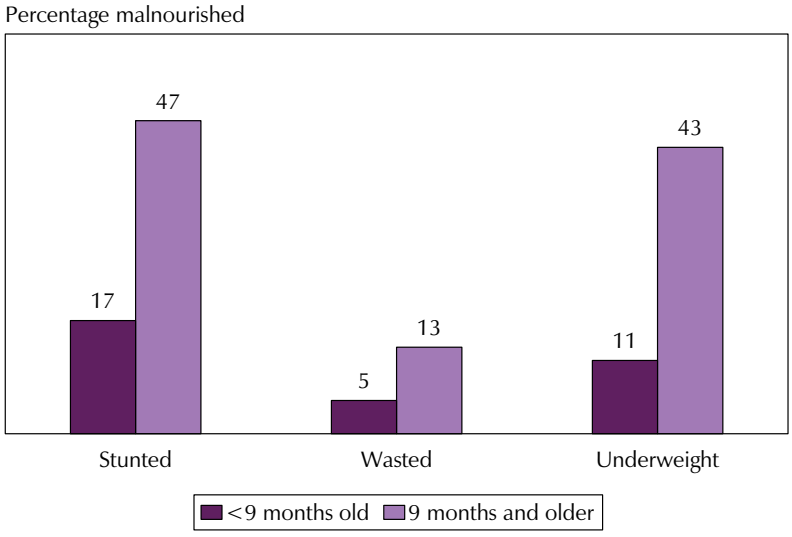


Figure 6.13 shows that for all three indices of nutritional status, rural children are much more likely to be malnourished than urban children and that the prevalence of malnutrition decreases steadily as mother's level of education increases. For example, 43 percent of children born to young mothers with no education are stunted compared with 36 percent of children whose mothers have primary education and 22 percent of children whose mothers have secondary or higher education. Furthermore, children whose mothers have no

education are six times more likely to be wasted than those whose mothers have secondary or higher education (12 percent versus 2 percent).

Between the 2000 and 2005 surveys, the percentage of stunting among children of mothers age 15-24 decreased from 47 percent to 41 percent and the percentage of underweight children decreased from 41 percent to 36 percent. On the other hand, wasting increased slightly, from 9 percent to 11 percent (Figure 6.15).

Figure 6.15 Trends in nutritional status of children under five years of mothers age 15-24, Ethiopia 2000 and 2005

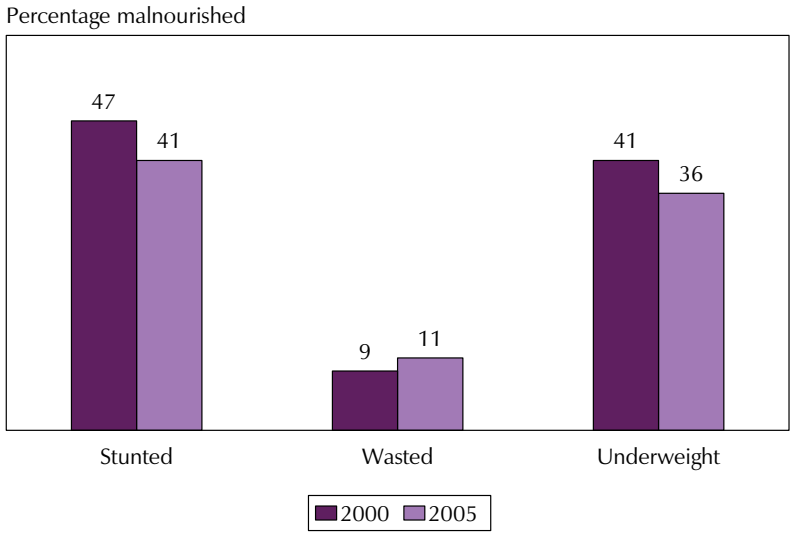
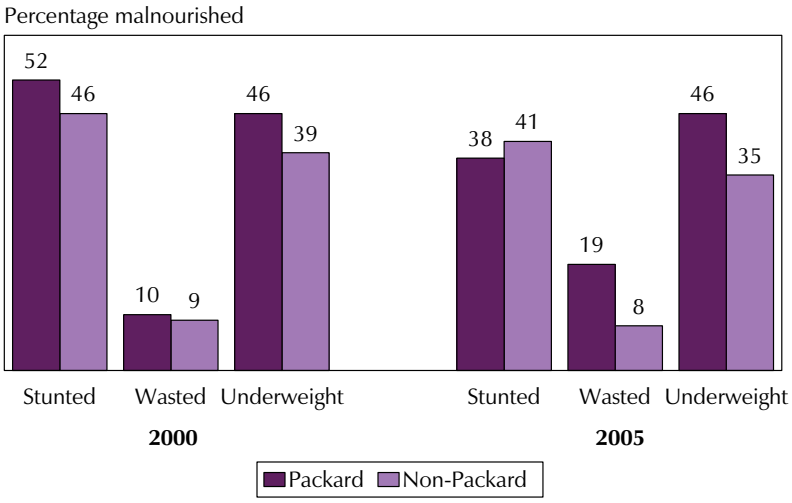


Figure 6.16 shows trends in the nutritional status among children of mothers 15-24 for the Packard and non-Packard areas. In 2000, children of young mothers in the Packard areas had higher rates of stunting, wasting, and underweight than those in the non-Packard areas. The same pattern is observed in 2005, except for stunting which is slightly higher among children of young mothers in the non-Packard areas than those in the Packard areas. Between the 2000 and 2005 surveys, the percentage of stunting among children of young mothers decreased substantially from 52 percent to 38 percent among children in the Packard areas and decreased somewhat from 46 percent to 41 percent among children in the non-Packard areas. The percentage of underweight children decreased from 39 percent to 35 percent among children of young mothers in the non-Packard areas but remained constant at 46 percent among children in the Packard areas. On the other hand, wasting increased significantly from 10 percent to 19 percent among children of young mothers in the Packard areas but decreased slightly from 9 percent to 8 percent among those in the non-Packard areas.

Figure 6.16 Nutritional status of children under five years of mothers age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



Chapter 7

HIV/AIDS and Other Sexually Transmitted Infections

KEY FINDINGS

- Nearly all young Ethiopians have heard of AIDS.
- Overall, young men are more knowledgeable than young women about HIV transmission—particularly knowledge that the risk of transmission can be reduced by using condoms and by limiting sexual activity to one uninfected partner.
- Between 2000 and 2005, knowledge about AIDS and its means of transmission increased among youth.
- Risky sexual behavior among youth decreased markedly between 2000 and 2005.
- More than nine in ten young Ethiopians have never been tested for HIV.

In Ethiopia, as in most of sub-Saharan Africa, national HIV prevalence estimates were derived primarily from testing pregnant women who received antenatal care (ANC) at sentinel surveillance sites. The information from the ANC surveillance system was very useful for assessing HIV levels, and especially for monitoring trends in HIV prevalence. The 2005 EDHS was the first national survey in Ethiopia to include population-based HIV testing, offering the opportunity to obtain information on the magnitude and patterns of HIV infection in the general reproductive age population for both males and females in Ethiopia. Results from the 2005 EDHS indicate that 1.4 percent of Ethiopian adults age 15-49 are infected with HIV; the HIV prevalence in women is nearly 2 percent, while for men 15-49, it is just under 1 percent (CSA and ORC Macro, 2006).

The 2005 EDHS data show that 0.4 percent of respondents age 15-19 and 1.1 percent of respondents age 20-24 are HIV positive. Looking at age patterns by gender, young women are particularly vulnerable to HIV infection compared with young men. Among women age 15-19, for example, 0.7 percent are HIV infected, compared with 0.1 percent of men age 15-19. HIV prevalence among women age 20-24 is more than three times that of men in the same age group (1.7 percent and 0.4 percent, respectively) (CSA and ORC Macro, 2006). These undoubtedly reflect the gender differences in sexual activity shown earlier.

The AIDS epidemic remains a priority in Ethiopia's development agenda. HIV is one of the components of the national Plan for Accelerated Development to End Poverty. The national response to AIDS is built around six strategic issues: capacity-building; community mobilization and empowerment; integration with health programs; leadership and mainstreaming; coordination and networking; and targeted response. In the recent past, the strong leadership from the Ministry of Health has resulted in a significant strengthening of the response to AIDS, in particular within the health sector. In all regions of the country, there has been a gradual increase in the availability of voluntary counseling and testing and of antiretroviral therapy.

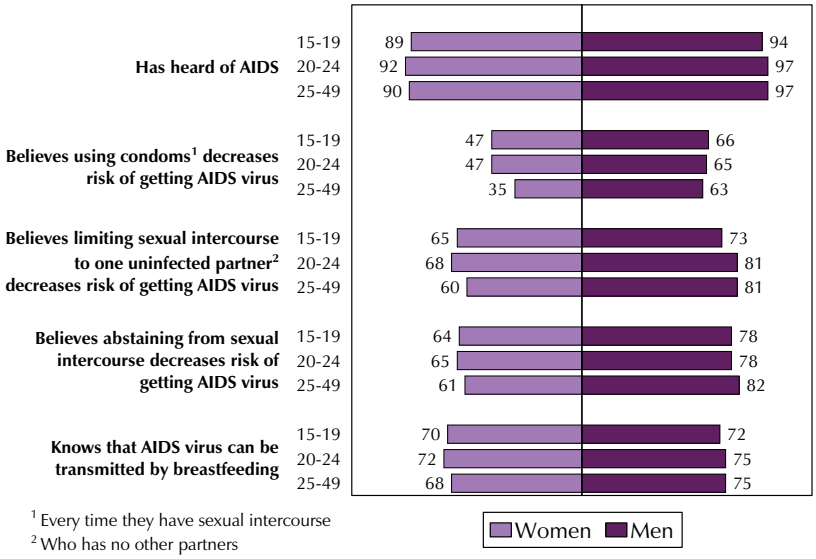
Sexually transmitted infections (STIs) are often used as a marker of unprotected sexual intercourse and as a cofactor for HIV transmission. The 2005 EDHS respondents who had ever had sexual intercourse were asked whether they had had an STI in the past 12 months. They were also asked whether, in the past year, they had experienced a genital sore or ulcer, and whether they had any genital discharge. These symptoms have been shown to be useful in identifying STIs in men. They are less easily interpreted in women because women are likely to experience more non-STI conditions of the reproductive tract that produce a discharge.

7.1 KNOWLEDGE OF HIV/AIDS AND OF TRANSMISSION AND PREVENTION METHODS

Knowledge of HIV/AIDS issues and related sexual behavior among youth age 15-24 is of particular interest because the period between sexual initiation and marriage is for many young people a time of sexual experimentation that may involve high-risk behaviors. This section considers a number of issues that relate to both transmission and prevention of HIV/AIDS among youth, including the extent to which youth have knowledge of the modes of HIV/AIDS transmission and prevention.

The vast majority of Ethiopians of reproductive age are aware of HIV/AIDS (Figure 7.1). In 2005, the percentage of respondents who had heard of AIDS is nearly 90 percent or higher for all age groups of women and men. Within each age group, men are more likely to have heard of AIDS than women. The percentage of respondents who have heard of AIDS does not vary much by age, though in general, for both men and women, respondents age 15-19 are less knowledgeable than respondents in the other two age groups.

Figure 7.1 Knowledge about HIV/AIDS among women and men by age, Ethiopia 2005



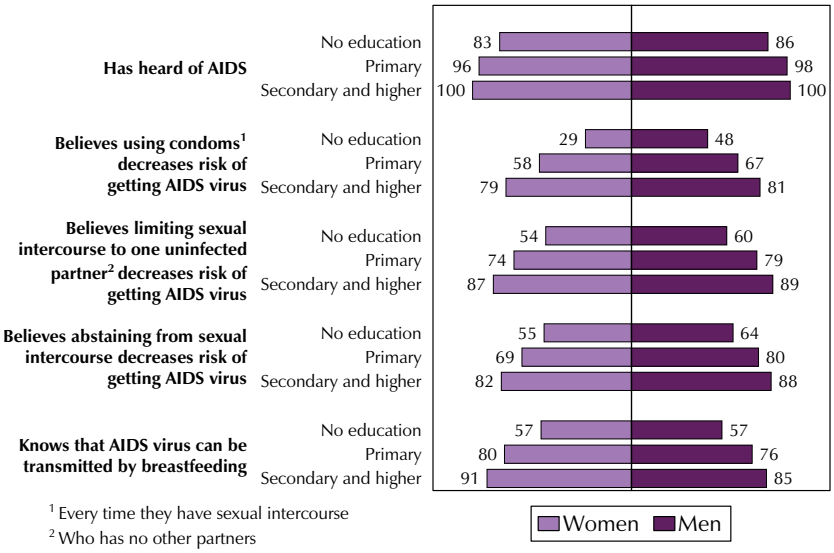
[1] Every time they have sexual intercourse
[2] Who has no other partners

Knowledge of how HIV is transmitted is crucial to enabling young people to avoid AIDS. Young people are often at greater risk because they may have shorter relationships with more partners or engage in other risky behaviors. HIV/AIDS prevention programs focus their messages and efforts on three important aspects of behavior: delaying sexual debut in young persons (abstinence), limiting the number of sexual partners/staying faithful to one partner, and use of condoms (the ABC message). To ascertain whether programs have effectively communicated these messages, EDHS respondents were prompted with specific questions about whether it is possible to reduce the chances of getting the AIDS virus by having just one faithful sexual partner, using a condom at every sexual encounter, and abstaining from sexual intercourse. Furthermore, increasing knowledge of ways in which HIV can be transmitted from mother to child is critical in reducing mother-to-child transmission (MTCT). To obtain information on these issues, respondents in the 2005 EDHS were also asked if the virus that causes AIDS can be transmitted from a mother to a child during breastfeeding.

Though the vast majority of respondents have heard of AIDS, there is room for improvement in knowledge of the means of HIV transmission and prevention, particularly among women (Figure 7.1). Only about half of young women and three-fifths of young men believe that using condoms decreases the risk of getting the AIDS virus and about three-fifths of young women and about four-fifths of young men believe that limiting sexual intercourse to one uninfected partner or abstinence can reduce the risk of getting infected with the AIDS virus. Women age 15-24 are more likely to have knowledge about the risk-reducing effect of condoms than older women. Additionally, around seven-tenths of young women and young men are aware that the virus can be transmitted from mother to child through breastfeeding (Figure 7.1). There is not much variation in HIV/AIDS-related knowledge by age among men. Among women, those age 25-49 are less likely than younger women to have knowledge of transmission and prevention methods.

Multivariate analyses reveal that the higher level of knowledge among teenagers is entirely due to the fact that they have more education than older women. As seen in Figure 7.2, women's knowledge about AIDS increases with their education. Overall, for all indicators shown in Figure 7.1, men are more knowledgeable than women, which may be a reflection of the fact that they are more educated than women. Knowledge about HIV/AIDS increases steadily with young respondents' education for all knowledge indicators (Figure 7.2). For example, 29 percent of women and 48 percent of men age 15-24 with no education believe that using condoms decreases the risk of getting infected with the AIDS virus, compared with 79 percent of young women and 81 percent of young men with secondary and higher education.

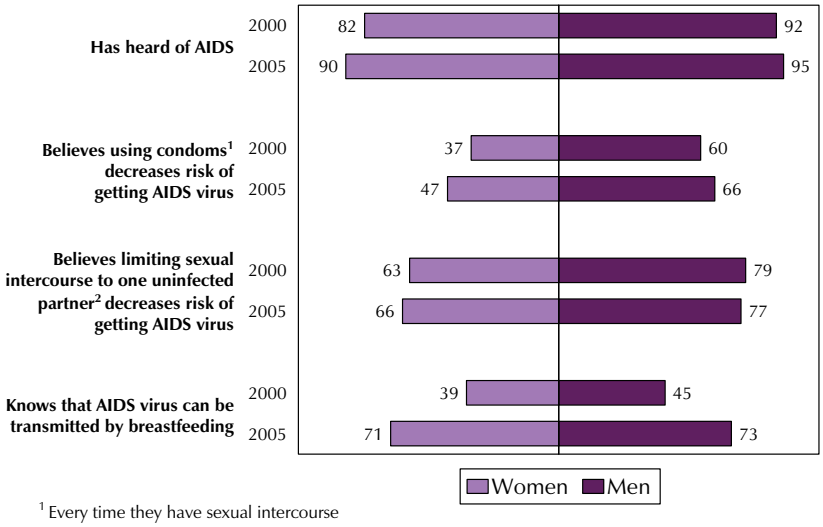
Figure 7.2 Knowledge about HIV/AIDS among women and men age 15-24 by education, Ethiopia 2005



[1] Every time they have sexual intercourse
[2] Who has no other partners

Among both women and men age 15-24, knowledge about AIDS and AIDS-related issues generally increased between 2000 and 2005 (Figure 7.3). For example, among young men, knowledge about transmission of the AIDS virus by breastfeeding increased markedly from 45 percent to 73 percent between 2000 and 2005, while among young women it increased from 39 percent to 71 percent over the same period. Among both women and men, knowledge of HIV/AIDS-related issues increased over this period for all components, except that young men in 2005 are somewhat less likely than those in 2000 to believe that the risk of getting the AIDS virus is decreased by limiting sexual intercourse to one uninfected partner.

Figure 7.3 Trends in knowledge about HIV/AIDS among women and men age 15-24, Ethiopia 2000 and 2005



[1] Every time they have sexual intercourse
[2] Who has no other partners

Figure 7.4 shows data on knowledge about AIDS among youth in the Packard and non-Packard areas in 2000 and 2005. In 2005, young Ethiopian women and men who reside in the non-Packard areas are slightly more likely than those who reside in the Packard areas to have heard of AIDS. Young men in the Packard areas are also less likely than those in the non-Packard areas to believe that using condoms decreases the risk of getting the AIDS virus, that limiting sexual intercourse to one uninfected partner decreases the risk of getting the AIDS virus, and that the AIDS virus can be transmitted by breastfeeding. In contrast, young women in the Packard areas are somewhat more likely than women in the non-Packard areas to believe that limiting sexual intercourse to one uninfected partner reduces the risk of getting the AIDS virus and that the HIV virus can be transmitted by breastfeeding. There is no difference in 2005 between the areas in the level

Figure 7.4 Knowledge about HIV/AIDS among women and men age 15-24, in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005

[1] Every time they have sexual intercourse
[2] Who has no other partners

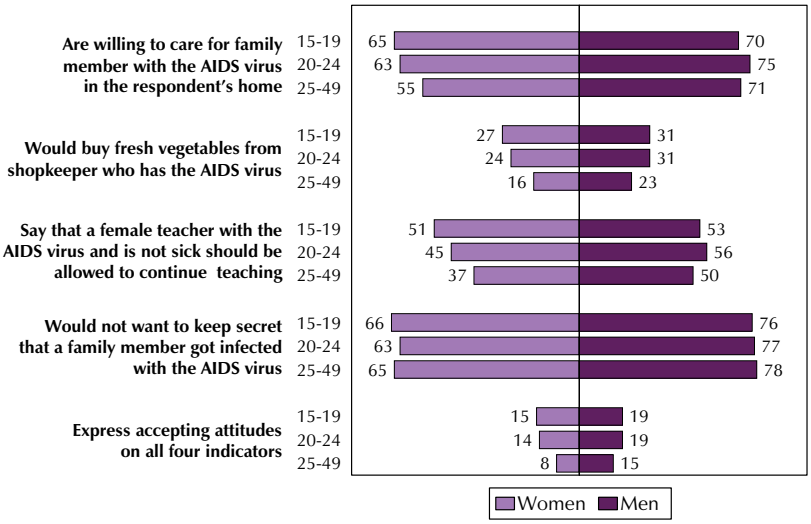
of knowledge among young women that using condoms decreases the risk of getting the AIDS virus. The data show substantial differences between 2000 and 2005, with considerable improvement in both areas for nearly all indicators for women, especially in their knowledge that AIDS can be transmitted by breastfeeding. For men, improvements in knowledge are seen in the non-Packard areas for all indicators, but the extent of positive change is smaller in the Packard areas, and for three of the four indicators, knowledge decreased between 2000 and 2005. In both areas, as for women, the greatest improvement between 2000 and 2005 is in the knowledge that AIDS can be transmitted by breastfeeding, and the least improvement is seen for knowledge that the risk of getting AIDS can be reduced by limiting sexual intercourse to one uninfected partner.

7.2 STIGMA ASSOCIATED WITH AIDS AND ATTITUDES RELATED TO HIV/AIDS

Knowledge and beliefs about AIDS affect the attitude towards people living with HIV/AIDS. In the 2005 EDHS, a number of questions were posed to respondents to measure their attitudes towards HIV-infected people including questions about their willingness to buy vegetables from an infected vegetable seller, to let others know the HIV status of family members, and to take care of relatives who have the AIDS virus in their own household. They were also asked whether an HIV-positive female teacher who is not sick should be allowed to continue teaching.

In general, youth age 15-24 exhibit more accepting attitudes towards those living with HIV than older respondents age 25-49 (Figure 7.5). For example, 27 percent of women age 15-19 and 31 percent of men of that age say that they would buy fresh vegetables from a shopkeeper who has the AIDS virus, compared with 16 percent of women and 23 percent of men age 25-49. Among women, those age 15-19 are somewhat more accepting of people living with HIV than those in their early twenties, while the opposite is true of men.

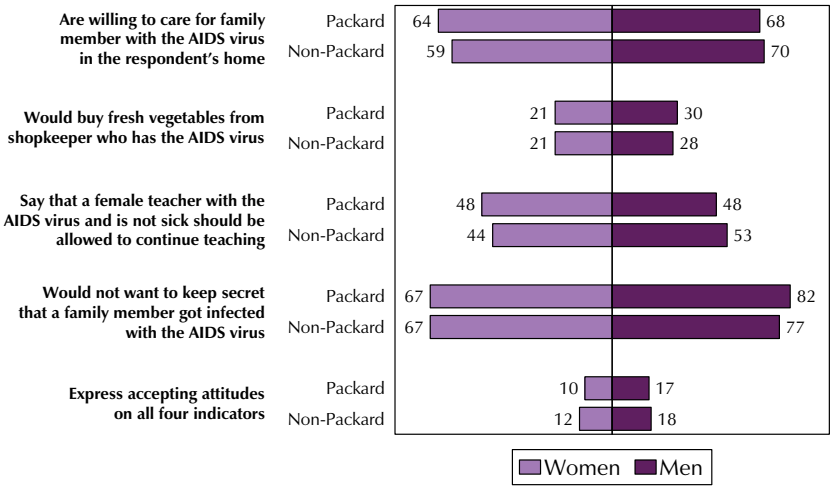
Figure 7.5 Accepting attitudes toward those living with HIV by age, Ethiopia 2005



Note: Figure is based on respondents who have heard of AIDS.

Figure 7.6 shows the accepting attitudes towards those living with HIV among youth in the Packard and non-Packard areas. Overall, there is little difference by place of residence in the proportion of young women and men expressing accepting attitudes on all four indicators; youth in the Packard areas are slightly more likely to express accepting attitudes than those in the non-Packard areas.

Figure 7.6 Accepting attitudes toward those living with HIV among women and men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2005



Note: Figure is based on respondents who have heard of AIDS.

7.3 Multiple Sexual Partners and Higher-Risk Sex

Given that most HIV infections in Ethiopia are contracted through heterosexual contact, information on sexual behavior is important in designing and monitoring intervention programs to control the spread of the epidemic. In the context of HIV/AIDS prevention, limiting the number of sexual partners and having protected sexual intercourse are crucial to combating the epidemic.

The 2005 EDHS included questions on respondent's sexual partners during the 12 months preceding the survey. Information was collected from both women and men on the use of condoms at last sexual encounter with each type of partner. Sexually active women and men were also asked about the total number of partners they had during their lifetime. In interpreting the results in this section it is important to remember that respondents' answers may be subject to some reporting bias because of the sensitive and highly personal nature of these questions.

Table 7.1 presents several indicators based on information collected from women and men who ever had sexual intercourse about their sexual partners during the 12-month period before the survey and over their lifetime. The first two indicators in the tables assess the prevalence of multiple partners and of higher-risk sexual intercourse among women and men who reported having sexual intercourse during the 12 months prior to the survey. Higher-risk sex involves sexual intercourse with someone who is neither a spouse nor a cohabiting partner. The third indicator relates to condom use during the last higher-risk sexual encounter. The mean number of sexual partners that a woman or man has had during their lifetime provides an assessment of lifetime exposure to higher-risk sex.

Table 7.1 Multiple sexual partners and higher-risk sexual intercourse in the past 12 months

Among respondents age 15-49 who had sexual intercourse in the past 12 months, the percentage who had intercourse with more than one partner and the percentage who had higher-risk sexual intercourse in the past 12 months, and among those having higher-risk intercourse in the past 12 months, the percentage reporting that a condom was used at last higher-risk intercourse, and for respondents who ever had sexual intercourse the mean number of sexual partners in lifetime, by age groups, Ethiopia 2005

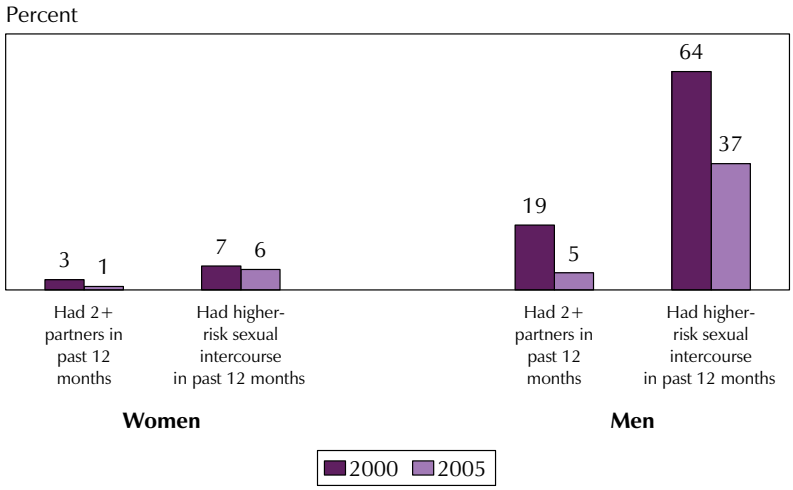
	Respondents who had sexual intercourse in past 12 months			Respondents who had higher-risk intercourse in the past 12 months		Respondents who ever had sexual intercourse	
Age	Percentage who had 2+ partners in past 12 months	Percentage who had higher-risk intercourse[1] in past 12 months	Number of respondents	Percentage who reported using a condom at last higher-risk intercourse[1]	Number of respondents	Mean number of sexual partners in lifetime	Number of respondents
WOMEN							
15-24	0.5	5.8	1,212	28.4	71	1.2	1,360
15-19	0.4	7.2	411	27.1	29	1.2	469
20-24	0.6	5.1	800	29.3	41	1.3	891
25-49	0.1	1.5	3,142	16.5	48	1.5	3,746
MEN							
15-24	4.8	37.4	446	50.2	167	2.0	561
15-19	3.9	68.0	78	44.0	53	2.0	96
20-24	5.0	31.0	368	53.1	114	2.0	465
25-49	4.0	3.6	2,675	54.8	97	2.9	2,857

[1] Sexual intercourse with a partner who is neither a spouse nor who lived with the respondent

Prevalence of multiple partners is low in 2005. Among respondents who had sexual intercourse in the 12 months preceding the survey, less than 1 percent of women and 4-5 percent of men had two or more sexual partners. For both men and women, the percentage is highest among respondents age 20-24. A higher proportion of respondents engage in higher-risk sexual intercourse when compared with the proportion with multiple partners during the preceding 12 months, especially for men. For both men and women, the percentage who had higher-risk sexual intercourse decreases markedly with age; among women it decreases from 7 percent among teenagers to 2 percent among those age 25-49, while among men it decreases from 68 percent among teenagers to 4 percent among those age 25-49. The high proportion of teenage men who are engaged in higher-risk sexual intercourse may be explained by the fact that very few young men are married or cohabiting at this age. Table 7.1 also shows that less than three-tenths of young women and half of young men reported using a condom the last time they had higher-risk sexual intercourse. Among women, condom use at last higher-risk sexual encounter generally decreases with age, while for men it generally increases. The mean number of lifetime sexual partners is higher among men than among women (by about 1 partner). As expected, older respondents age 25-49 report a higher number of lifetime sexual partners than those age 15-24.

The percentage of both women and men age 15-24 who had more than one partner and the percentage who had higher-risk sexual intercourse decreased substantially between 2000 and 2005 (Figure 7.7). The change is greater among young men than among young women. For example, in 2000, nearly two-thirds (64 percent) of men age 15-24 had higher-risk sexual intercourse compared with three eighths (37 percent) in 2005. These figures show that there has been considerable movement towards safer sexual practices among youth between 2000 and 2005, but there is still room for more improvement.

Figure 7.7 Trends in multiple sexual partners and higher-risk sexual intercourse in the past 12 months among sexually active women and men age 15-24, Ethiopia 2000 and 2005



Figures 7.8 and 7.9 show the changes between 2000 and 2005 in the above indicators among youth in the Packard and non-Packard areas. The percentage of both young women and young men who had more than one partner decreased substantially over this period in both areas. Among young women, the change is larger among those in the Packard areas, while among young men it is more pronounced among those in the non-Packard areas. The percentage of young women who had higher-risk sexual intercourse in the 12 months before the survey decreased considerably between 2000 and 2005 for those in the Packard areas, while it increased slightly among young women in the non-Packard areas. Among young men, the percentage who had higher-risk sexual intercourse decreased noticeably between the two surveys, with the rate of decrease being somewhat higher among young men in the non-Packard areas.

Figure 7.8 Multiple sexual partners and higher-risk sexual intercourse in the past 12 months among sexually active women age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005

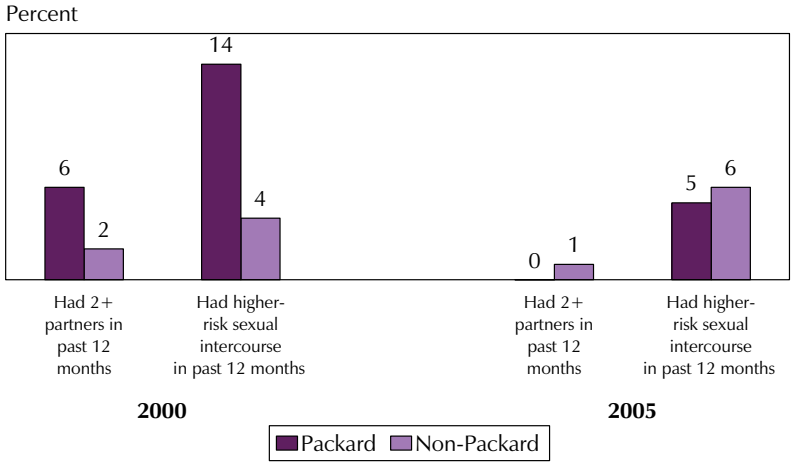
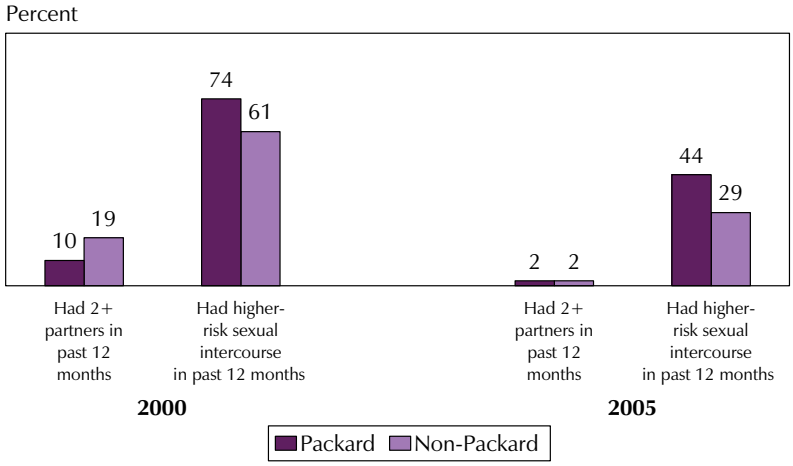


Figure 7.9 Multiple sexual partners and higher-risk sexual intercourse in the past 12 months among sexually active men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



7.4 TESTING FOR HIV

Young people may believe there are barriers to accessing and using many health services and facilities, particularly for sensitive concerns relating to sexual health, such as sexually transmitted infections like HIV/AIDS. Knowledge of HIV status helps HIV-negative individuals make specific decisions to reduce risk and increase safer sexual practices so they can remain disease free. For those who are HIV infected, knowledge of their status allows them to take action to protect their sexual partners, to access treatment, and to plan for the future. Testing of pregnant women is especially important so action can be taken to prevent mother-to-child transmission. To obtain information on the prevalence of HIV testing, all respondents were asked whether they had ever been tested for HIV. If they said that they had, they were asked whether they had received the results of their last test.

Table 7.2 shows that the vast majority of Ethiopians, more than nine in ten, have never been tested for HIV. The proportion of young women age 15-24 who have been tested and who have received results form an HIV test taken in the previous year is somewhat higher than that for older women age 25-49. For both men and women, those age 20-24 are the most likely to have been tested and the most likely to have received results.

Slightly higher proportions of youth from the Packard areas have received results for an HIV test taken in the 12 months before the survey than those in the non-Packard areas.

Table 7.2 Coverage of prior HIV testing

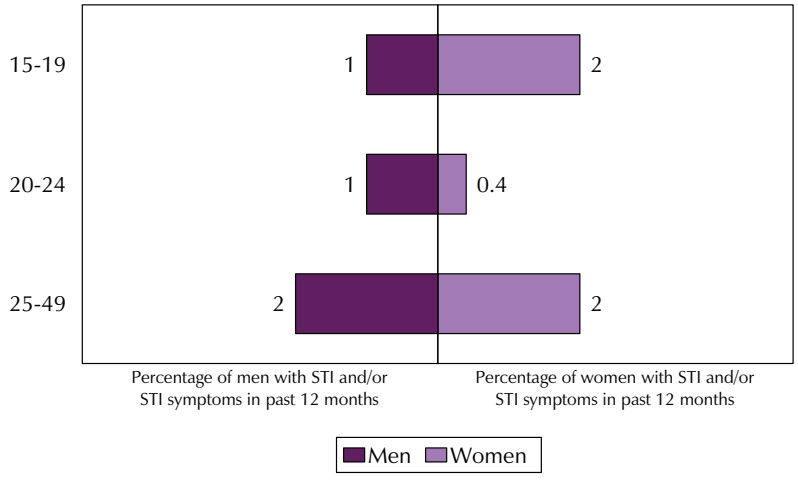
Percent distribution of respondents by whether tested for HIV and by whether received the results of the test, and the percentage of respondents who received their test results the last time they were tested for HIV in the past 12 months, according to age group and for Packard and Non-Packard areas, Ethiopia 2005

Age group	Ever tested: Received results	Ever tested: No results	Ever tested: Don't know/ missing whether received results	Never tested, don't know, missing	Total	Percentage who received results from HIV test taken in past 12 months	Number of respondents
WOMEN							
15-24	4.9	0.2	0.5	94.3	100.0	2.9	2,872
15-19	3.6	0.4	0.5	95.5	100.0	2.4	1,645
20-24	6.7	0.0	0.6	92.7	100.0	3.6	1,228
25-49	2.9	0.1	0.5	96.5	100.0	1.1	3,879
MEN							
15-24	4.7	0.3	0.1	94.8	100.0	2.6	2,399
15-19	2.0	0.0	0.2	97.7	100.0	1.5	1,335
20-24	8.1	0.7	0.0	91.2	100.0	4.0	1,064
25-49	5.1	0.6	0.0	94.2	100.0	2.0	3,064
PACKARD (All respondents)							
15-24	3.7	0.0	0.5	95.8	100.0	3.7	363
NON-PACKARD (All respondents)							
15-24	3.4	0.2	0.5	95.9	100.0	1.7	1,339

7.5 REPORTS OF RECENT SEXUALLY TRANSMITTED INFECTIONS

Only a small proportion of women and men (1-2 percent) reported having had an STI or STI symptoms in the 12 months preceding the 2005 EDHS (Figure 7.10).

Figure 7.10 Self-reported prevalence of STIs and/or STI symptoms by age, Ethiopia 2005

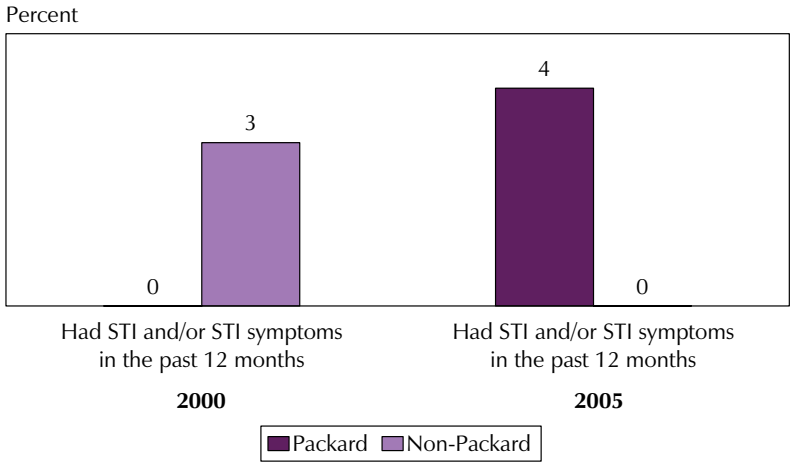


Note: Figure is based on respondents who have ever had sexual intercourse.

The prevalence of STIs among young men decreased somewhat from 3 percent to 1 percent between 2000 and 2005. Female respondents were not asked questions concerning prevalence of STIs and/or STI symptoms in the 2000 EDHS; hence, an analysis of trends is not possible for young women.

Figure 7.11 shows the self-reported prevalence of STIs and/or STI symptoms among young men in the Packard and non-Packard areas in 2000 and 2005. In 2000, a higher proportion of young men in the non-Packard areas reported an STI and/or symptoms compared with young men in the Packard areas (3 percent compared with close to 0 percent). The reverse is true in 2005; a higher proportion of young men in the Packard areas reported an STI and/or STI symptoms compared with young men in the non-Packard areas (4 percent versus close to 0 percent).

Figure 7.11 Self-reported prevalence of STIs and/or STI symptoms among men age 15-24 in Packard and non-Packard areas, Amhara and Oromiya 2000 and 2005



Note: Figure is based on men who have ever had sexual intercourse.

Chapter 8

Programmatic Implications

PROGRAMMATIC IMPLICATIONS AND POLICY RECOMMENDATIONS

There are many intervention programs targeting adolescents and youth in Ethiopia and they are bringing improvements to the overall health and well-being of Ethiopian youth. Today, youth are better educated than in the past. They are waiting longer to begin sexual activity, and they are more knowledgeable about contraception. The number of children young people in Ethiopia consider ideal is much smaller than the number considered ideal by older Ethiopians. Along with smaller desired family size and greater knowledge of contraception, young people are waiting longer to initiate sexual activity and to enter into marriage; and when they do, they are more likely to use a contraceptive method.

Nonetheless, there remains substantial room for improvement and Ethiopian youth face many challenges. The 2002 Packard report on youth reproductive health in Ethiopia identified key areas in which the policies and programs dealing with the health and well-being of youth need to be addressed. The current Packard study, which focuses on the trends in youth reproductive health in Ethiopia between 2000 and 2005, builds on the 2002 recommendations by examining the key areas from the perspective of the new survey data.

Improving education, exposure to mass media, and employment opportunities for youth

The 2005 EDHS found that nearly half of young women age 15-24 have no education and about six in ten are illiterate. Young women with little or no education and those in rural areas are much less likely to know about contraception or to use contraceptive methods. They are also less likely to obtain good medical care for themselves or their children. These young women tend to have more children than other women their age.

The educational status of youth has improved over the past five years, but programs targeting youth need to continue efforts to increase education levels. Education has a direct impact on knowledge and behavior and there is a positive correlation between level of education and improvements in the health and well-being of youth. Knowledge of contraception increases with level of education, increasing the likelihood that they will use contraception when they become sexually active. Better educated youth have more employment opportunities available to them, and better employment opportunities lead to improved socioeconomic status, especially among young women.

The education programs targeting youth should be tailored to meet their needs. This means giving them the tools to adequately prepare for being successful in life, both socially and professionally. In-school and out-of-school education and cultural programs should cooperate to attract more youth. They should continue using entertainment and youth-to-youth counseling approaches to reach the target audiences, as well as expand the quality of and access to these programs; young women in rural areas and their children, if any, are of particular concern. Finally, the content of formal education should continue to include socially sensitive topics such as sex education, reproductive health, family planning, higher-risk sexual behaviors, and HIV/AIDS and other STIs.

The data from the 2000 and 2005 EDHS surveys indicate that youth in Ethiopia are more exposed to mass media than older people and that over time this exposure has been increasing. However, in 2005, a large majority of youth age 15-24 still did not have access to any form of mass media on a weekly basis, especially in the rural areas. The radio continues to be the most important source of information for most youth, particularly in rural areas, while television is more popular among youth in urban areas. On the other hand, in

2005, relatively large proportions of youth—over half of all women and men age 15-24—had been exposed to a family planning message in the 12 months preceding the survey. Young women are most likely to receive these messages at community events while young men are most likely to receive them over the radio. Mass media provide an important educational and sensitization tool, especially for purposes of reaching large numbers of youth in different parts of the country. Youth reproductive health programs should analyze their target audiences and identify the media venues most commonly used by them. They should then design programs that make use of these venues, thereby reaching the largest number of youth in the most efficient way. The content of the media messages should be tailored specifically to address the needs of youth and should encourage them to acquire health and other information that will contribute to healthy attitudes and behaviors. Youth-to-youth counseling and peer education are important when addressing sensitive topics such as sex education and HIV/AIDS and other STIs.

As mentioned earlier, rapid population growth in Ethiopia has posed a challenge to the government in its effort to create employment opportunities for youth. More than half of the 1.8 million unemployed people in Ethiopia are youth (CSA, 2006), and the 2005 EDHS survey data show that young women are less likely to be employed than young men. Seven in ten young men were employed at the time of the 2005 EDHS, but only about three in ten young women were. Both young women and young men are less likely to be employed than their older counterparts. Therefore, unemployment is a major problem among youth, especially urban youth. Providing employment opportunities for youth, particularly those who drop out of school at an early age is, and should remain, a key component of the reproductive health programs addressing youth. Vocational training and programs to create marketable skills should be implemented through the formal educational system, along with on-the-job training in cooperation with various employers.

Continue to improve reproductive health services and contraception knowledge and use

In 2005, over three-quarters of all sexually experienced women age 15-24 had never used family planning. Youth with little or no education, and those in rural areas, were much less likely to know about contraception or to have used a contraceptive method than other youth. Nevertheless, there was an overall improvement in these indicators between 2000 and 2005; for example, among sexually experienced youth, the percentage using a method of contraception at the time of the survey doubled between 2000 and 2005. The increase in knowledge and use of contraception was often largest among those who were least educated and those living in rural areas (because they started at a lower base), thus narrowing somewhat the educational and urban-rural differentials. Despite these improvements, there continue to be substantial differentials. Uneducated women and women in rural areas merit particular attention.

Improving access to and quality of reproductive health services should remain a key focus of youth programs. Cultural and gender barriers continue to pose difficulties for such programs. Youth have less access to reproductive health education and services compared with older people because the health system is designed to accommodate the needs of the older population.

Marriage and childbearing start early in Ethiopia and societal norms encourage young women to marry and have children. Hence, the health system and health providers should develop programs that will work toward improving the reproductive health of youth. Health care providers need to be educated and trained to deal effectively (and sensitively) with the special needs of youth regardless of gender or marital status. At the same time, reproductive health programs need to increase youth access to information about

family planning, thereby generating grassroots demand for improved contraceptive services for young people. Special attention should be given to young women at risk and to rural women by encouraging and facilitating improvements in the accessibility and quality of both family planning services and maternity care services.

Reduce or eliminate certain practices such as early sexual initiation and early marriage and childbearing

Sexual initiation typically occurs at an early age for young women in Ethiopia, and usually in the context of marriage. Premarital sex, which increases exposure to sexually transmitted infections, is relatively more common among urban women than rural women, and more common among young men than young women.

While there was a decrease in the percentage of young women who had [ever] married between 2000 and 2005 (at all ages except age 22), overall, women in Ethiopia continue to marry at a very young age. Early marriage often reflects traditional practices, but may also result from poor economic status. Childbearing usually begins shortly after marriage. By the end of her reproductive years, a woman has had an average of six children. At this rate, young adults will have nearly two children by age 24. While pregnancy-related complications occur more frequently among young women, utilization of basic maternal health services is low in Ethiopia, with most women not having access to trained health professionals during pregnancy, at delivery, or during the postpartum period.

These, and other traditional practices such as marriage by abduction and female genital cutting, are harmful to the health and well-being of young people. Lack of education and living in a rural area are risk factors associated with these practices. For example, the percentage of women age 15-24 with no education who were mothers at the time of the survey increased from 45 percent in 2000 to 55 percent in 2005, while the percentage with secondary education decreased from 20 percent to 14 percent over the period. Among young women, unmet need for family planning to limit births increased slightly between 2000 and 2005, reflecting an increase in the proportion of women who want no more children. And, in 2005, unmet need for family planning was nearly three times greater for women in rural areas than for those in urban areas.

The impact of education and residence should be taken into consideration when designing programs to improve youth reproductive health. Such programs need to be specific in context and design so that they are responsive to the special situations and problems faced by youth. They need to consider the varying needs of educated and uneducated women, as well as those of women living in urban and rural areas. All young women should be empowered through better education and increased employment opportunity to make informed decisions about their lives, decisions not dictated by perceived gender roles or socioeconomic status.

Continue information, education, and counseling on HIV/AIDS and other STIs

Ethiopian youth are increasingly faced with problems related to HIV/AIDS and other sexually transmitted infections. Results from the 2005 EDHS indicate that 1.4 percent of Ethiopian adults age 15-49 are infected with HIV. Data show that the number of women age 15-19 who tested positive for HIV is much higher than the number of males in the same age group. This discrepancy is attributed to the earlier age at marriage among women and sexual intercourse between young women and older men (CSA and ORC Macro, 2006). Data from 82 sentinel sites in Ethiopia (MOH, 2006) show that among pregnant women, the highest prevalence of HIV in 2005 was among young women age 15-24 (5.6 percent). However, the 2005 EDHS data

show that the vast majority of Ethiopians, more than nine in ten, have never been tested for HIV. The most likely to have been tested (and received the results) are men and women age 20-24.

The 2005 EDHS data show that, while almost all youth have heard of HIV/AIDS, knowledge about the ways in which HIV is transmitted is far from universal. Overall, young men are more knowledgeable about HIV/AIDS than young women. This is particularly the case in terms of knowing that the risk of transmission can be reduced by using condoms and by limiting sexual activity to one uninfected partner. Sexually transmitted infections pose considerable risk to the youth population because of the practice of having multiple partners and the limited use of condoms. It is important to note, however, that between 2000 and 2005, the proportion of youth who had more than one partner and the percentage who had higher-risk sex decreased markedly. Nonetheless, teenage men in Ethiopia who have sexual experience are likely to engage in higher-risk sex.

The survey data on contraceptive knowledge, attitudes, and behavior indicate there is a continued need for reproductive health programs to educate youth (especially young women) about ways to avoid HIV and other STIs, and the risk factors associated with these infections. Peer education and youth-to-youth counseling, community events, and entertainment can all be effective in educating youth about sex, reproductive health, and how to protect themselves against HIV/AIDS.

More needs to be done to strengthen the capacity of the health sector to educate youth and deliver HIV-related services such as voluntary counseling and testing (VCT). It is also important to increase the capacity of other sectors, particularly the wider civil society, to incorporate HIV/AIDS into core activities (UNAIDS, 2007).

In conclusion, programs targeting youth can increase their impact by utilizing the most popular youth venues to reach the wider youth population with reproductive health messages. Program planners need to design programs that take into consideration the characteristics and needs of youth populations. They need to pay special attention to the specific circumstances of young people in local settings—particularly, vulnerable, hard-to-reach sub-groups of adolescents, including girls (Erulkar et al., 2006). In this way, youth programs can focus their activities and messages, and address the reproductive needs of youth throughout the country. Youth programs should also continue to employ a multi-sectoral approach in addressing youth issues.

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