Young Lives

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Improving Sexual and Reproductive Health in Ethiopia:

Young Lives Evidence Shows Inequalities Continue to Disadvantage Adolescent Girls and Young Women

Improving the sexual and reproductive health (SRH) of young people in Ethiopia, particularly adolescent girls and young women, requires coordinated and regionally tailored approaches to address persistent inequalities and entrenched patriarchal norms. This includes delivering:

- **increased SRH awareness-raising targeting adolescent girls and young women**, through age-appropriate information in school curriculums, girls' clubs and community health extension workers, including reaching adolescent girls who have dropped out of school;
- **increased access to SRH services, which may have been disrupted during the pandemic and recent conflict,** through expanding and strengthening the Health Extension Programme, including better access to contraception and provision of safe abortion where appropriate for adolescent girls and young women, regardless of marital status;
- **initiatives to ensure unmarried and first-time mothers in rural areas are not left behind in efforts to move away from home births** and enable safer deliveries in health centres and hospitals;
- **a renewed focus on eliminating female genital mutilation/cutting** especially where prevalence remains high, by shifting cultural beliefs, preventing medicalisation of the practice, and targeting approaches in response to different regional practices;
- **broad approaches to eliminate child marriage and reduce teenage pregnancy**, including tackling the underlying drivers of poverty and gender discrimination, and supporting adolescent girls to stay in school, particularly in rural areas where they are more at risk of dropping out;
- **engagement across whole communities to challenge discriminatory gender stereotypes and entrenched patriarchal norms**, including working with boys and men, traditional and religious leaders, regional government leaders, local and national NGOs, and the media.

Prioritising and integrating accessible SRH services for young people in post-conflict reconstruction and humanitarian policies and programmes is critical as Ethiopia recovers from the recent conflict and grapples with the impact of climate change, including drought and food insecurity.

Overview

Ethiopia has made significant improvements in sexual and reproductive health (SRH) over the past two decades, through key policy initiatives and strategic objectives[1] in support of achieving the Sustainable Development Goals. Overall prevalence rates of female genital mutilation/cutting (FGM/C), child marriage and teenage pregnancy have decreased, while access to some SRH services, including ante and postnatal care and safer institutional births have increased, improving health outcomes, and lowering maternal mortality rates (Akwara et al., 2022).

Despite these positive trends, inequalities and entrenched patriarchal norms continue to disadvantage adolescent girls and young women, particularly those from poor households and in rural areas.

Regional variations in cultural beliefs and practices leave many girls still at significant risk of FGM/C, particularly in rural Oromia, Afar and Somali. Unmarried girls have particularly poor knowledge of fertility, HIV and other sexually transmitted diseases (STDs), including those who dropped out of school early or have less-educated parents. Limited access to contraception among adolescent girls in rural areas increases the risk of unplanned teenage pregnancies, which may lead to child or forced marriage, unsafe abortion and maternal mortality.

Child marriage remains a significant risk in rural areas, where poverty can push parents to arrange early marriages for their daughters, particularly those who have dropped out of school. While the shift from home births to deliveries in health centres and hospitals has improved maternal and infant health, unmarried and first-time mothers in rural areas are still being left behind.

This policy brief summarises research findings on SRH in Ethiopia from over two decades of the Young Lives study and presents key policy recommendations.

Young Lives' longitudinal evidence informing international policy debates over two decades

Young Lives is a unique longitudinal study that has been following the lives of 12,000 young people in Ethiopia, India (in the states of Andhra Pradesh and Telangana), Peru and Vietnam since 2001. In each country, the study is divided into two age groups:2,000 young people born in 2001 (the Younger Cohort) and 1,000 born in 1994 (the Older Cohort).

In Ethiopia, Young Lives collects data from 20 sites across five regions: Addis Ababa, Amhara, Oromia, Southern Nations, Nationalities and Peoples' Region (SNNP) and Tigray. The sample has a pro-poor bias, focusing on food-insecure sites and both rural and urban poverty. We have also conducted longitudinal qualitative interviews since 2007 with a sub-sample of 100 young people, their families and communities, from across the five regions.

The evidence in this policy brief is primarily from our comprehensive new report, **SRH and Inequalities in Ethiopia: Insights from Young Lives Longitudinal Research** (Pankhurst and Espinoza 2022). This report synthesises – for the first time – SRH-related findings from **27 Young Lives publications**, with a strong focus on our qualitative evidence. It also includes **new analysis** of Young Lives data from our recent COVID-19 phone survey carried out in 2020 and 2021, and qualitative research carried out in partnership with UNICEF across ten sites in 2019.

Young Lives is led by the University of Oxford, in partnership in Ethiopia with the Policy Studies Institute (PSI) and Pankhurst Development Research and Consulting (PDRC).

Young Lives findings

Significant regional variation in the prevalence and type of FGM/C is driven by different cultural beliefs and practices

While Ethiopia has made significant progress in reducing FGM/C over the last two decades, urgent action is required if the government is to meet its target of ending FGM/C by 2025. For the whole population, the prevalence rate among adolescent girls aged 15–19 fell from 62 per cent in 2005 to 47 per cent in 2016 (UNICEF 2022b). While more recent (post-2016) national data on FGM/C prevalence rates are not yet available,[2] qualitative data from 2019 suggested a continuing downward trend (Pankhurst and Espinoza 2022).

Despite this progress, our evidence shows significant regional variation, **with very high FGM/C prevalence rates in rural Oromia**. Regional variation is driven primarily by different cultural beliefs and practices, and in some cases, misconceptions about religious doctrines.

1 These include the National Strategy and Action Plan on Harmful Traditional Practices against Women and Children (2013); the National Reproductive Health Strategy (2016–20); the National Costed Roadmap to End Child Marriage and FGM/C (2020–24); the National Adolescents and Youth Health Strategy (2021–25); and the Minimum Service Package for Adolescents and Youth Health (2022).

2 The most recent comprehensive national survey was Ethiopia's Demographic and Health Survey (DHS) conducted in 2016. See Central Statistical Agency (2017).

Across our study sites, FGM/C is mainly practiced in rural areas and is much less common in urban areas. It has been drastically reduced in Addis Ababa and Tigray, with declining rates in Amhara and SNNP, though persistently high rates remain in rural Oromia, and as other studies show, in Afar and Somali (Endale et al. 2022).

There is also significant regional variation in the type of FGM/C practised[3] and the age at which girls are affected. This has important implications in terms of severity and health risks, as well as for policy responses. In the northern regions of Amhara, Tigray and Afar, and some urban areas in Addis Ababa and SNNP, FGM/C is often performed soon after birth as a cut to remove the clitoris. Across other parts of the country, FGM/C is more commonly carried out when girls are in late childhood or their early teens, often as a prelude to marriage. In southern and western regions (notably in Oromia), it is typically performed through excision, removing both the clitoris and surrounding labia, while in eastern regions, the practice of infibulation includes narrowing the vaginal opening (particularly among agro-pastoral communities in Afar and Somali).

Cultural beliefs and deeply entrenched patriarchal norms continue to drive FGM/C; shifting these is critical to end this harmful practice. Our evidence shows that although knowledge about the government ban and rationales for stopping the practice are widespread, cultural beliefs about the perceived benefits of FGM/C often outweigh the perceived health or legal risks. Many people, particularly in rural areas, still believe that FGM/C is a natural and necessary part of transitioning to marriage and adulthood, protecting a girl's honour, and reducing the likelihood of pre and extramarital sex (Pankhurst 2014).

> "The community believes that if girls are not circumcised, they may face challenges in their sexual life and may have complications during delivery … some parents circumcise because it is simply a tradition that a girl should not miss …"
>
> Focus group of caregivers in Amhara (Boyden 2012)

In some areas, including our sites in rural Oromia, increased knowledge about the ban on FGM/C has led to clandestine ceremonies, often carried out at night and in unsafe places. Ceremonies are typically performed by traditional practitioners, though we have also seen some evidence of the **medicalisation of FGM/C** involving participation by local health extension workers. In one case, 35 teenage girls organised their own FGM/C ceremony, apparently in defiance of their parents, though perhaps also to avoid their parents being at risk of legal action. These findings highlight that whole communities need to be involved to shift cultural beliefs, including the beliefs of health extension workers, and the beliefs of girls themselves.

Inequalities affect young people's knowledge about SRH and access to contraceptives, particularly unmarried girls in rural areas; gender knowledge gaps widen in late adolescence

Young people have low knowledge of fertility, HIV and other STDs, particularly those living in poor households and in rural areas, those who dropped out of school early, and those with less-educated parents. Among our sample, less than a third (27 per cent) of 15 year olds demonstrated good knowledge about conception, and less than half (40 per cent) had a good understanding of STD transmission. By the age of 19, a growing gender knowledge gap means that young men have significantly better SRH knowledge than young women (Pankhurst and Espinoza 2022).

Unmarried girls have less access to contraception due to limited knowledge and social stigma. Health extension workers are often ambivalent about providing adolescent girls with contraception, due to concerns about community disapproval and fears this could encourage sexual activity. Limited access to contraception means that unmarried girls face serious dilemmas and risks including unplanned pregnancies, which may increase the pressure on them to enter marriage (or cohabitation in urban areas), and in some cases lead to unsafe abortions that risk maternal mortality, or face the challenges of single motherhood (Pankhurst and Espinoza 2022).

Poverty and discriminatory gender norms continue to push girls into child marriage, particularly in rural areas; girls who have dropped out of school are at increased risk

Ethiopia has made significant progress in reducing child marriage over the last two decades. Across the whole population, the percentage of women aged 20–24 who were first married or in a union before the age of 18 decreased from 59 per cent in 2005 to 40 per cent in 2016 (UNICEF 2018). While more recent (post-2016) national statistics on child marriage rates are not yet available, data from our COVID-19 phone survey in 2021 suggests a continuing downward trend (Favara et al. 2021).

Encouragingly, our qualitative evidence also suggests that forced marriage through abduction has significantly decreased in recent years and is now largely absent in urban areas, though it is still a concern among girls and young women in rural Oromia, with some reported occurrences in SNNP and Tigray.

Despite this progress, poverty and persistent discriminatory gender norms continue to put a significant number of vulnerable girls at risk of child marriage (and teenage pregnancy). Young girls are also still at significant risk of gender-based violence, with rape reported as a serious risk in urban areas (Pankhurst and Espinoza 2022).

3 WHO (n.d.) classifies four main types of FGM/C. Type 1: Partial or total removal of the clitoris ('clitoridectomy'); Type 2: Partial or total removal of the clitoris and labia/vulva ('excision'); Type 3: Narrowing of the vaginal opening by creating a seal from cutting and repositioning the labia either by suturing or scar tissue ('infibulation'); Type 4: All other harmful procedures to the female genitalia for non-medical purposes.

Child marriage is much more common among girls than boys. Among our Older Cohort, almost a third (32 per cent) of young women were married or cohabiting by the age of 22, compared to only 7 per cent of young men. Among those married, 37 per cent of young women were married between 13 and 17 years old, many of whom expressed feelings of disempowerment, particularly those who had married in their teens. Almost 40 per cent of married women reported that they did not have a say in the decision to get married, and over half (52 per cent) thought they had married at too young an age (Pankhurst and Espinoza 2022).

Poverty remains a main underlying driver of early marriage: growing up in a poor household increases the risk of child marriage, especially in rural areas. Among those married by the age of 22, 42 per cent were from the poorest households, compared to only 19 per cent from the least-poor households, with most marriages (81 per cent) taking place in rural areas (Pankhurst and Espinoza 2022).

There are increasing concerns about the impact of recent droughts and spiralling food and fuel prices pushing parents to arrange early marriages for their daughters to secure bride price payments from the groom's family (UNICEF 2022a). In times of financial stress, there is often significant pressure on girls to undertake income-generating activities instead of going to school. Our research shows that girls with a heavy workload at home may decide that marriage provides a possible escape from unpaid and/or paid work burdens, particularly in rural areas (Crivello, Boyden, and Pankhurst 2019).

Girls who drop out of school are significantly more at risk of child marriage, especially those living in poor households and in rural areas. Our data show that girls who are still at school at 15 are significantly less likely to marry early or have children in their teens, compared to those who have already dropped out. 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 deciding to leave education specifically to get married (Pesando and Abufhele 2018).

Family circumstances also matter, including the gender composition of the household. Our data suggest that girls who grow up in a household with sisters (especially older sisters) are significantly less likely to marry early than girls who grow up in a household with *only* brothers (Pesando and Abufhele 2018). While more research is needed to understand why the gender of siblings has such a significant impact on when girls marry, it is likely that patriarchal norms governing sibling and parental relationships have a strong influence. In addition, girls who have a strong relationship with their parents are significantly less likely to marry early (Bhan et al. 2019), while family shocks such as death, divorce, illness or parental absence (especially fathers) increases the risk (Pankhurst, Tiumelissan and Chuta 2016).

Child marriage is linked to early (and closely spaced) pregnancies, with teenage pregnancy much more common among those living in rural areas and poor households. Not surprisingly, girls typically marrying at a much younger age than boys results in huge gender differences in fertility rates. By the age of 19, the fertility rates of young women in our study were six times higher than young men, and this gap had doubled by the age of 22.

Young women typically have limited decision-making in marriage and come under pressure to 'prove their fertility'

Once married (or cohabitating in urban areas), patriarchal norms continue to influence household roles and decision-making. The unequal division of labour within marriage assigns significantly heavier burdens of domestic and care work to young women, which our research shows has been exacerbated by the COVID-19 pandemic (Favara et al. 2022). This reduces young women's opportunities to continue their education or access decent jobs. Caring for children is universally regarded as the mother's role, and it is exceptional to see young fathers doing household tasks or caring for children. Fathers typically focus on providing financial support, though young mothers are also expected to engage in some income-generating activities. Young wives are generally subordinate to their husbands on most issues, including decisions relating to fertility, such as the use of contraception, child spacing and abortion (Chuta, Birhanu, and Vinci 2020).

Newly married women often have limited access to contraception, especially when they come under strong pressure from husbands, in-laws and parents to 'prove their fertility' and get pregnant soon after marriage. Young women, and their husbands and families, often do not want to use contraceptives until they had at least one child, while those who do not conceive soon after marriage may come under suspicion of using contraceptives (Chuta, Birhanu, and Vinci 2020).

Child marriage also increases the likelihood of early divorce, with young couples unprepared for the economic and social strains of married life. While young men can generally remarry relatively easily, divorced women face significant discrimination and social stigma, and find it much harder to remarry, especially if they have children. Divorced women may also be left with significant financial difficulties, despite some attempts by local government to enforce child support payments from fathers (Pankhurst and Crivello 2020).

Girls who become pregnant outside marriage face significant social and economic repercussions; unsafe abortions carry considerable risks

While most pregnancies occur within marriage, girls who become pregnant outside marriage face significant social and economic repercussions. In rural areas, there is considerable pressure from parents and traditional leaders for pregnant girls to marry at a young age, with early cohabitation an alternative option in urban areas. In some cases, young women may consider unsafe or illegal abortions if still living with their parents. We have also heard cases where young men have experienced considerable intimidation relating to pregnancy outside marriage, including imprisonment (Pankhurst and Espinoza 2022). While some young women consider abortions if they want to delay having

children or increase the space between their children, most do not, mainly on religious grounds or due to pressure from husbands, in-laws or their own relatives.

Where young women have resorted to abortion, this is typically carried out in secret and with considerable risks. Our qualitative study has recorded cases where young women have taken overdoses or traditional medicines, often going to customary or illegal practitioners. We have even heard cases where school girls have subsequently died, with others suffering physical and emotional harm (Pankhurst and Espinoza 2022).

> "I attempted to abort the baby because my first child was too young. I had not consulted anyone 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. I pounded leaves of mimi tree and drank it, I also drank insecticide."
>
> Young woman in rural Oromia (Pankhurst and Espinoza 2022)

There has been a significant shift from home births to safer deliveries in health centres and hospitals, but unmarried and first-time mothers in rural areas are still being left behind

Encouragingly, our data suggest there has been a significant increase in access to antenatal care and having a health worker in attendance during labour over the last two decades. Government initiatives to discourage home births and increase the proportion of institutional births have resulted in the proportion of young women benefitting from a skilled health personnel in attendance during labour increasing dramatically, from 17 per cent in 2002 to 94 per cent in 2021 (Favara et al. 2021). Young mothers who give birth in hospitals and health centres are also more likely to attend ante and postnatal care, gaining better information and access to contraception that can help to increase spacing between children.

Specific government initiatives have supported increased institutional deliveries; these include accessible ambulance services for women in labour and providing porridge and coffee in hospital to emulate customary ceremonies. These services have been widely welcomed across our study sites, despite some localised implementation issues. For example, in drought-affected areas in Oromia limited food supplies resulted in some new mothers not receiving the expected porridge and coffee ceremony, or ambulance services not being available at the weekends. While efforts to encourage institutional deliveries are clearly having a positive effect, there have also been reports of intimidation to enforce institutional deliveries through threats of fines across sites in Oromia, SNNP and Tigray (Pankhurst and Espinoza 2022).

There has been a significant shift from home births to institutional deliveries, but our qualitative evidence suggests there remains a strong tradition in many rural areas for women to give birth to their first child in their mothers' home. Unmarried women may also prefer to give birth at home due to social stigma and fear of humiliation. In addition, young women from poor households often attend fewer antenatal visits than those from less poor households (Pankhurst and Espinoza 2022).

Better provision of primary health care has improved SRH for young women, notably through the Health Extension Programme

Our data suggest that access to the community Health Extension Programme (HEP)[4] has resulted in a significant improvement in SRH. Young women who live in households that benefit from the HEP have better knowledge about fertility, lower rates of child marriage (reduced by 18 percentage points), and lower rates of teenage pregnancy (reduced by 19 percentage points), compared to those not benefitting from the programme (Rudgard et al. 2022).

Ethiopia's Community Based Health Insurance (CBHI)[5] scheme has also improved access to primary health care services, although there have been significant regional differences in the rollout of this scheme. While the programme is widely appreciated among our respondents, our qualitative evidence shows that poor households who are unable to pay CBHI contributions can be excluded from accessing primary health care, with priority sometimes given to households who are able to pay for medicines in cash (Tafere and Chuta 2020).

Other recent studies also highlight the negative impact of the COVID-19 pandemic for vulnerable young people accessing SRH services, particularly those living in urban areas where the impact of lockdowns and other restrictive measures led to reduced availability of face-to-face services and increased reluctance among young people to attend clinics (Jones et al. 2022).

Policy implications

Our longitudinal findings over the last two decades in Ethiopia show that inequalities and regional differences in cultural beliefs and practices have a significant impact on young people's SRH. Entrenched patriarchal norms disadvantage adolescent girls and young women, particularly those living in rural areas and poor households. These findings have important implications for policy responses.

4 The HEP was launched in 2003 to deliver cost-effective primary health care at the community level, including through the deployment of female health extension workers. See Ministry of Health – Ethiopia (n.d.-a).

5 The CBHI scheme was introduced in 2011 and aims to provide financial protection against the cost of illness and improve access to health care services for communities engaged in the informal economy. See Ministry of Health – Ethiopia (n.d.-b).

Policy recommendations to promote and improve SRH for young people in Ethiopia

1 Persistent gender inequality and entrenched patriarchal norms continue to disadvantage adolescent girls and young women, particularly in rural areas and those from poor households.

- **Challenging discriminatory gender stereotypes, which are often reinforced in times of crises, should be prioritised through targeted initiatives to engage whole communities.** It is crucial to engage boys and men to challenge patriarchal norms and the discrimination faced by girls and women; this should also include working with traditional and religious leaders, regional government leaders, local and national NGOs, and the media.
- **Shifting gender norms among young people needs to start at an early age and continue throughout adolescence, including through inclusion in school curriculums and engaging young families.** Empowering girls and young women to stay in school and gain decent employment, supporting girls to have improved decision-making over their fertility and marriage, and encouraging fathers to be more engaged in childcare and domestic work, can all help to discourage discriminatory gender roles.

2 Significant regional variation in the prevalence and type of FGM/C is driven by different cultural beliefs and practices.

- **Renewed focus on reducing FGM/C in regions where prevalence remains high is vital** to meet the government's target of ending the practice by 2025. This should include regionally tailored programming that responds to different local practices and beliefs, including the type of FGM/C and age at which girls are affected.
- **Where FGM/C is typically practised during adolescence, programming should be tailored to include targeting girls themselves**, alongside their mothers and the wider community; prioritising engagement with pregnant women and health extension workers may be more effective in regions where FGM/C is practised shortly after birth.
- **Efforts should be made to prevent the medicalisation of FGM/C** in areas where this is prevalent to ensure that health professionals do not carry out the practice. Further investment in health extension workers should include a priority focus on SRH.
- **Programmes to promote and enforce current legislation banning FGM/C are critical**, particularly in rural areas. Initiatives to implement the ban should be carefully planned to avoid unintended consequences such as increasing the extent of clandestine practices. This requires working closely with communities to understand and respond to prevailing cultural beliefs that continue to drive the practice.
- **Targeted awareness-raising campaigns on the legal and health risks of FGM/C should also challenge cultural beliefs and patriarchal norms,** including addressing the stigma and discrimination experienced by unmarried girls who are uncut.

3 Young people have limited knowledge about SRH and access to contraceptives, particularly unmarried girls in rural areas; gender inequality increases in late adolescence.

- **Better information and SRH awareness-raising campaigns should target adolescent girls and young (unmarried) women**, particularly in rural areas and those from poor households. This should involve working with health extension workers, local clinics, schools and the media.
- **Schools can play an important role in increasing adolescents' understanding of SRH issues.** Increasing the coverage of SRH in curriculums beyond basic biology lessons could help to ensure both girls and boys receive age-appropriate information. Promoting discussion of SRH through peer group support networks in schools (including girls' clubs) and community groups (including youth clubs), could also provide a supportive environment to improve knowledge and help to shift cultural beliefs and challenge discriminatory gender norms.
- **Specific efforts should be made to target unmarried girls who have dropped out of school, particularly in rural area**s; improving knowledge of SRH and access to contraception is particularly important to reduce the risk of teenage pregnancy and child marriage for girls who have left education. Health extension workers should be encouraged and supported to provide advice and access to affordable contraception to girls and young women, regardless of marital status.

Policy recommendations to promote and improve SRH for young people in Ethiopia

4 Poverty and discriminatory gender norms continue to push many adolescent girls into child marriages.

- **Policymakers need to adopt a broad approach to addressing child marriage** which includes tackling the underlying causes of poverty and persistent discriminatory gender norms, particularly in rural areas.
- **Efforts to reduce child marriage need to be underpinned by strong and comprehensive social protection systems** to support vulnerable households and alleviate the economic hardships that may push parents towards arranging marriages for their daughters at a young age.
- **Supporting adolescent girls to stay in school can have a significant impact on reducing child marriage.** Ensuring that schools are safe and accessible becomes increasingly critical as girls enter adolescence to avoid early drop out, including safe and reliable transport and providing suitable water and sanitation facilities for during menstruation.
- **Practical measures to reduce the burden of domestic work on girls and young women** can also increase the likelihood of adolescent girls staying in school and marrying later. This could include improving childcare support,[6] cash benefits for families, and the expansion of affordable and accessible crèches and preschools.

5 Young women typically have limited decision-making in their marriage and often come under significant pressure from husbands and in-laws to 'prove their fertility'.

- **Challenging social norms that put pressure on young married couples to 'prove their fertility'** is important to reduce the number of early pregnancies and increase the agency of girls and young women over fertility decisions.
- **Efforts to increase access to family planning and contraception** should include targeting young couples who had their first birth at home and communities where access is much more limited.
- **The dominance of patriarchal gender norms and unequal power relations within marriages need to be countered** by promoting awareness of women's rights and more equal division of labour and childcare, including when marriages break up, in order to ensure that mothers obtain adequate child support.
- **Increased support is required to reduce the incidence of and risks associated with unsafe abortions, particularly in rural areas.** Policymakers should assess whether the current legal framework on abortion is sufficient to protect girls and young women from the harmful effects of unsafe abortions, while taking into account widely held religious and social norms.

6 Efforts to improve the quality and accessibility of SRH services should target adolescent girls and young women in rural areas regardless of marital status, including unmarried girls and first-time mothers.

- **Prioritise and expand access to the HEP scheme** to deliver timely and effective primary health care across all regions in Ethiopia, increasing the focus on SRH services.
- **Prioritise successful initiatives to further encourage institutional deliveries** and improve access to ante and postnatal care; this should include targeting first-time mothers in rural areas and unmarried mothers.
- **Improve access to primary health care, including SRH services, for those living in poor households** who are unable to afford basic contributions to the CBHI.
- **Ensure all front-line SRH services disrupted by the COVID-19 pandemic and recent conflict are resumed as soon as possible,** including in both rural and urban areas.

6 For example, a pilot initiative to extend childcare services through the Ethiopia Productive Safety Nets Program (PSNP) could lead to wider benefits for girls and young women staying at school. See UNICEF (2020); World Bank (2022).

Continuing to follow Young Lives

Young Lives will return to the field in 2023 to conduct our next comprehensive in-person survey across our four study countries. This data will enable us to generate important new insights into the SRH of young people and their families in early adulthood, including the ongoing impact of global crises, with a focus on the compounding effects of food insecurity and recent conflict in Ethiopia.

Continuing to build a robust longitudinal evidence base on SRH is essential for delivering effective and timely policy interventions to improve the lives of young people and their families in Ethiopia.

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