Research Report

Sexual and Reproductive Health and Inequalities in Ethiopia: Insights from Young Lives Longitudinal Research

Alula Pankhurst and Patricia Espinoza

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Young Lives

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Summary

This report summarises key findings from 27 Young Lives publications on sexual and reproductive health (SRH) across five themes: female genital mutilation/cutting (FGM/C); marriage and cohabitation; contraception knowledge and use; pregnancy, childbirth, and parenting; and SRH services. It also presents new survey and qualitative analysis focusing on inequalities based on gender, generation, age and cohorts, family composition, household circumstances, personal characteristics, marital status and residence.

The report demonstrates that gender differences and inequalities are regulated by patriarchal norms which become accentuated through adolescence; young women have far higher rates of child marriage and fertility, and face risks of forced marriage and abduction. Young women have less knowledge about fertility than young men. Unmarried girls have limited access to contraception and face serious risks due to unplanned pregnancies, notably potentially unsafe abortion, and are pressured into cohabitation or early marriage, or face the challenges of single motherhood.

Gendered inequalities interact with, and are accentuated by, other differentials. These include age, with teenage girls having far less agency, education and work for pay. The latter two are preventive and predictive, respectively, of teen marriage and parenthood. These in turn interact with family composition, including having protective sisters, and poverty and household shocks that are predictive of child marriage and parenting. Inequalities based on gender, age, and household circumstances are exacerbated by rurality, and also affected by regional, community and cultural differences.

Despite the persistence of prevailing patriarchal norms, there has been significant change. FGM/C and abductions have decreased, while access to contraception and institutional delivery have improved. There are lower rates of child, early and forced marriage (CEFM) and fertility among girls compared to their mothers, and the Younger Cohort compared to the Older Cohort. Although these changes are grounds for optimism, patriarchal values remain strongly entrenched, with significant urban/rural and regional differences, and family circumstances continue to disadvantage girls from poorer households, and families having faced shocks.

The findings have important policy implications regarding girls' education and work, suggesting the need for better social protection, particularly for poor and vulnerable households and those most at risk, such as teenage and less-educated mothers, who were more likely to have undernourished infants. Gendered differences in knowledge about SRH and access to contraception suggest a need for better information and awareness raising campaigns, involving health extension workers, in schools and through the media.

Improvements in the quality of services are required, including contraception access, safe abortion, delivery, and childcare, especially for categories at risk, notably unmarried adolescents and single mothers. Pervasive patriarchal norms need challenging, especially around customs including FGM/C, child marriage and marital payments, and gender-based violence. Improvements in gender relations and more equal decision making in marital affairs need promoting, particularly over the sexual division of labour and childcare (including when marriages break up), in order to ensure that mothers obtain child support.

1. Introduction

This Young Lives report has been produced to understand health equity gaps in sexual and reproductive health (SRH) and contribute to the National Health Equity Strategy Plan launched by the Ethiopian Federal Ministry of Health in 2021.[1] Young Lives is an international longitudinal study of childhood poverty carried out in four countries: Ethiopia, India, Peru and Vietnam. The study, which is run by the University of Oxford with core funding from the UK's Foreign, Commonwealth & Development Office (FCDO), has followed 12,000 children for over 20 years. In each country, 2,000 children have been tracked from birth to early adulthood (the Younger Cohort), along with of 1,000 children who are seven years older (the Older Cohort). The research has documented and analysed inequalities based on gender, location, family circumstances, education, work, wealth, and marital and other statuses.

1.1. Young Lives research in Ethiopia

In Ethiopia, Young Lives research has been carried out in 20 sites in five regions, including urban and rural communities, with a pro-poor focus in the site selection. The research follows a mixed methods approach. Five surveys have been carried out since 2002 at the community, household and individual levels, followed by five phone surveys in 2020 and 2021 focusing on the effects of COVID-19 and other shocks, including conflict and climate change. In addition, five qualitative waves have been carried out since 2007 with 60 children, caregivers and community respondents in five sites in different regions: Addis Ababa, Amhara, Oromia, Southern Nations, Nationalities and Peoples (SNNP) and Tigray. The last of these, funded by UNICEF in 2019, was carried out in ten sites in five regions. Young Lives has also carried out ten sub-studies on specific policy-related issues, including health care financing, food security and safety nets, orphans and vulnerable children, child work and labour, early learning, child marriage, cohabitation and parenting, violence affecting children and young people, and urban relocation.

Ethical clearance for all the surveys was obtained from the institutional review boards of the University of Oxford and from the Addis Ababa University's College of Health Sciences. In addition, for the fifth qualitative wave and sub-studies, ethical approval was received from the institutional review board of the Ethiopian Society of Sociologists, Social Workers, and Anthropologists (ESSSWA). All the respondents completed consent forms and caregivers filled in forms for minors.

1.2. Scope and outputs

Young Lives has looked at all aspects of children's lives as they transition to adulthood, so far without a specific focus on sexual and reproductive health (SRH). This report summarises Young Lives evidence on SRH and inequalities, reviewing the publications produced by Young Lives over the years and carrying out further analysis of recent qualitative and quantitative data.

This report comprises three main sections. The first reviews 27 Young Lives publications across five SRH themes: female genital mutilation/cutting (FGM/C); marriage and cohabitation; contraception knowledge and use; pregnancy, childbirth, and parenting; and SRH services.[2]

1 A longer version of this report, including more case material and details of the reviewed literature and longitudinal SRH case studies, is available on request.

2 See Annex for details of these publications by type, data source and theme.

The second section summarises new analysis comparing survey data from several survey rounds and the phone call survey in 2021 to address issues relating to the five themes, while the qualitative component analyses the fifth qualitative wave (2019) data on specific topics with reference to six longitudinal case studies. The third section presents the findings by types of inequalities, including gender, generation, cohorts and age, location, personal and household characteristics, poverty/wealth, and household shocks. Inequalities are considered largely in relative terms, for example, comparing boys and girls, generations, mothers and daughters, differences between the two cohorts, between urban and rural and different regions, and between poorer and richer households. This is followed by an analysis of gender and intersectionality of different types of inequalities and a discussion of recent changes. The conclusion summarises key findings and outlines policy implications and further research priorities.

This report will be followed by a policy brief highlighting the implications of the findings and providing recommendations that can be useful for the Ethiopian Ministry of Health and other stakeholders in improving the design and implementation of SRH policies and programmes, including the National Health Equity Strategic Plan, in order to take account of inequalities and promote better inclusion.

2. Thematic issues from the literature review

Twenty-seven Young Lives publications with relevant findings on SRH have been produced since 2010, including 11 since 2020: they comprise 12 working papers, seven policy briefs, six journal articles and two research reports. These were analysed in terms of five selected themes.

2.1. Female genital mutilation/cutting (FGM/C)

> *… the community believes that if girls are not circumcised, they may face challenges in their sexual life and … have complications during delivery … Some parents circumcise because it is simply a tradition that a girl should not miss … Those who do not circumcise their daughters don't feel comfortable because they think that their daughter has missed something important.*
>
> Focus group of caregivers in Amhara site, quoted in Boyden (2012)

FGM/C was found to be an expression of patriarchal norms about sexuality and marriage, justified through cultural values and sometimes religious beliefs. Knowledge about the government ban and rationale for ending the practice was widespread, and many within communities had done so. However, some respondents, including adolescent girls, believed that it was benign or even useful in protecting girls' honour, reducing risks of pre- and extra-marital sex, and a natural and necessary part of transitioning to marriage and adulthood. So long as the practice continues to have social power, social concerns were often considered to outweigh health risks, which have sometimes been exaggerated, or risk of punishment. In some societies, adolescent girls may wish to be cut, often due to peer pressure. In one site in Oromia, 35 girls organised their own circumcision ceremony, allegedly in defiance of their parents, though perhaps also to avoid legal action against them.

FGM/C was declining, due to a combination of a favourable legal framework, political will, sanctions and threats, and interventions by the government with support from international organisations, NGOs, and the media, as well as broader processes of modernisation, including urbanisation, education and migration. However, attempts to enforce the prohibition have often resulted in divided communities, discrimination and unintended consequences, with the practice pushed underground. Sometimes this has increased risks for girls and some communities have transformed rather than abandoned the practice. Clandestine practices included carrying out the cutting when girls are younger than is customary, camouflaging it as a circumcision of boys (considered acceptable), and performing the operation at night, in the bush or remote places, increasing risks (Pankhurst 2014).

There were important cultural differences within Ethiopia between the north (Amhara and Tigray regions), and elsewhere in the *timing* of FGM/C. In the north, it was practiced soon after birth and girls have no recollection of this, whereas in many other parts of the country it was carried out in their early teens, often considered as a necessary prelude to marriage. There were also significant differences in the *type* of FGM/C, with a small cut more common in the north, excision more common in the south and west, notably in Oromia, and infibulation in the east among the agro-pastoral Afar and Somali (EGLDAM 2008).

In Young Lives sites, the practice was found to be much less common in urban than rural areas. FGM/C was prevalent in the Oromia sites, where adolescent girls were among those wanting to be cut. The practice had been abandoned in the Tigray sites, continued to some degree in Amhara sites, and modified to a minor cut or token incision by some in urban sites in SNNP and Addis Ababa.

2.2. Child, early and forced marriage (CEFM)

> *In rural areas, if a girl is asked for in marriage but she or her family rejects it, she will be in trouble. It becomes worse for girls such as Haymanot who usually spend the day outside their house and work with men and women. Some people may create problems … It is safer for a girl in this community to get married a soon as possible, because I always worry about what if my daughter is raped and brings me a child from an unknown person, or that she might be beaten by a man whose marriage proposal is rejected.*
>
> Mother of Haymanot, from Zeytuni in Tigray, quoted in Chuta and Morrow (2015:14)

Young Lives has 17 publications on CEFM,[3] improving understanding of different forms of marriage and cohabitation and their links with SRH, coercion and consent. The research identified factors that are predictive of, and protective against, teenage marriage, and the longer-term consequences and effects of child and early marriage. There are important findings on inequalities based on gender, age, education, location, poverty, shocks, and marital status. The research shows how disparities interact to exacerbate inequalities, and how these can develop and increase over children's life courses, as they move from early childhood to young adulthood.

Table 1: Prevalence of marriage among the Older Cohort at age 22 (2016)

	Female	%	Male	%	Total	%
Never married or cohabiting	246	68.0	383	93.2	629	81.4
Married or cohabiting	116	32.0	28	6.8	144	18.6
Married/cohabiting by age 18	55	15.2	11	2.7	66	8.6
Married/cohabiting after age 18	61	16.9	17	4.1	78	10.0
Sample size	362		411		773	

Source: Round 5 survey factsheet (Woldehanna, Araya and Pankhurst 2018).

In terms of prevalence, the proportion of the Older Cohort who were married or cohabiting tripled in four years, from 6 per cent at age 19 to 18 per cent by age 22 (Table 1). The gender differences were stark. The proportion of married/cohabiting women increased from 13 per cent at age 19 to 32 per cent at age 22; in contrast, the proportion of married/cohabiting young men only increased from 0.6 per cent at age 19, to 16.8 per cent by age 22.

The *factors* predisposing girls to get married in their teens included involvement in paid work, and the death or illness of parents, especially the breadwinning father (Pankhurst, Tiumelissan, and Chuta 2016). Paid work was associated with teen marriage at age 12 and found to be predictive from age 15 (Pesando and Abufhele 2018). Marriage was seen by some as a means of escaping the burdens of working for their family or paid work (Pankhurst 2020).

Among the protective factors were remaining in school, having better educated parents, and having sisters. Girls who were still at school in their early teens were far less likely to be married in their late teens. Teen marriage was less likely for girls who have sisters, especially older sisters; girls who had only brothers were more likely to be married by 19 (Pesando and Abufhele 2018).

3 The term 'child early and forced marriage' (CEFM) is used in the literature by networks such as Girls not Brides, NGOs such as Care, advocacy groups such as Parliamentarians for Global Action, and UN Women, UNICEF and UNFPA, and the Office for the Commissioner for Human Rights, with four UN general assembly resolutions from 2014 to 2018. Child marriage, including teen or adolescent marriage, refers to children married prior to the legal age of 18. However, marriage of young people above 18 also involves serious risks. Teen marriage includes 19-year-olds, and the Young Lives Round 6 survey took place when the Older Cohort was 19. Including forced marriage in the analysis is also important in a context of arranged marriages often without the spouse's consent, especially the bride. Young Lives has also documented changes in the extent and types of forced marriage.

While girls are generally consulted and sometimes able to reject suitors, almost 40 per cent of teenage girls still stated they had no say in selecting their husband (Briones and Porter 2019). Those who knew their partners longer were more likely to make the decision themselves, though decision making was often complex and girls seem to have more agency than is often assumed (Pankhurst, Tiumelissan, and Chuta 2016). Marriage can offer an escape route for girls engaged in hard labour who would rather be housewives. By their late teens, many girls and boys desired independence from their families: girls through marriage and boys through employment and work (Tafere et al. 2020).

Despite an apparent increase in adolescents' agency, customary and patriarchal norms still tended to regulate marriage processes and practices, especially in *rural* areas, constraining girls' and young women's choices. Given the centrality of marriage and motherhood to womanhood, parents were sometimes complicit in entrapping girls into marrying against their will, or young people were pushed into relationships due to pressurising circumstances, such as a family health, economic or social shock, or in response to an unintended pregnancy (Tafere et al. 2020). Girls who rated themselves poorly as students, had fallen behind with their studies, or left school early often saw marriage as the obvious alternative option. It was also difficult for adolescent girls who had already left school to resist family pressure to get married, which was seen as the logical next step in their social maturity and in securing a livelihood.

Regarding the *consequences* of early marriage, women who were married early were less educated and generally interrupted their studies. Fewer than 30 per cent had obtained their secondary certificate by age 22 (Briones and Porter 2019), limiting their formal employment prospects. Young wives were also less likely to be working outside the home (56 per cent, versus 83 per cent of males) (Pankhurst et al. 2018). Women who were married, cohabiting or pregnant in their teens scored lower in tests on agency and life satisfaction, and were less able to make decisions around buying assets. Women who had married, given birth, or were pregnant by age 19 had a higher probability of neither studying nor working by age 22 (Briones and Porter 2019).

Despite widespread assumptions about greater gender equality, patriarchal norms continue to bear heavily on household roles, in relations between young couples and decision making within marriage. Inequalities in marriage relate to the division of labour, with wives responsible for domestic work and childcare having given up paid work, though many hoped to go back to work when their children were no longer infants.

Young wives were generally subordinate to their husbands, including in matters relating to fertility, with husbands often making decisions on contraceptive use, abortion, and child spacing, and wives' bargaining power was constrained (Chuta 2017). Generally, husbands decided whether their wives engaged in paid work after marriage and childbirth. In some cases, if the family was poor, the husband might agree or even want the wife to work. However, even if they allowed their wives to participate in income-generating activities, the responsibilities associated with being a mother and a wife were often prohibitive (Chuta 2017). Though there are job opportunities available for women, particularly in urban areas, having children usually meant a career interruption, and thus deepened their financial dependency on their husbands.

The research found that early marriage often leads to early divorce, with young couples unprepared for the economic and social strains of married life (Pankhurst and Crivello 2020). While young men were generally able to remarry easily, young women faced social opprobrium and greater difficulty remarrying, especially if they have children. The main reasons for separation and divorce included early age at marriage; inability to finance the household; spousal conflict; suspected affairs; and husbands' drinking and spending habits. Economic issues often contributed to the separation of cohabiting couples in urban areas. The high cost of rental housing forced some young couples to separate and return to live with their respective families, even though they would have preferred to stay together.

There are striking gender inequalities, with far higher rates of child or early marriage among women and an average seven-year age gap between spouses. Inequalities between young women who marry or have children in their teens and those who do not increased during adolescence with a fall in aspirations by age 15 among those who go on to marry or give birth by age 22 (Briones and Porter 2019). Those who got married or had children were also much more likely to be in paid work and less likely to be studying than those who are not married and did not have children. Younger teens also had less ability to resist child marriage and were less likely to know their husbands before marriage.

There were cultural differences in marriage arrangements between areas in the north (in Tigray with dowry gifts from the bride's family, and traditionally in Amhara equal endowments of land and livestock from both sets of parents), and with other areas where there were bride wealth payments from the groom's kin to the bride's family, with implications for intergenerational relations. Early marriage was much more common in rural areas, with cohabitation being largely an urban phenomenon, regional differences with greater prevalence in Oromia and Amhara, and considerable site-level differences, suggesting 'hotspots' where child marriage is more prevalent.

Early marriage was also strongly correlated with poverty. Only 10 per cent of married girls in the Round 4 survey had parents in the top tercile in the Round 1 survey, compared to 38 per cent of those who were not married. The significance of wealth decreased over Rounds 2 and 3, suggesting that early poverty can be predictive. However, some rich families arranged teen marriages to form customary alliances and marriage payments also sometimes encouraged early marriage (Pankhurst, Tiumelissan, and Chuta 2016).

Education of both girls and their parents, in particular fathers made a difference. Enrolment in school at age 15 was a strong predictor of girls not getting married in their teens (Pesando and Abufhele 2018). While girls going to school were less likely to get married, they often dropped out in order to work to support their families and then married – rather than dropping out specifically to get married. There is a statistically significant relationship between highest grade completed and marital status. Very few married girls were still in education (7 per cent, compared to 60 per cent of single girls). Case material suggests that household wealth is important in enabling married girls to continue with their schooling, especially in Addis Ababa and a city in SNNP.

There is an optimistic view about prospects of returning to schooling among all, but more so among single girls who had left school (65 per cent) than those who were married (54 per cent). Conversely, a higher proportion of married girls (14 per cent) said they definitely would not return to school than single girls (9 per cent). Case material suggests that there are constraints on married girls going back to school due to them being older than their peers, being ashamed, as well as the cost of secondary and tertiary education and fear for their safely.

Family circumstances also matter: having older sisters and good relations with parents reduced the likelihood of teen marriage, whereas death, illness or absence of parents increased the risk. Education of girls and their parents were protective, whereas involvement in work was predictive. Good parent–daughter teenage relations were protective against child marriage. Girls reporting good parent-child communication and high parent-child relationship quality at age 12 were significantly less likely to marry before age 16 (Bhan et al. 2019).

Single mothers often assumed responsibility both for generating income to support their household and for caring for their children, often with no, or only nominal, support from the fathers of their children. Single women and especially single mothers faced difficulties earning a living and finding childcare, with limited formal support available, and often had to rely on family

or neighbours. However, there is evidence of some local level changes in support, especially around divorce and child support.[4]

2.3. Fertility and contraception

> *After I married, my family wanted me to have a child. However, my wife started using contraceptives soon after marriage. Initially, she was using a three-month injectable, and then after a discussion, we changed to a three-year implant. Because we did not have anything at hand, we believed that it was good to have a child when our economy became good. One day while my wife was working in the kitchen, my mother discovered something strange in my wife's arms and became mad at us. Though I tried to explain, it was difficult to convince my mother as she believes children are God's gifts. So, with this pressure, we went to a health centre and withdrew the contraception.*
>
> Kuru, from Leki in Oromia, 2018, quoted in Chuta, Nardos, and van der Gaag (2021:26-7)

Table 2: Prevalence of fertility among the Older Cohort at age 22 (2016)

	Female	%	Male	%	Total	%
Never had a child	267	73.8	403	98.1	670	86.6
Has had a child	95	26.2	8	1.9	103	13.4
Had a child by age 18	37	10.2	2	0.5	39	5.0
Had a child after age 18	58	16.0	6	1.5	64	8.2
Average number of children	1.2	-	1.1	-	1.2	-
Sample size	362		411		773	

Source: Round 5 survey factsheet (Woldehanna, Araya and Pankhurst 2018).

The rate of childbirth in 2016 increased from 5 per cent at the age of 19 to 13 per cent at the age of 22, with considerable gender differences; by age 22, over a quarter of the women (26.2 per cent) had a child compared to only 1.9 per cent of the men (Table 2). Of these, 10.2 per cent of women had a child by the time they were 18, compared to only 0.5 per cent of men (Woldehanna, Araya, and Pankhurst 2018). Maternal stunting and adolescent childbearing were found to be associated with offspring stunting in infancy, persisting through offsprings' early adolescence (Benny, Dornan and Georgiadis 2017).

Adolescents had limited knowledge about SRH prior to marriage, with some gaining knowledge from schools, media (TV and radio) and health extension workers (HEWs), while many learnt about SRH after pregnancy during antenatal check-ups. Adolescents were influenced by friends, family, in-laws, parents and grandparents, but less by HEWs, who sometimes faced community disapproval about providing contraceptives to adolescents. Young married women came under strong pressure from husbands, in-laws, and parents to 'prove their fertility' soon after marriage and avoid contraception. If they did not, they were sometimes suspected of infertility or using contraception. Husbands often had the final say on contraception use, and wives' decision making was constrained by social norms. Barriers to contraception use and unintended pregnancies often pushed young couples into untimely cohabitation or marriage for which they were socially, psychologically, and materially unprepared. Implants and injectables were the most common forms of contraception and some women changed types or moved to the calendar method if they experienced adverse effects.

4 See Section 4.6.

There were massive differences between young women and young men in having children. Young women had six times higher fertility than young men by age 19 and more than 12 times higher by age 22. Young men had more knowledge about fertility and sexually transmitted infection (STI) transmission at the age of 19 than young women. At the age of 19 a much larger proportion of boys answered all five questions correctly (between 4 and 12 percentage points differences) (Rudgard et al. 2022).[5] Young women's decision making and access to contraception was constrained by patriarchal norms, with husbands often not wanting wives to start or continue using contraception. Unmarried women had less access to contraception due to social stigma and fear of intimidation, and HEWs were ambivalent about providing contraception to teenagers, fearing this could encourage sexual relations.

Fertility was lower in urban areas than rural areas, where contraception knowledge was lower, cultural misconceptions more common, and choice and access more limited. By age 18, in the qualitative sample a third of women in rural areas had given birth but none had in urban areas. Better education of young people and their parents was associated with greater acceptance of contraception, and young people who dropped out of school had less access to information than those in school obtained from biology classes. Poverty sometimes led to a wish to delay having children until couples were more established, but other couples wanted children, including to help with labour. Some young women from relatively poorer households with insufficient food said they did not want to use daily oral contraceptives and preferred injectables (Tafere et al. 2020). Some rural young people who were living in poverty said they did not use contraception, given the limited choices and need to travel to towns to go to private providers; there was also resistance to contraceptive use among some in Muslim communities on religious grounds.

2.4. Pregnancy, childbirth and parenting

> *The way I entered into marriage is full of accidental situations. I didn't have any plan for marriage. The pregnancy came suddenly and she had to live with me. After the pregnancy, we fully decided that we needed to live together.*
>
> Bereket, age 20, from Bertukan in Addis Ababa, quoted in Tafere et al. (2020:19)

Young Lives evidence demonstrates close linkages between pregnancy and marriage. A quarter of Older Cohort women (23 per cent) were in the TMCP category (teen married, cohabiting or parent) at the age of 22 (Briones and Porter 2019). About one in five parents (19 per cent) did not expect their daughter (aged 12 at the time) to have her first child before their twenties. However, teenage pregnancy and conception continues and is far higher than for boys (Crivello, Boyden, and Pankhurst 2019).

Unintended pregnancies led to cohabitation and/or marriage, which, in turn, generally led to rapid childbirth (Tafere et al. 2020). Most pregnancies were reported to have occurred in the context of marriage, and having children was seen as proving fertility and cementing the marital relationship. Due to low contraception use, living together often led to childbearing even if young couples often did not yet feel prepared to be parents. The evidence also points to the problems women face with pregnancy prior to marriage, including stigma and mental distress. Fears of becoming pregnant and the desire to maintain a sexual relationship led to cohabitation in urban areas and marriage in rural areas. Many young couples did not feel prepared to live together or become parents, but when faced with an unplanned pregnancy, they felt it was the right thing to do. However, informal unions were fragile and subject to breakdown (Pankhurst and Crivello 2020).

[5] For a more detailed discussion, see Section 3.1.2.

Most adolescent girls and young women preferred to give birth in health centres or hospitals rather than at home, and government policies have encouraged institutional delivery, which has become common. However, the tradition remains strong for young women in rural areas to have their first child in their mothers' home.

As in other aspects of marital and fertility decision making, young women's preferences are often secondary to those of their husbands and senior family members. While married women can more easily deliver in health centres, some unmarried young women tended to give birth at home for fear of humiliation. Many rural young women mentioned that the ambulance service helped them reach health centres to give birth. Young mothers who gave birth at health centres were more likely to start taking contraception after giving birth as they were given advice at the centre.

Patriarchal norms influenced the gendered roles that young mothers and fathers played in childcare and children's health, leading to unequal sharing of care work. Patriarchal norms seem to have shifted very little in the generation that are now becoming young parents, despite a belief that gender equality is increasing (Tiumelissan et al. 2020). Caring for children was universally regarded as the mother's role, whereas young fathers' role was to provide for the family. Having more than three children was found to be statistically associated with elevated maternal mental distress.

Regarding differentials and inequalities, patriarchal values meant that gender differences were marked, with young women bearing the risks and worries of early pregnancy and childbearing. Teenage pregnancy was predominantly rural, and more common in Oromia, followed by Amhara and then Tigray (Pankhurst, Tiumelissan, and Chuta 2016). There was also an association with poverty, with a higher incidence of teenage pregnancy among girls from households at the lower end of the wealth distribution. Having sisters and enrolment in school at age 15 reduced the likelihood of teenage pregnancy. Categories more at risk included young women who got pregnant outside marriage, who tended to face stigma, young mothers in informal unions, and divorcees, who faced some of the greatest challenges in providing for their children.

2.5. Health and SRH services

A Young Lives study of health care user fees (Barnett and Tefera 2010) found that these could present psychological and financial burdens which could be a barrier to health care use, and that health care shocks could lead to indebtedness, distress and further entrenchment of poverty cycles. Community-based health insurance was appreciated in improving health care provision; however, some poor households were still unable to pay and priority given to those able to pay for medicines in cash resulted in some exclusions (Tafere and Chuta 2020).

Some adolescents reported learning about family planning in school; others learnt about contraception from HEW visits, and some only during antenatal visits or deliveries. Better awareness about contraception and child spacing was reported by respondents from visits to health centres for ante and postnatal care (Chuta, Nardos, and van der Gagg 2021).

While improvements were noted in institutional delivery, childcare services seemed limited beyond immunisation and supplementary feeding. Local administrations in some regions were playing a role in ensuring that fathers provide child support after divorces (Pankhurst and Crivello 2020).

Adolescents in households that had been beneficiaries of the health extension programme had lower rates of child marriage and pregnancy, although the link with improved knowledge about fertility was less strong (Rudgard et al. 2022).

Regarding differentials and inequalities, user fees were more of a barrier for poorer households and rural households often sought health care at private facilities. There were regional differences

in the rollout of community-based health insurance. (Tafere et al. 2020). Urban sites had more choice of family planning services than rural health centres, so rural young people often went to private providers in towns. Boys in families that had participated in the health extension programme seemed to have better knowledge of fertility and STIs, were less likely to be working long hours, and had higher literacy and numeracy scores (Rudgard et al. 2022).

3. New research findings

The following sections focus on new analysis of Young Lives data: first, quantitative analysis of findings from earlier survey rounds and data from the COVID-19 phone survey in 2021; and second, qualitative analysis of aspects of the fifth wave of research in 2019 relating to the five selected themes which have not yet been covered in Young Lives publications.

3.1. Quantitative survey findings

This analysis is based on a descriptive exploration of SRH domains not covered in the Young Lives publications reviewed. It uses two survey rounds for the Younger Cohort and three for the Older Cohort, including the fourth phone survey (conducted in August 2021 in Ethiopia) (Table 3). These were analysed in relation to: marriage and cohabitation; knowledge of fertility and sexually transmitted diseases; access to contraception; pregnancy and childbirth (including place of delivery and antenatal care visits); and fertility attitudes and preferences.

Table 3: Young Lives survey rounds

	Round 1 (2001)	Round 2 (2005)	Round 3 (2009)	Round 4 (2013)	Round 5 (2016)	Phone survey PS4 (2021)
Younger Cohort	1	5	8	12	15	20
Older Cohort	8	12	15	19	22	27

Note. Survey rounds used in the quantitative analysis are in bold.

3.1.1. Marriage and cohabitation and attitudes towards marriage

By 2016, about 18 per cent of 22-year-old respondents were already married or had cohabited with a partner (Table 4). Marriage was more common for young women (82 per cent) than for young men (18 per cent), and while most partnerships happened from the age of 18 onwards, for 37.1 per cent of married women, marriage happened between the ages of 13 and 17. For young people who were married by age 22, the average age of first marriage or cohabitation was 18.4 years, with no significant differences between men and women. When asked what they thought about their age at marriage, a little over half (52.4 per cent) of young women said they thought they were married too young, 46 per cent thought they were married at the right age, and 1.6 per cent thought they were married older than usual.

Table 4: Marriage and cohabiting status by sex, location, and wealth terciles (2016)

		Ever married or cohabited by 22 No	Ever married or cohabited by 22 Yes
Sex	Male	61.0	18.0
	Female	39.1	82.0
Location	Urban	36.5	19.3
	Rural	63.6	80.8
Wealth terciles	Poorest	30.2	42.5
	Middle	36.1	38.8
	Richest	33.7	18.8

The incidence of partnerships by age 22 was greater in rural areas than in urban areas, and in poorer households than in richer households (both showing significant differences). Traditional marriages (through local elders) were the most common type (39.2 per cent), followed by *Samania* or *nika* (36.2 per cent). [6] Marriages by abduction were a small proportion of all marriages (9.2 per cent of marriages by the age of 22) with all, except one, happening in Oromia region.

The ideal age for marriage, asked to unmarried 22-year-olds in 2016, was 27 years old. This, however, varied significantly for men and women: for young men, the ideal age to get married was 28, while for women it was 25. There were also significant differences in terms of location, with young people in rural areas believing the ideal age to get married should be lower than those in urban areas. No differences were observed in terms of socio-economic status.[7]

In 2021, at the age of 20, 37 (3.2 per cent) of the Younger Cohort were married and six (0.5 per cent) were cohabiting. Of the 43 partnerships, 31 (72 per cent) were by young women and 12 (28 per cent) by young men. Though the number is small, the latter is a significant increase in marriages of young men in relation to Older Cohort 19-year-olds (3.9 per cent) and even the Older Cohort at age 22 (18 per cent).

3.1.2. Knowledge about fertility and sexually transmitted diseases (STDs)

This exploration was based on the self-administered questionnaire (SAQ) answered by Young Lives children at ages 15 (in 2016) and 19 (in 2013).[8] In general, there was less knowledge on fertility issues than for STDs (Table 5). At age 15, only 27.3 per cent of the Younger Cohort answered questions about fertility correctly, while 40.3 per cent answered all the STD questions correctly. There was little overlap in knowledge of both topics. Only about half of the 15-year-olds who answered fertility questions correctly also did so for the STD questions. Knowledge on these topics increases with age, especially on fertility issues, which for 19-year-olds reached 39 per cent.

Table 5: Knowledge about fertility and STDs, 15- and 19-year-olds

Knowledge domain	15-year-olds 2016	19-year-olds 2013
Fertility	27.3	39.1
STD	40.3	46.0
N	1,537	906

Note: The percentages are of those answering the questions correctly.

There were no significant differences between 15-year-old girls and boys or between urban and rural respondents in their knowledge of fertility or STD issues. By age 19, however, knowledge about both fertility and STDs showed significant differences by sex in favour of boys. Socio-economic differentials were the most consistent across ages; 15-year-olds living in urban areas scored higher in the STD questions. By age 22, young people in rural areas seemed to have more knowledge about STDs, but the difference was not statistically significant.

6 *Samania* are customary marriages based on an agreement between the families of the spouses, while *Nika* is the Muslim term for marriages with the blessing of a religious leader.

7 By age 27, fewer than a third of this cohort was married.

8 Fertility knowledge was measured as correct responses of both of the following questions: Q1. A woman/girl cannot get pregnant the first time she has sex; and Q2. If a girl washes herself after sex, she will not get pregnant. Knowledge on STDs was measured as correct responses to all three following questions: Q1. Using a condom can prevent getting a disease through sex; Q2. A person who looks very healthy cannot pass on a disease through sex; and Q.3 A person can get HIV or Aids by having sex.

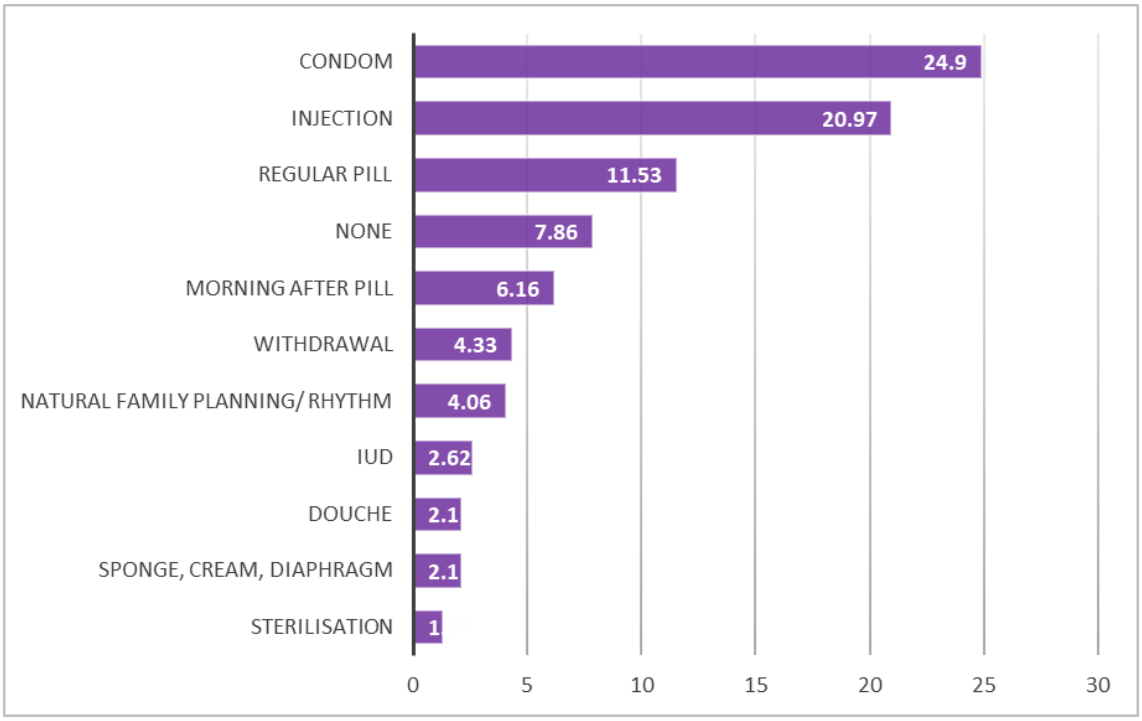
Children from richer households, whether 15 or 19 years old, had more knowledge on both fertility and STD issues, scoring between 5 and 11 percentage points higher than children from poorer households.

3.1.3. Contraception: access and methods

In 2016, 15- and 22-year-old respondents were asked where they would go if they needed a condom. While the majority of both 15- and 22-year-olds said they would go to a shop, street vendor, pharmacy, or family planning/health facilities, there was a clear difference by age. Unsurprisingly, younger adolescents were also more likely than older youth to say they did not know or not answer the question. Older youth (22 years old) said they would be more likely to buy a condom from a public/official place, whereas younger adolescents (15 years old) were more likely to get one from a family member or their boyfriend/girlfriend. Gender, location, and socio-economic differentials were observed: boys/men, those living in urban areas and from richer households, were more likely to access contraception from shops, street vendor or pharmacies; women were more likely to get them from family members or their spouses or partners; and young people in rural areas and from poorer households were more likely to access contraception from health facilities or family planning services.

The SAQ asked 22-year-olds to select the contraceptive methods they use from a list. Figure 1 outlines their responses.

Figure 1: Contraceptive methods used, 22-year-olds



For the analysis, these methods have been categorised as **none, traditional, modern, other, and doesn't know.** A variable was then created to allow for combinations of contraceptive methods: none, only traditional, only modern, a mix of traditional and modern, other, not known.

Table 6: Types of contraceptive methods used, 22-year-olds

Contraceptive method	Freq.	%	Cum.
None	47	11.2	11.2
Traditional	15	3.6	14.8
Modern	285	68.2	83.0
Mix of traditional and modern	45	10.8	93.8
Other	5	1.2	95.0
Not known	21	5.0	100.0
Total	418	100.0	

Note: The sample size is smaller because many children reported never having sex or declined to answer the question.

Modern contraceptive methods were the most common type used (Table 6), with no significant differences in terms of gender or socio-economic status. However, a much higher proportion of 22-year-old women (7.9 per cent) than men (4.5 per cent) reported using no contraception at all. Inversely, more 22-year-old men reported using a mix of traditional and modern methods than women. This was also true for 22-year-olds living in poorer households. Interestingly, there are significant differences in terms of location, with more 22-year-olds in rural areas reporting using modern methods of contraception than in urban areas (39.6 per cent and 33.2 per cent, respectively).

3.1.4. Fertility, childbirth, services, and attitudes towards fertility

Regarding *fertility and childbearing*, 8.8 per cent of 19-year-old girls and 1.2 per cent of 19-year-old boys had had at least one child. Of these births, 52.6 per cent were delivered either at their own homes (36.8 per cent) or another home (15.8 per cent), 23.7 per cent in a government health centre, and 15.8 per cent in a government hospital. By 2016, the number of children of 22-year-olds increased to 109, 99 were of young women and 10 of young men (Table 7). The average number of antenatal visits was 4.03, with no significant differences between urban and rural areas, but with significant differences between the lowest and highest wealth terciles (3.84 versus 5.03 visits, respectively). At this point, 45.9 per cent of births were in a government health centre, 21.3 per cent at home and 20.5 per cent in a government hospital. This suggests a trend of fewer births taking place at home and more taking place in health centres and hospitals. Births at home were significantly more likely to happen in rural areas and poorer households.

Table 7: Number of children for 22-year-olds in 2016

Number of births	Young men	Young women	Total
One child	9	85	94
Two children	1	13	14
Three children	0	1	1
Total	10	99	109

In 2013, the vast majority of 19-year-olds expressed their desire to have children one day (95.9 per cent) or already had children or were pregnant (1.8 per cent), with an average ideal of 3.2 children. There were no significant differences between girls and boys, or wealth terciles, but significant (yet small) differences in terms of location: the ideal number of children for 19-year-olds living in rural areas was slightly higher (3.3) than for those in urban areas (3.1). Three years later, at 22 years old, the ideal number of children was 3.6, with young women reporting a higher

number than men (3.8 and 3.5, respectively). Both young men and women preferred to have sons, as reported by a slightly higher ideal number of sons (1.9) than daughters (1.7).

3.2. Qualitative research findings

This section analyses the fifth wave of qualitative research carried out in 2019 on selected topics related to the five themes addressed in this report.

3.2.1. Female genital mutilation/cutting

> *We established a committee to eradicate harmful traditional practices, who report to us whenever something happens. Because of strong efforts we are now able to declare six out of seven of our areas free from harmful traditional practices. In the last one, parents take their daughters to the countryside to get them circumcised and also used to cut uvula. We warned households to refrain from doing such activities and now the cases are reduced. You can see that green flag* [a flag in the corner of the room]*. We put six flags, one in each neighbourhood, to indicate that they are free from harmful traditional practices and this one flag is left. This shows that no harm or abuse will happen to children in … villages where the green flag is flying. Women's development groups discuss this and report any cases. We are also working to make the community aware, so there are big changes in this regard.*
>
> Head of Women and Children's Office, Leku, SNNP

FGM/C was seen to be linked with other harmful traditional practices and there was considerable government attention towards eradicating the practice. There was also clear evidence of a decline in the practice, with urban/rural and regional differences. FGM/C was no longer practiced in four out of nine sites: two sites in Addis Ababa and two in Tigray. In the sites in Amhara and SNNP the practice was clearly declining through proactive interventions, though there were differences between and within sites.

The practice was only widespread in the rural site in Oromia, with young women from the qualitative sample having been cut themselves, but also planning to cut their daughters when they reached marriageable age. Some young women wanted to be circumcised prior to marriage to avoid the insults towards uncut girls within their community and even arranged their own circumcision at night. There were differences in responses about the age at which women wanted to cut their daughters, ranging between 12 and 18 years. The *timing* and *place* where cutting took place varied, with some being cut at their mother's home before marriage and others at their husband's home within a couple of days of marriage. Since the practice is outlawed, it is done in secret, either by traditional practitioners or by health workers who were paid more since it is illegal.

3.2.2. Marriage by forced and voluntary abduction

> *When I returned* [from Saudi Arabia]*, other men began to ask me for marriage but he approached me and said 'I have been in love with you even before you left', and asked me to be with him but I preferred to remain silent. My family arranged marriage for me with another guy without my knowledge; however, my husband gathered his friends and abducted me when I went to a bride's home to chat with girls there.*
>
> Wife of Samir, young woman in Timatim, SNNP

Forced or voluntary abduction was found to be related to negotiations over marriage and relations between parents and daughters. Forced abduction has been decreasing and was not considered to be a serious issue in urban areas, unlike rape. While there were a few mentions of the issue in sites in Tigray and SNNP, in Oromia sites the issue was still a concern. However, even sites had

seen a significant reduction, comparing girls to their mothers' generation. When the mother of Mulualem from Leki in Oromia was asked if she feared that her daughter might be abducted, she answered with laughter saying:

> *There is no abduction in this time. Marriage is undertaken based on consent. Abduction has been abandoned in the contemporary period.*

In contrast, several mothers spoke of their own abductions, sometimes when they were young girls. For instance, in Leki the mother of Tufa recalled that her husband wanted to abduct an older girl, who heard about it and hid, and that he abducted her instead. Her father took court action that led to her husband and his father being imprisoned:

> *I was in Grade 5 … They … got me while I was travelling to school and abducted me. My father sued them in the court saying [I was] too young, and my husband and his father were imprisoned.*

The Women and Children's Affairs officer in Lomi in Oromia recalled how they managed to prevent an abduction:

> *These days the practice is nearly non-existent. But, in September this year, there was an attempted abduction. The girl was going to school early and the abductors put her on a motorbike. She was … screaming for help but no one came to rescue her. Fortunately, a guy from another kebele heard and phoned me right away. As my husband and my neighbour are militias, I took them and waited for the abductors on the road. We successfully arrested them and they were … taken to woreda court and sentenced to six years imprisonment ...*

However, some young women still expressed fears. Mulualem, a Younger Cohort girl in Leki, recalled an incident when a young man she knew came with a *bajaj* taxi, but she suspected he was going to abduct her and started avoiding him as he was harassing her:

> *One day, he came to me when I was at river to fetch water. He called me pretending that he would tell me some good thing … He invited me to get into the bajaj. I refused. He asked me to wait for me so that I would go home and get back to meet him. I lied to him that I would do.*

There has also been an increasing tendency in 'voluntary abduction' or elopement by young women in cases where parents' disapproved of suitors, or their boyfriends could not pay the customary payments, or when daughters were suspected of having had sexual relations. However, some caregivers were also concerned about young couples entering hasty relationships which might not last. Moreover, voluntary abductions needed to be formalised through negotiations and compensation payments for relations to be re-established between the couple and the bride's family.

3.2.3. Family planning and contraception access and use

Regarding family planning services, HEWs mentioned holding 'awareness conferences' for pregnant women about family planning every month, while some HEWs discussed pressure on wives from their husbands not to use contraceptives.

There were regional and location differences in the types of contraception provided. In the urban site in Amhara, many women did not want to use contraceptives until they had a child, and they then preferred using longer-term methods, notably implants in the arm rather than loops in the uterus:[9] in contrast, in the rural site most women preferred injectables in the arm. In the SNNP rural site with a Muslim majority, husbands were resistant to using contraception until their wives

9 The term 'loop' was most commonly used to refer to intrauterine devices (IUDs)/intrauterine contraceptive devices (IUCDs).

had a child and some feared that contraception could lead to infertility. In the Tigray rural site, women preferred longer-term contraception, including loops that can be used for up to 10 years, whereas urban women feared that these may have health risks.

3.2.4. Unmarried adolescents' contraception access and use

Unmarried young women's access to contraception was constrained by their lack of knowledge and fears of family or the community finding out. HEWs often had ambivalent views about providing contraceptives to unmarried girls, fearing this might be seen to be encouraging sexual activity. In some cases HEWs were supportive, as one young woman from Bertukan in Addis Ababa recalled:

> *The health workers were not happy that I was taking contraceptives as they felt I was too young to start sex. But later I shared all my story and they helped me. After some days, I went back and took the injection for six months. (Tafere et al. 2020:30)*

There were gender differentials in rural areas, with young men able to get condoms but young women having to go to towns to obtain other forms of contraception from private providers, as a HEW from Lomi reported:

> *Women can get a family planning/contraceptive service from the health post but unmarried young female don't come for this, instead they prefer to use private services at a local town. Young men are less frightened to take condoms from the health post.*

3.2.5. Pregnancy, cohabitation, and marriage

> *There are five girls who became pregnant and gave birth at their parents' house, and their boyfriends also still live at their own parents' house. The community look down on these girls and they are demoralised when they see their friends doing well in their education.*
>
> Young man in a focus group discussion in Bertukan, Addis Ababa

There was a notable difference regarding pregnancies between urban areas, where this often led to cohabitation, and rural sites, where it generally led to marriage. Unmarried girls who became pregnant often faced difficult social and economic repercussions. Adolescent boys' sexuality was less constrained and they did not face the same degree of social scorn if they become unmarried fathers.

Abortion

Young women who became pregnant prior to marriage often had to or wanted to consider abortion, especially if they were still living with their parents and were not ready for cohabitation or marriage. In rural areas they often had to go away to urban areas, incurring serious risks. One woman in a focus group in Gomen, a town in Tigray, mentioned the risks unemployed young women faced, leading to unwanted pregnancies and needing to decide if they wanted to abort:

> *If a young woman is unemployed, she may be exposed to addiction and illegal acts. She may also be vulnerable to sexually communicable diseases and unwanted pregnancy. As the pregnancy is unwanted, she may try to abort it. Therefore, it has a risk* [to] *life.*

Some wives also considered abortions if they wanted to delay having children or increase the space between children. However, many women did not consider abortion on religious grounds and wives who did often came under considerable pressure from husbands, in-laws or their own relatives not to have abortions. One woman who did attempt an abortion almost died. Buzunesh got married before she felt she was ready after people saw her spending time with her boyfriend. After having her first child, her husband used to come home drunk and insult and beat her. When she was four months pregnant with her second child she tried to abort in several ways. She did

not tell anyone for fear they would inform her husband but asked an elderly woman how women abort. She took traditional herbs twice, drinking the juice of *mimi* leaves; she also tried drinking soap and finally insecticide. She said:

> *I attempted to abort the baby because my first child was too young. I had not consulted any one as I feared they would tell him [her husband]. There was no stone left unturned to abort her. I dissolved soap and drank it out of anger and became sick.*

After taking the pesticide she became very ill and was taken to a local hospital, where they could not help her, and then to another hospital further away. Her husband sold a bull to cover the medical expenses and she survived. In the end she was happy to have the child, whom she called Beloved, saying: '*I am happy about her now, if it was not for her I would have died'.*

Institutional delivery

Young Lives documented notable changes regarding institutional delivery between young women and their mothers, older siblings, and even among Older Cohort women between their first and subsequent children. With strong governmental advocacy, institutional delivery has become the norm and HEWs are evaluated on their performance in preventing home births. However, there is still a strong tradition of wives returning from their husband's to their mother's home to give birth, especially in rural areas. Exceptions to institutional delivery were seen due to remoteness, access issues during rainy seasons, fears about operations and dissatisfaction with services, as well as cultural preferences.

There was evidence of trying to enforce institutional delivery though threats of fines in three regions: Oromia, SNNP and Tigray. In Leki in Oromia, the HEW mentioned that giving birth at home had been banned. In Timatim in SNNP, Mina said that when she delivered her second child she was told there was a penalty if a mother delivers at home. In Zeytuni in Tigray, the health centre director said that the government together with the community declared that the husband of a pregnant woman or a traditional birth attendant who assisted a home delivery would be fined 150 birr:

> *The Ministry of Health has a moto which says that 'No mother will die when she gives birth'. Therefore, there is a strict rule in each kebele that no women should give birth at home. If it occurred the household is penalised 150 birr. If she gives birth at home she may not properly get different vaccinations and injections such as oxytocin, polio, etc.*

The government's strong promotion of institutional delivery is fairly recent. Ayu, from Leki in Oromia, said that when she had her first child seven years earlier (in 2012) no one had told her about institutional delivery and she gave birth at home with the help of a traditional midwife; however, she delivered her second child at the health centre.

Ambulance services

The prioritisation of ambulance services for women in labour has been an important and welcome incentive which sent a strong message about government concern to prevent maternal mortality and no doubt saved lives. The service was often efficient and appreciated. For instance, Wubanchi from Lomi in Oromia said that the ambulance was called on time and took her to the health centre, where she gave birth. The Women and Children's Affairs officer from Kok town in Amhara explained how ambulances were important in their work to prevent home births:

> *Now we have an ambulance service and even from rural areas they come with it and return to their homes. But there are [still] women who give birth outside the clinic and we are working to reduce this to zero.*

However, some issues were reported, ranging from ambulances breaking down, not being available at night or when raining, being allowed only one way (going to the health facilities or

returning), to women expecting the ambulance to be uncomfortable and/or preferring to go by foot if close or by horse cart or *bajaj* taxis. There were also instances where ambulances could not travel due to unrest, and even one case where the ambulance driver was reluctant to drive to a woman's house in a rural village.

Food provided to women who gave birth at the health centre

Another initiative to encourage institution delivery was the provision of porridge customarily given to women after giving birth along with a coffee ceremony. This was organised by HEWs using community contributions. While this too was much appreciated, there were also some issues reported. This included that it was not done if a woman gave birth over the weekend, and in one community in Oromia households were unwilling to contribute, and in another people did not have grain to contribute during a drought year.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4. Differences by types of inequalities

This section addresses different types of inequalities, how they interact, and recent changes. The differences are largely comparative and relative as they contrast different categories, such as: boys and girls; mothers and daughters; older and younger adolescents; differences between the cohorts; girls who are educated compared to those who are not; girls who work as teenagers compared to those who do not; rural versus urban respondents; different regions and communities; and poor versus rich households.

4.1. Gender differences

Gender differences are the most pervasive and starkest form of inequalities. The differences between boys and girls started in early childhood with the norms about the sexual division of labour, and girls generally spent more time on household work, to the detriment of their education. These differences continued to grow during adolescence, and become far more pronounced with the onset of puberty, with inequalities mostly linked to sexuality and prevailing patriarchal norms that regulate and control sexuality. There are also significant differences in SRH knowledge: young men, by age 19, have better knowledge than young women of both fertility and STDs – a gap that emerges after the age of 15. Similarly, unmarried young men found it easier to access condoms, whereas unmarried young rural women had to go to towns to obtain contraceptives from private providers. Furthermore, at age 22, young women were more likely than young men to use no contraception at all and less likely to get a condom from a health facility.

Gender inequalities were reinforced through marriage, childbirth and parenting. In CEFM, patriarchal norms prevailed in arranging marriages and girls' agency over their choice of partner was constrained, especially in their early teens. Child marriage rates for girls were much higher than for boys, and girls were subjected to gender-based violence, notably risk of abduction and rape. Although the risk of abduction has reduced significantly, rape was reported as being a serious risk in urban areas.

After marriage, patriarchal norms continue to constrain wives' involvement in decision making and there was little change in the cultural norms around the unequal division of labour and assigning domestic and care work to women. Gender differences and inequalities around fertility have profound consequences with young women far more likely to give birth as teenagers. Unintended pregnancies often forced young women to consider unsafe abortions and precipitated cohabitation or marriage for which young couples were not prepared. Young wives often came under pressure from husbands, in-laws and their relatives to not use contraception and to conceive rapidly to prove their fertility. Women's decision making in marriage was constrained by patriarchal norms, which regulate the division of labour allocating domestic and childcare roles to wives, who generally abandoned paid work. By age 22, young women were much more likely to have not just one, but also a second child, than young men. Moreover, young women desired more children on average than young men, while both young men and young women ideally preferring slightly more sons than daughters.

There have been changes leading to greater girls' agency related to the expansion of education, work, urbanisation and migration, better communications, and the role of media, including social media. These have increased opportunities for young people to get to know each other and make their own decisions about forming relationships, and have generated better awareness of children and women's rights. Unlike in the past, young women are generally consulted if a suitor

approaches their parents and they can often refuse marriage proposals. At age 19, most young women (61 per cent) reported that they had a say in this decision.

Nonetheless, customary and patriarchal norms continued to regulate marriage practices, constraining women's choices, and girls came under pressure from their parents, especially if they are no longer in school, or as a result of family health or other problems. It is particularly revealing and worrying that almost 40 per cent of young women still reported not having a say. Moreover, once married or cohabiting, patriarchal norms, economic and domestic division of labour, reproduction and childcare seriously constrained young women's agency, limited their bargaining power, and increased their dependency on husbands. Women who were married, cohabiting or pregnant in their teens scored lower in tests on agency and life satisfaction, and had lower decision making with respect to buying or selling large assets.

4.2. Generation, cohort and age differences

Differences based on generation, between the two cohorts and as adolescents transitioned to adulthood were also significant. There has been a considerable increase in girls' agency compared to their mothers in decision making over marriage and family planning; there have also been some changes between the two cohorts over a seven-year gap, with slightly lower marriage and fertility rates by age 19. However, younger adolescent girls had less choice than older adolescents, and differences between those who married, cohabited or became parents as teenagers and those who remained single increased by the time they were young adults.

Young Lives longitudinal evidence demonstrates that inequalities linked to SRH increased over time during the teen years. There were few differences at the ages of 8 and 12 between women who went on to marry, cohabit or have children during their teens (TMCP) and those who did not. However, by age 15, TMCP women had lower aspirations, and in the transition to early adulthood by age 22 there were clear divergences, with the women 19 per cent more likely not to be working in paid work or studying. Adolescents' knowledge about contraception and STDs increased between the ages of 15 and 19. However, even by age 19 only 40 per cent and 46 per cent, respectively, answered fertility and STD questions correctly. By the age of 22, only 5 per cent of adolescents did not know where to get a condom and higher proportions said they would go to health facilities.

The basic differences between ages 19 and 22 for the Older Cohort girls were clear in terms of marriage, more than doubling from 13 per cent to 32 per cent, and especially in terms of fertility, with the proportion having had a child almost tripling, from 9 per cent to 26 per cent. In terms of agency, younger teenage girls often had less ability to resist arranged marriages and were less likely to have known their partner prior to marriage, whereas older teenagers may even go against their parents' wishes and elope with the partner of their choice. There was also a significant reduction in home deliveries, and a corresponding increase in institutional deliveries from 40 per cent among 19-year-olds to 66 per cent among 22-year-olds. However, the ideal number of children that young people aspired to have increased from 3.2 at age 19 to 3.6 by age 22.

4.3. Differences based on location

Locational differences lead to clear inequalities. These include differences between region in the north of the country and other parts in customs relating to FMG/C with implications for girls' agency, and marriage payment customs that are interlinked with poverty and wealth. There were clear *rural/urban differences* in all aspects; cohabitation was more common in urban areas than rural areas, whereas marriage was the norm in rural sites, and child marriage and teenager motherhood were largely rural phenomena. Most marriages (81 per cent) by the age of 22 were in rural sites. In rural areas, access to contraception was more constrained and births at home

more common. However, institutional deliveries have increased remarkably at the expense of home deliveries. Promotion of institutional delivery, notably through prioritisation of ambulance provision for women in labour and provision of customary food and drink have made a difference despite some implementation challenges. *Regional differences* were also significant, with FGM/C, child marriage and teenage motherhood most common in Oromia, high rates of child marriage and fertility in Amhara and to a lesser extent Tigray, and lower rates in SNNP and Addis Ababa. There were also community, cultural and religious differences which affect marriage practices and SRH, including religious views against abortion and contraception use, notably in Muslim communities.

4.4. Personal and household characteristics

Differences based on personal and household attributes are very important in explaining variations leading to significant inequalities. Girls' *education*, and that of their parents, is protective against child marriage and fertility, whereas involvement in *paid work* during girls' early teens is predictive of child marriage and parenting. Once married, wives generally were unable to continue with their studies due to domestic and childcare work and cultural attitudes about the roles of married women. *Family composition* also matters, and girls with sisters were less likely to marry early.

4.5. Poverty and household shocks

Household circumstances also made a huge difference. There was a clear association between poverty and early marriage. Household wealth was negatively associated with teen marriage, suggesting poverty was a major determinant. Only 10 per cent of married girls in the Round 4 survey had parents in the top tercile in Round 1, compared to 38 per cent of those who were not married. By the age of 22, 42 per cent of marriages were among the poorest tercile compared to only 19 per cent among the richest tercile. Knowledge about fertility and STDs was also much higher among children and young people from richer households. There was also an association between poverty and early pregnancy, with higher incidence of teenage pregnancy for girls from poorer households. This was partly related to adolescents from poorer households dropping out of school to work and then marrying early. Women in wealthier households also had a higher rate of antenatal visits. Looking at marriage and fertility together, 34 per cent of Older Cohort women who were in the TMCP category at age 22 were from households in the bottom wealth category, compared to 25 per cent in the middle category and only 11 per cent in the top category.

Household shocks also often compounded inequalities. Family misfortune, notably death or absence of parents, particularly fathers, can contribute to early marriage. A higher proportion of married girls had lost parents. Parental illness and in some cases illness of the girl was also a driver of child marriage. Death of a father was compounded in some cases by the mother being unwell and wanting to see her daughter cared for. Some teenage girls dropped out of school due to parental loss or illness and the need to work to support the household, and then got married.

Child marriage also often led to early divorce, as couples who marry too young tend not to be psychologically, economically and socially ready for the responsibilities of married life. Divorce, especially for mothers, often resulted in social opprobrium and economic difficulties in raising children with limited or no support from former husbands, despite attempts by local government to enforce child support.

4.6. Marital status

Being a single woman, whether unmarried or separated/divorced, led to difficulties in earning a living and often involved social stigma. Unmarried adolescent girls who dropped out of school

often came under considerable pressure from their parents to get married. Adolescent teenagers were expected to not have sexual relationships, so getting access to contraception was often difficult. Teenage girls often did not feel comfortable going to health clinics and went to private pharmacies in towns to obtain contraceptives, whereas teenage boys could obtain condoms from health posts. The constraints on contraception access meant that teenage girls having sexual relationships often faced unwanted pregnancies. This raised the question of whether they remained with their parents, in which case they often came under pressure to have an abortion, with many potential complications and risks, or whether they got married to the father of the child or became a single parent living on their own.

Unmarried girls who became pregnant often faced a host of difficult social and economic repercussions. These included pressure for marriage from both customary leaders and the local administration. There were cases of threats and sometimes actual imprisonment in some sites, and some young men fleeing the community to avoid this. While married women could more easily deliver their baby in health centres, unmarried young women tended to give birth at home for fear of humiliation.

Young mothers and young fathers in informal unions and those who had separated or divorced faced some of the greatest challenges in providing for their children. Divorced, separated and single mothers found it difficult to earn a living while securing their children's care, and many relied on family or neighbours. Many received no, or only nominal, support from the fathers of their children.

Single mothers were especially vulnerable and faced negative social attitudes and discrimination. If they decided to have a child without getting married, they could be rejected by the father of their child or their own family, and become socially ostracised. Single mothers often did not feel confident to seek out maternal and childcare services, or assert their rights to child support. However, there is some evidence of changes at a local level in certain sites in supporting women's rights, with divorce and child support.

While young single mothers generally had custody of children, young divorced or separated fathers also faced social judgement and came under pressure to support their children. Some felt a strong sense of responsibility and did their best to provide child support and visit their child, though many lacked the resources, preparation or willingness to do so.

4.7. Gender and intersectionality

The intersection between gender and other inequalities comes across clearly in this report. Regarding *age and agency*, patriarchal norms meant that younger teenage girls were less able to resist arranged marriages. Teenage girls' fertility was also closely regulated by the same norms. Adolescent girls' knowledge about fertility was lower than that of boys, and their access to contraception was likewise highly constrained. After marriage, wives' decision making, including around fertility, was limited, and husbands, in-laws and parents were often against their use of contraception and wanted wives to conceive to prove their fertility.

Gender inequalities also interacted with personal and family circumstances to further disadvantage girls. There were very strong correlations between both girls' education and working during their teens and child or early marriage and fertility, and wives generally give up studying and working for pay.

Poverty compounded these inequalities, with girls from poorer families more likely to abandon education in order to work. Girls growing up in families that have experienced shocks, such as death or illness of parents, notably the father, or whose parents have divorced and are brought up by single mothers, were more likely to marry and have children early.

These intersecting inequalities were further accentuated by locational differences, with girls in rural areas and in certain regions (especially Oromia, but also Amhara and Tigray) more likely to marry and have children as teenagers. Thus, rurality, poverty and shocks affected girls' access to education and need to work, contrasting starkly with girls from better off households with educated parents in good health living in urban areas.

Young Lives has also documented and analysed changes and significant improvements in all the themes reviewed when comparing girls with their mothers and older sisters, between the two cohorts and changes within the reproductive lives of the Older Cohort, particularly in relation to service provision, notably in the promotion of institutional delivery.

5. Conclusions, policy implications and further research priorities

5.1. Conclusions

This report has demonstrated that gender differences and inequalities are regulated by patriarchal norms which become more accentuated as children progress through adolescence; young women have far higher rates of child marriage and fertility, and face the risk of forced marriage and abduction. By the age of 19, young women also have less knowledge about fertility and STDs than young men. Over half the young people who were married by age 22 said they thought they were married too young. However, the report also documents important changes and increases in girls' and women's agency compared to mothers, older sisters, and between the cohorts with a seven-year gap. There is also evidence of a decrease in home deliveries and an increase in institutional deliveries by the age of 22.

Nonetheless, unmarried girls generally have less knowledge and access to contraception and face serious dilemmas and risks due to unplanned pregnancies, notably potentially unsafe abortion, and are pressured into cohabitation or early marriage for which they do not feel ready, in unions that are often unstable. Otherwise, they face the challenges of single motherhood, including social stigma and the economic difficulties of bringing up children with limited or no support from their children's fathers.

Gendered inequalities interact with, and are accentuated by, other differentials. These include age, with teenage girls having far less agency, education and work for pay. The latter two are preventive and predictive, respectively, of teen marriage and parenthood. These in turn interact with family composition and circumstances, including having protective sisters, and poverty and household shocks that are predictive of child marriage and parenting. Inequalities based on gender, age, and household circumstances are also exacerbated by rurality, and affected by regional, community and cultural differences. Young women from rural and poorer households are far more likely to get married and have children in their teens.

Despite the persistence of prevailing patriarchal norms, there have been significant changes. The practices of FGM/C and abduction have decreased, while access to contraception and institutional delivery have improved. There are lower rates of CEFM and fertility among girls compared to their mothers, the Younger Cohort compared to the Older Cohort, and within the reproductive lives of the Older Cohort girls. Although these changes are grounds for optimism, patriarchal values remain strongly entrenched, with significant urban/rural and regional differences, and family circumstances continue to disadvantage girls from poorer households, and families that have faced shocks.

5.2. Policy implications

The findings have important policy implications on several topics related to SRH, including girls' continuing education and not starting work too early, suggesting a need for better social protection, particularly for poor and vulnerable households and categories most at risk, such as teenage and less-educated mothers, who were found to be more likely to have undernourished infants. Gendered differences in knowledge about SRH and access to contraception suggest a need for better information and awareness raising campaigns, involving HEWs, in schools and through the media.

Improvements in the quality of services are required, including contraception access, abortion, delivery, and childcare, especially for categories at risk, notably unmarried adolescents and single mothers who face multiple challenges regarding SRH. Wide gaps between urban and rural sites and between richer and poorer households suggest more efforts are needed to ensure that SRH service provision promotes greater equity.

Pervasive and persisting patriarchal norms need challenging, especially around customs including FGM/C, child marriage and marital payments, and regarding gender-based violence. Improvements in gender relations and more equal decision making in marital affairs need promoting, particularly over the sexual division of labour and childcare, including when marriages break up, in order to ensure that mothers obtain child support.

5.3. Further research priorities

This report has identified important research priorities, drawing on the strengths of Young Lives' longitudinal, mixed methods and holistic design. These include differential knowledge and access to contraceptives for unmarried young women and young men, and the longitudinal impact of CEFM and teen and early childbearing on later outcomes, as the young women and men Young Lives has followed through childhood and into early adulthood transition to the labour market, form households, and raise families.

Young Lives can assess changes in fertility knowledge, aspirations and behaviour regarding SRH, fertility and parenting, and provide a better understanding of the determinants of gender-based differences, and how these interact with other socio-economic factors, in particularly rurality and poverty. It can also document change during early adulthood, comparing the two cohorts in their twenties, while qualitative research could assess the evolution of relations between couples, including around decision making, fertility and parenting, as well as gender-based violence.

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Annex: List of reviewed Young Lives publications

No	AUTHORS	TITLE	DATE	PUBLICATION DETAILS	TYPE OF PUBLICATION	KEYWORDS	DATA SOURCES	FGM/C	MARRIAGE	PREGNANCY, CHILDBIRTH	CONTRA-CEPTION	SRH SERVICES	Parenthood	Other
1	Barnett, Inka and Tefera, Bekele	Poor Households' Experiences and Perception of User Fees for Healthcare: A Mixed-method Study from Ethiopia	2010	Young Lives Working Paper 59	Working paper	Health services	Based on Round 2 survey in 2006 and a qualitative sub-study of 64 cases in four Young Lives sites: three rural in Amhara, SNNP and Tigray, and one urban in Oromia							X
2	Benny, Liza, Dornan, Paul, and Georgiadis, Andreas	Maternal Undernutrition and Childbearing in Adolescence and Offspring Growth and Development: Is Adolescence a Critical Window for Interventions Against Stunting?	2017	Young Lives Working Paper 165	Working paper	Maternal characteristics, childbearing, child outcomes	Four rounds, at ages 1, 5, 8, and 12 for the Younger Cohort, and three rounds for the Older Cohort, at ages 12,15 and 19			X				
3	Bhan, Nandita, Gautsch, Leslie, McDougal, Lotus, Lapsansky, Charlotte, Obregon, Rafael, and Raj, Anita	Effects of Parent-Child Relationships on Child Marriage of Girls in Ethiopia, India, Peru, and Vietnam: Evidence from a Prospective Cohort	2019	Journal of Adolescent Health 65: 498–506	Journal article	Marriage	Older Cohort girls across Rounds 1 to 4 in all four countries (1,648 girls in total, 419 from Ethiopia), who were aged 19 by Round 4 in 2013		X					
4	Boyden, Jo	Why are Current Efforts to Eliminate Female Circumcision in Ethiopia Misplaced?	2012	Culture, Health and Sexuality 14.10: 1111–23	Journal article	FGM, harmful practices	Qualitative sample, especially 15 Older Cohort girls, and interviews with caregivers and community respondents and service providers	X	X					
5	Boyden, Jo, Pankhurst, Alula, and Tafere, Yisak	Harmful Traditional Practices and Child Protection: Contested Understandings and Practices of Female Early Marriage and Circumcision in Ethiopia	2013	Young Lives Working Paper 93	Working paper	FGM, harmful practices	Qualitative sample, especially 15 Older Cohort girls, and interviews with caregivers and community respondents and service providers	x	x					

No	AUTHORS	TITLE	DATE	PUBLICATION DETAILS	TYPE OF PUBLICATION	KEYWORDS	DATA SOURCES	FGM/C	MARRIAGE	PREGNANCY, CHILDBIRTH	CONTRA-CEPTION	SRH SERVICES	Parenthood	Other
6	Boyden, Jo, Pankhurst, Alula, and Tafere, Yisak	Harmful Traditional Practices and Child Protection: Female Early Marriage and Genital Modification in Ethiopia	2012	Development in Practice 22.4: 4510–22	Journal article	FGM, marriage	Qualitative sample, especially 15 Older Cohort girls, and interviews with caregivers and community respondents and service providers	x	x					
7	Briones, Kristine and Porter, Catherine	How Does Teenage Marriage and Motherhood Affect the Lives of Young Women in Ethiopia, India, Peru and Vietnam?	2019	Young Lives Working Paper 186	Working paper		Data from five survey rounds from age 8 to 22; focusing on 366 Older Cohort girls in the TMCP category by age 19		X	X			X	
8	Chuta, Nardos	Young Women's Household Bargaining Power in Marriage and Parenthood in Ethiopia	2017	Young Lives Working Paper 166	Working paper	Marriage, parenthood, couple relations	Four qualitative waves between 2007 and 2014 in three communities, two rural and one urban in different regions, and 2015 qualitative sub-study on young people's pathways to marriage and parenthood		X	X			X	
9	Chuta, Nardos and Morrow, Virginia	Youth Trajectories Through Work and Marriage in Rural Ethiopia	2015	Young Lives Working Paper 135	Working paper	Marriage, work	Three qualitative waves from 2007 to 2011 in two sites in Oromia and Tigray		X					
10	Chuta, Nardos and van der Gaag, Nikki	Neglected Experience: Fertility and Childbearing Among Young People in Ethiopia	2021	Young Lives Policy Brief 42	Policy brief	Fertility, childbearing	Summary from Chuta et al. 2021; fifth qualitative wave mid-2019. Eight sites in five regions, (Addis Ababa, Amhara, Oromia, SNNP and Tigray), three in urban and five in rural areas. Focus on 42 cases		X	X	X	X	X	
11	Chuta, Nardos, Birhanu, Kiros, and Vinci, Vincenzo	Who Decides? Fertility and Childbearing Experiences of Young Married Couples in Ethiopia	2021	Young Working Paper 196	Working paper	Fertility, childbearing	Fifth qualitative wave mid-2019. Eight sites in five regions, (Addis Ababa, Amhara, Oromia, SNNP and Tigray), three in urban and five in rural areas. Focus on 42 cases		X	X	X	X		

No	AUTHORS	TITLE	DATE	PUBLICATION DETAILS	TYPE OF PUBLICATION	KEYWORDS	DATA SOURCES	FGM/C	MARRIAGE	PREGNANCY, CHILDBIRTH	CONTRA-CEPTION	SRH SERVICES	Parenthood	Other
12	Crivello, Gina, Boyden, Jo, and Pankhurst, Alula	'Motherhood in Childhood': Generational Change in Ethiopia	2019	Feminist Encounters: A Journal of Critical Studies in Culture and Politics 3.1-2: 12	Journal article	Parenthood, motherhood	Four waves of qualitative research in all five qualitative sites		X	X			X	
13	Nguyen, Amanda, Haroz, Emily, Mendelson, Tamar and Bass, Judith	Symptom Endorsement and Socio-demographic Correlates of Postnatal Distress in Three Low-Income Countries	2016	Depression Research and Treatment 2016: Article 1823836	Journal article	Maternal health	Self-reporting questionnaire from over 5,000 mothers (1,855 from Ethiopia)			X				
14	Pankhurst, Alula	Continuity and Change: Marriage and Parenthood Among Ethiopian Adolescents	2020	Young Lives Policy Brief 5	Policy brief	Marriage, parenthood	Based on two qualitative sub-studies: 'Pathways to Marriage and Parenthood' in three rural sites, in Amhara, Oromia and Tigray regions in 2016; and 'Young Marriage and Parenthood' in the same two rural communities in Oromia and Tigray and in an urban site in Addis Ababa in 2018		X	X			X	
15	Pankhurst, Alula	Child Marriage and FGM: Evidence from Ethiopia	2014	Young Lives Policy Brief 21	Policy brief	Marriage, FGM	For FGM/C qualitative sample, especially 15 Older Cohort girls, and caregivers, community respondents and service providers	X	X					
16	Pankhurst, Alula and Crivello, Gina	When Things Fall Apart: Separation and Divorce Among Adolescents and Young Couples in Ethiopia	2020	Young Lives Working Paper 193	Working paper	Divorce	Based on 2019 fifth qualitative wave, focus on 59 cases from four sites in different regions		X				X	

No	AUTHORS	TITLE	DATE	PUBLICATION DETAILS	TYPE OF PUBLICATION	KEYWORDS	DATA SOURCES	FGM/C	MARRIAGE	PREGNANCY, CHILDBIRTH	CONTRA-CEPTION	SRH SERVICES	Parenthood	Other
17	Pankhurst, Alula, Tiumelissan, Agazi, and Chuta, Nardos	The Interplay Between Community, Household and Child-Level Influences on Trajectories to Early Marriage in Ethiopia	2016	Young Lives Working Paper 162	Working paper	Marriage	Three qualitative rounds (2008, 2011, 2014), focus on five married girls from the qualitative sub-sample and nine from the survey, plus analysis of fourth and earlier survey rounds		X					
18	Pesando, Luca Maria, and Abufhele, Alejandra	Household Determinants of Teen Marriage and Childbearing: Sister Effects Across Four Low- and Middle-Income Countries	2018	University of Pennsylvania Population Center Working Paper (PSC/PARC), 2018-16	Working paper	Marriage, childbearing	Data from Rounds 1 to 4 (2002, 2006, 2009, 2013) restricted to Older Cohort girls (total of 1,666 girls; 420 from Ethiopia)		X	X				
19	Rudgard, William, Dzumbunu, Silinganisiwe, Yates, Rachel, Toska, Elona, Stöckl, Heidi, Hertzog, Lucas, and Cluver, Lucie	Impacts of the Ethiopian Health Extension Programme on Eleven Areas of Adolescent Health and Wellbeing	2021	UKRI Accelerate Hub Policy Brief	Policy brief		Rounds 1 to 4 (2002 to 2013) Older Cohort in four regions, considering how support at ages 12 and 15 resulted in outcomes at age 19							
20	Rudgard, William, Dzumbunu, Silinganisiwe, Yates, Rachel, Toska, Elona, Stöckl, Heidi, Hertzog, Lucas, and Cluver, Lucie	Multiple Impacts of Ethiopia's Health Extension Programme on Adolescent Health and Wellbeing: A Quasi-experimental Study 2002–2013	2022	Journal of Adolescent Health 71.3: 308–16	Journal article		Rounds 1 to 4 (2002 to 2013) Older Cohort in four regions, considering how support at ages 12 and 15 resulted in outcomes at age 19							
21	Sabates, Ricardo	Can Maternal Education Hinder, Sustain or Enhance the Benefits of Early Life Interventions? Evidence from the Young Lives Longitudinal Study	2013	EFA Global Monitoring Report 2013/4, Teaching and Learning: Achieving Quality for All	Policy brief	Maternal characteristics	Round 1 and 2 survey data from Younger Cohort at ages 1 and 5			X			X	
22	Tafere, Yisak and Chuta, Nardos	Gendered Trajectories of Young People through School, Work and Marriage in Ethiopia	2016	Young Lives Working Paper 155	Working paper	Marriage, school, work	Four qualitative waves over seven years focusing on 30 children in five sites between the ages of 12 and 19		X					

No	AUTHORS	TITLE	DATE	PUBLICATION DETAILS	TYPE OF PUBLICATION	KEYWORDS	DATA SOURCES	FGM/C	MARRIAGE	PREGNANCY, CHILDBIRTH	CONTRA-CEPTION	SRH SERVICES	Parenthood	Other
23	Tafere, Yisak and Chuta, Nardos	Transitions to Adulthood in Ethiopia. Preliminary Findings: Summary and Policy Issues	2020	Young Lives fifth wave qualitative study summary report	Research report	Transitions to adulthood	2019 fifth qualitative wave; interviews with 241 respondents in ten sites, two in each of the five regions		X					
24	Tafere, Yisak, Chuta, Nardos, Pankhurst, Alula, and Crivello, Gina	Young Marriage, Parenthood and Divorce in Ethiopia	2020	Young Lives research report	Research report	Marriage, parenthood, divorce	Qualitative study in three communities: one urban in Addis Ababa and two rural sites, one each in Oromia and Tigray		X	X			X	
25	Tiumelissan, Agazi, Birhanu, Kiros, Pankhurst, Alula, and Vinci, Vincenzo	'Caring for a Baby is Mother's Responsibility': Parenting and Health Service Experience of Young Mothers and Fathers in Young Lives Communities in Ethiopia	2020	Young Lives Working Paper 195	Working paper	Parenthood, health services	2019 fifth qualitative wave with data from 29 young people in seven sites			X			X	
26	van der Gaag, Nikki	'How Could He help Me?' The Gendered Experiences of Young Parents in Ethiopia	2020	Young Lives Policy Brief 41	Policy brief	Parenthood	2019 fifth qualitative wave with data from 29 young people in seven sites			X			X	
27	van der Gaag, Nikki	Love Alone is Not Enough: The Challenges of Separation and Divorce Among Young Couples in Ethiopia	2020	Young Lives Policy Brief 39	Policy brief	Divorce	2019 fifth qualitative wave, focus on 59 cases from four sites, each in a different region		X				X	
							TOTALS	**4**	**19**	**13**	**2**	**2**	**11**	**1**

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