

Who Decides? Fertility and Childbearing Experiences of Young Married Couples in Ethiopia

Nardos Chuta, Kiros Birhanu and Vincenzo Vinci



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Summary

This working paper explores the way young couples in Ethiopia make decisions about fertility and childbearing, and examines their experiences of contraceptive use. In Ethiopia, early marriage and early parenthood are perpetuated by patriarchal societal norms. The paper draws on longitudinal qualitative data and quantitative information from young mothers and fathers, spouses, caregivers, community representatives and service providers in eight communities. The paper focuses on the following research questions: (1) What is the relationship between early marriage and young parenthood? (2) What are the experiences of fertility and childbearing among young married couples? (3) What factors affect the decision-making powers of young married people?

The findings show that early marriage is associated with early fertility, and women's autonomy over fertility and childbearing is constrained by poverty, with social and religious norms widening the gender gap. Poverty impacts young married couples' fertility and childbearing decisions in two contrasting ways: some young couples from very poor economic backgrounds want to delay pregnancy and increase child spacing, while other young women in rural communities, who do not receive enough to eat, prefer not to use contraceptives or else use other options they assume have less impact on their health. The findings also reveal that there are negative perceptions of contraception use, stemming from a lack of knowledge, and that social and religious norms and expectations obstruct contraception uptake among young women in both urban and rural settings. There are also differences in knowledge and information about sexual and reproductive health, with couples in rural areas having limited knowledge and information about contraception and childbearing, while their urban counterparts are better informed.

The paper recommends the implementation of existing gender equality policies (related to Sustainable Development Goal 5) regarding fertility and childbearing through the creation of stronger and more gendered approaches to family planning policies and programmes to address the health needs and rights of both men and women. Second, by empowering women both economically and educationally, women would be able to negotiate more equally with men on fertility issues. Formal communication interventions using media, targeting different actors at different levels with increased reproductive health education, need to be strengthened to address the knowledge and information gap in fertility and childbearing. There is also a need to offer age-appropriate comprehensive sex education to ensure that young people have suitable information before their first sexual experience. Finally, the persistence of deep-rooted gender norms remains the key driver of child marriage and early fertility. Adequate laws and interventions that consider encouraging social norms that delay the age of first marriage and childbearing should be in place. Mothers-in-law, religious leaders, officials and others should be included in programmes to enable effective and sustainable changes.

1. Introduction

Globally, one in five young women aged 20–24 were married as children, with an estimated 16 million 15–19-year-olds and 777,000 10–14-year-olds giving birth in developing countries (Woog and Kagesten 2017; WHO 2020). By the time young women in developing countries reach the age of 25, nearly 60 per cent have become mothers, in contrast to young men, who transition to parenthood later, usually between the ages of 25 and 29 (World Bank 2006).

In Ethiopia, 40 per cent of girls are married before the age of 18, and 14 per cent marry before their fifteenth birthday (UNICEF 2014; CSA [Ethiopia] and ICF 2016). According to UNICEF, despite many efforts and progress made over the past years to reduce this figure, Ethiopia has still the fifteenth-highest prevalence rate of child marriage in the world and the fifth-highest absolute number of child brides. Of 15 million child brides, 6 million were married before age 15 (UNFPA 2018; UNICEF 2014). In some rural parts of the country, the numbers continue to rise (UNFPA 2012; Jones et al. 2016; Pankhurst, Crivello and Tiemelissan 2016).

Ethiopia is the twelfth-most populated country in the world, with a population of more than 115 million, and second-most populated country in Africa, with a yearly population growth rate of 2.57 per cent and a fertility rate of 4.1 births per woman (Worldometer 2020). This is mainly because of early age pregnancy and childbirth. The latest Ethiopian Demographic and Health Survey (EDHS) report indicates that 13 per cent of adolescent females aged 15–19 are already mothers or pregnant with their first child (CSA and ICF 2016). The fertility rate of Ethiopian adolescents, aged 15–19, is estimated at 79 births per 1,000 (CSA [Ethiopia] and ICF International 2012), higher than the world average of 46 per 1,000 but lower than Africa's average of 98 per 1,000 (UN 2015a). Teenage pregnancy is higher in rural areas (15 per cent) than urban areas (5 per cent) (CSA and ICF 2017). Young people transitioning into adulthood face unique challenges in accessing sexual and reproductive health services. There are pronounced disparities in accessing birth control between unmarried girls who became pregnant outside marriage and married girls. Only 36 per cent of married women aged 15–49 use any method of family planning (CSA and ICF 2016). The EDHS revealed that 18.7 per cent of 15–19-year-old married women reported unmet needs for contraception, which is significantly higher than the 14.8 per cent of adult married women (CSA and ICF 2017). Despite the high levels of early marriage and subsequently unintended pregnancy, young married women's contraceptive utilisation in Ethiopia is among the lowest in sub-Saharan Africa (CSA 2014b). Contraception use among young people remains very limited, although there was a slight increase in rural areas in 2019 (Ministry of Finance and UNICEF Ethiopia 2019).

A body of literature examines the link between child/early marriage and different socio-economic and health outcomes for women. Child/early marriage is associated with higher fertility, teenage pregnancy, and lower age at first birth. As a result of early marriage, Ethiopia has one of the highest adolescent fertility rates in sub-Saharan Africa, at 65 births for every 1,000 young women aged 15–19 (World Bank 2018). Moreover, only 42.5 per cent of pregnant women receive any form of prenatal care (UNFPA 2012).

Child marriage is also associated with negative health outcomes. Younger women in rural areas had lower demand for contraception, an indication of rural married adolescents continuing to comply with traditional norms that dictate giving birth immediately after marriage (Dingeta et al. 2019). This makes them experience the adverse health consequences of

complex early age pregnancy, such as fistula and other pelvic floor disorders due to immature reproductive organs (Dingeta et al. 2019; Solanke 2015; Raj et al. 2009). Child marriage is also linked with higher rates of low birth weight, pre-term delivery, respiratory diseases and infant mortality (Sychareun et al. 2018).

Child marriage is also linked with school dropout, particularly for girls (Jensen and Thornton 2003; Solanke 2015; Raj et al. 2009; Boyden, Pankhurst and Tafere 2013). Many early-married female pupils are forced to discontinue their schooling (Emirie 2005; Erulkar 2013). This also decreases their say in household decision-making, including contraception use (Jones et al. 2014). Once married it is difficult for a woman to remain in school. If a woman was married as a child, her children's education may not be directly affected in a negative way. However, this can have an indirect effect, because the mother's education was curtailed, and children of educated mothers are known to do better in school themselves. (Wodon et al. 2018). Child marriages and early childbirths conflict with the ability of girls to continue their education, which depresses earnings in adulthood (Wodon and Yedan 2017) and also lowers their bargaining power within the marriage as the age difference between partners creates an imbalance in women's participation in fertility decisions (Jensen and Thornton 2003; Elborgh-Woytek, Newiak, and Newiak 2007; Solanke 2015).

Early marriage further represents serious constraints to child spacing and/or limiting (CSA and ICF 2017). Most early first births happen immediately after marriage, as pregnancy has often been the cause of the marriage in the first place, increasing the woman's capacity to bear more children later (Erulkar 2013). In many countries birth intervals are shortest among the youngest mothers and this is assumed to perpetuate a cycle of poverty and inequality, especially in poor, less educated, and rural communities (Save the Children 2019; Chernet, Shebeshi and Banbeta 2019).

This paper aims to understand how early marriage correlates with high fertility, low bargaining power and poor health. It builds on other Young Lives studies in Ethiopia to assess how the 42 poor young people in the study who entered into marriage early manage fertility, child spacing, and the number of children they have, as well as how they use sexual and reproductive health (SRH) services. The paper is concerned with how patriarchal communities and the relative powerlessness of women perpetuate early marriage, pregnancy and motherhood in some Ethiopian communities. It addresses policy issues around gender inequality within the context of strong patriarchal norms as well as women's wider empowerment. Ethiopia has made some strides with respect to the Sustainable Development Goals (SDGs), yet there is still some way to go in the general empowerment of women and there are still gaps in the provision of gendered, equitable SRH services.

2. Marital and gender relations regarding fertility and household bargaining

Young women in Ethiopia usually enter marriage poorly equipped to negotiate adult marital roles, given their limited education, knowledge, and skills (UNICEF 2011). The age difference between partners also creates an imbalance in women's involvement in decisions related to family planning, childbearing, and the use of maternal and child health services. According to the Central Statistical Authority, on average, men tend to enter marriage eight years later than women (CSA and ORC Macro 2005). This age difference is assumed to limit young girls' autonomy, power in the household, and control of their reproductive life (MOH 2006). Ethiopian women in general, and specifically those aged 15–24, have little autonomy with regard to household resources and little control over them, which indirectly impacts their decision-making power over reproductive health (CSA and ORC Marco 2005; Chuta 2017).

The persistence of deep-rooted patriarchal gender norms remains the key driver of child marriage and early fertility in Ethiopia. From making women undergo female genital mutilation to forcing them to have many children at a young age, women's decision-making and agency are shaped by underlying social and gender norms (CSA [Ethiopia] and ICF International 2012), which play a pivotal role in facilitating early and frequent pregnancies, and drive short birth intervals (Save the Children 2019; Chuta 2017; World Bank 2013).

Arranged marriage and marriage by abduction are still practised in some rural areas. In the Afar community in north-eastern Ethiopia, for example, the nature of marriage is more than just arranged marriage. Matrimony is arranged or determined even before birth. The *Absuma* tradition of cousins marrying serves to reinforce bonds within extended families rather than create wider alliances. (Dessalegn et al. 2020: 10). Similarly, marriage by abduction does not take into account the interests of the girl. Starting from not having a say in such types of marriages, married young women generally have little or no decision-making power in marriage and very limited control over their fertility (World Bank 2013; Chuta 2017; Dessalegn et al. 2020).

Economic and social factors limit women's ability to negotiate marriage and fertility. Women cannot make decisions about their own health, and husbands often control household decisions, including SRH access (Chuta 2017; Tadele, Tesfay and Kebede 2019). For example, married Ethiopian women have less right to sell farm products, and the decision for a woman to visit a health institution is greatly dependent on her husband's willingness (Tilahun 2014).

The majority of Ethiopian women lack the social self-determination needed to exercise their reproductive rights for various reasons. One is the subordinate position of women within society. In patriarchal societies like Ethiopia, women assume a subordinate position because religion and culture usually reinforce the supremacy of males, including within the household (Sida 2003). Most decisions, including those around fertility, are jointly made with husbands or else dominated by the husband (Angel-Urdinola and Wodon 2010). The right to control the number and spacing of their children is not enjoyed by most Ethiopian women (Sida 2003).

A study in Afar indicated that women were afraid to initiate discussions with their husbands as they thought it was taboo to disturb them. Furthermore, husbands hold their mothers in high esteem and tend to listen to them concerning marital issues. Mothers-in-law are often the final arbiters, with husbands mostly respecting their mothers' wishes, which means wives have no power to negotiate on fertility or where to give birth (Chekole et al. 2019). Gurara et al. (2020), in their study of the homebirth choices of women in Gamo Gofa zone of the Southern Nations, Nationalities and Peoples' Region (SNNPR), found that fear of medical intervention, a preference for home care, and a lack of women's decision-making power to choose institutional delivery are the main reasons for preferring homebirth.

As most women, especially in rural areas, depend on husbands for their livelihoods, they also fear asking their husbands to seek healthcare either for them or their children. Fatherhood is mainly characterised by the ability of men to provide financially for the family (Chili and Maharaji 2015). The fact that husbands are breadwinners and that they decide how household income is used may also contribute to the woman not being allowed to take a sick child to a health facility, in cases where payment is involved. Women are also less likely to have the kind of education that gives them the confidence to negotiate reproductive health rights (Kim 2016). Hence the social, economic and educational status of women negatively correlates with their desire and ability to regulate fertility, as well as to exercise reproductive health rights.

The relative advantages and drawbacks of addressing issues with men and women together or separately are unclear in the literature. (Save the Children 2019). Though gender-focused approaches that engage men and women in a coordinated way are very important, many such programmes are not run in a way that enables women to participate equally. So, empowering women to boost their decision-making role in reproductive health increases women's autonomy over fertility (Atake and Gnakou Ali 2019).

3. Policy context

3.1 Ethiopian health policy

The 1993 Ethiopian health policy recognises the equality of women and the need for the provision and expansion of health services to the most vulnerable and marginalised sections of society, notably women, children and the elderly. Special attention is given to mothers and children as they are particularly vulnerable to illnesses such as diarrhoea, malaria and fever, as a result of socio-economic and cultural issues and practices (FMOH 1995). Of the policy's many strategies, the preventive strategy is crucial in addressing the violation of women's reproductive health rights, including violations due to harmful traditional practices.¹ Female genital cutting can cause recurrent urinary tract infections, increased risk of childbirth complications and new-born deaths, while early marriage is associated with risks of obstetric fistula after prolonged labour because of the underdeveloped pelvis (Ras-Work 2006).

¹ These include female genital mutilation/cutting (FGM/C), early marriage, marriage by abduction, forced marriage and polygamy, which are particularly important because of their effect on reproductive health.

Ethiopia devised a five-year Health Sector Transformation Plan (HSTP) for July 2015 to June 2020, in line with the national long-term vision and Growth Transformation Plan (GTP). The three key features of the HSTP were quality and equity, universal health coverage, and transformation. By 2020, the HSTP aimed to reduce the maternal mortality ratio to 199 per 100,000 live births; and reduce the under-5, infant, and neonatal mortality rates to 30, 20, and 10 per 1,000 live births, respectively (FMOH 2015).

Ethiopia is also among the countries that endorsed conventional health standards on child and maternal mortality, morbidity and mortality from communicable diseases, malnutrition, and average life expectancy, all of which place the country as the least privileged nation in the world (FMOH 1995). The government believes that health policy cannot be seen in isolation from other relevant policies the country has designed. To this end, the national health policy issued in 1993 emphasises that quality primary healthcare services should be rendered to all segments of the population (FMOH 2014).

Similarly, several laws and policies have been put in place to promote women's status as well as their social and reproductive health rights. Yet many obstacles are impeding the implementation of these policies.

3.2. Trends in the Ethiopian health service

In recent years, the Federal Government of Ethiopia has put in place a number of health policies, one of which targets the decentralisation and democratisation of the healthcare system and the development of preventive, promotive and curative components of healthcare (FMOH 2010). The Health Extension Program aims to build equitable health services at a grassroots level, with a focus on sustained preventative health actions and increased health awareness. The program is carried out in each rural *kebele*² by health extension workers, who explicitly focus on community outreach programmes to mothers and children in households (Banteyerga 2011).³

Another recent development for the dissemination of safe health practices is the establishment of a Health Development Army, with one team leader for every 30 households in a one-to-five network⁴ mainly aiming to maintain mother and child health. There is also an awareness of the benefits of having an institutional delivery, with pregnant women encouraged to give birth in health facilities with the support of skilled birth attendants (FMOH 2015).

The introduction of a pilot community-based health insurance scheme in June 2011 to 300,000 households in three districts and four main regions⁵ (Mebratie et al. 2014) has also helped poor households who could not otherwise pay for any medication.

2 The *kebele* is the smallest administrative unit in Ethiopia, similar to a ward or neighbourhood.

3 This service includes the following: immunisation, growth monitoring, nutritional advice, and services that aim to halt and reverse the spread of major communicable diseases such as HIV and AIDS, TB and malaria. Antenatal care, a safe and clean environment for birth, a delivery service, new-born care, and referral of women with complications during labour are also included in the service (FMOH 2014).

4 A network whereby one woman out of every six households is chosen for her status as a 'model woman' who has adopted a healthy lifestyle, and encourages the others in the network to do likewise. The group works as unpaid volunteers and is supposed to take some of the burden of outreach from health extension workers, who previously were tasked with encouraging all women in their catchment area to lead a healthy lifestyle.

5 The districts are Amhara, Tigray, Oromia and SNNPR.

3.3. National adolescent and youth reproductive health

The Ethiopian Government has made some strides in formulating health and adolescent-friendly policies and strategies. The Federal Ministry of Health, in collaboration with different stakeholders, implements various strategies, manuals and guidelines on adolescent and youth reproductive health. The National Reproductive Health Strategy states: 'Youth-friendly service is not primarily about setting up separate dedicated services. However, the greatest benefit comes from improving generic health services in local communities and improving the competencies of healthcare providers to deal effectively with adolescents' (FMOH 2006b). Over the past decade, the Government has developed several policies and guidelines to support the implementation of youth-friendly services.

Ethiopia has begun a national reproductive health needs assessment to guide the implementation of the new reproductive health programme adopted in 1994, coordinated by the Ministry of Health and supported by the National Reproductive Health Task Force (WHO 1999; FMOH 2015b). The reproductive health strategy has three overriding priorities targeted at achieving the Millennium Development Goals (now replaced by the SDGs, with SDGs 3 and 5 focusing on health and gender equality, respectively), improving maternal health, promoting gender equality, and combating HIV/AIDS, which are the core of the strategy. They address the entire domain of reproductive health issues of fertility, gender, age of first birth, contraceptive prevalence, method choice, traditional practices, literacy and other factors primarily focusing on the health of men and women (FMOH 2006a).

Most of the adolescent and youth-friendly reproductive health services have been implemented to serve young people still attending school and those living in urban or peri-urban areas (FMOH 2006a). Adolescents in rural areas and who have been out of school were not being reached by these programmes (FMOH 2006b; Mekbib, Erulkar and Belete 2005). Awareness about SRH is low among Ethiopian adolescents and young people (FMOH 2016). A recent national study suggests that up to 78 per cent of unwanted pregnancies were attributed to non-use or incorrect use of contraceptives, or to method failure (Mekbib, Erulkar and Belete 2005: 19–20).

Early marriage and low use of contraceptives are assumed to contribute to the country's high fertility rates (FMOH 2006a). Poverty also affects young people's access to reproductive health (CSA 2011; FMOH 2004). Though Ethiopian adolescents' SRH has significantly improved over the last two decades, there are still barriers slowing down the progress and leading to possible reversals (FMOH 2004). In line with this, the paper focuses on the experiences of young mothers' and fathers' use of SRH and factors that limit their agency in household, community and institutional contexts.

4. Study context, data and methods

The paper draws on Young Lives⁶ longitudinal qualitative data gathered in 2007, 2008, 2011, 2014 and 2019 in eight Ethiopian communities (five rural, one urban and two semi-urban). It also uses Round 5 survey data for the Ethiopian sample on the prevalence of early marriage and fertility. Four of the study communities are from the qualitative sites and four from the quantitative sites. The paper is based on 42 young people from both cohorts in the eight sites who have experienced early marriage and fertility. Longitudinal qualitative data were gathered from a sample drawn from selected Young Lives sites and the full sample. Data from a sub-study that was carried out by the Young Marriage and Parenthood Study in 2018 has been added to the longitudinal qualitative study. The sub-study included additional young people from the wider quantitative sample who have experienced early marriage. We explore the longitudinal data to see general trends of early marriage, and then focus on the eight selected communities to see young people's contraceptive use experiences and factors that determine and change childbearing experiences over time. An inter-cohort comparison using both survey and qualitative data allows us to see such trends and changes.

In Ethiopia, Young Lives has collected five rounds of survey data on 3,000 girls and boys and their households – a Younger Cohort of 2,000 children, born in 2001 and an Older Cohort of 1,000 children, born in 1994 – in 20 sites distributed over five major regions in the country (Addis Ababa, Amhara, Oromia, SNNPR and Tigray). The methodology combines in-depth individual interviews with young mothers and fathers, and other adults (spouses of the Young Lives young people, caregivers, community representatives, and service providers). Data gathered are transcribed, translated, and coded using Atlas.ti qualitative data analysis software. The research has received ethical approval from the University of Oxford, Ministry of Science and Technology, and the Ethiopian Society of Social Workers and Anthropologists (ESSWA).

4.1 Profile of the study communities

The paper focuses on eight study communities distributed in five regions:⁷ Addis Ababa (Bertukan), Amhara (Kok and Tach-Meret), Oromia (Leki and Lomi), SNNPR (Timatim), and Tigray (Zeytuni and Gomen). Bertukan, Tach-Meret, Leki and Zeytuni communities are sites that have been included in the longitudinal qualitative study. The remaining four communities are additional survey sites that are included because we have recorded cases of early marriage and young parenthood.

Bertukan is an urban neighbourhood in the capital city, Addis Ababa. It is a hub for commerce and small-and medium-scale industries, where residents work in the informal economy, mainly street vending and vegetable trading. The population is ethnically and

6 Young Lives is an international study of childhood poverty and transitions to adulthood following the lives of 12,000 children in four countries – Ethiopia, India (in the states of Andhra Pradesh and Telangana), Peru and Vietnam – since 2001. . The study aims to improve understanding of the causes and consequences of childhood poverty and the role of policies in improving children's life chances.

7 Community names are pseudonyms to ensure the confidentiality of the study sites.

religiously diverse, while the Amhara ethnic group and Orthodox Christians comprise the majority. Poverty is widespread and young people find jobs as paid labourers in the informal economy. Infrastructure is very poor. Poor housing conditions and risky environments expose young people to unhealthy behaviours. Girls are at risk of young-age sexual relationships, unwanted pregnancy, and prostitution that has been associated with family poverty. The neighbourhood has been targeted by the Government for relocation projects to improve the area for commerce.⁸

Kok is a semi-urban community in Amhara region, known for its tourist attractions. Surrounded by poor rural communities, residents earn a living from small-scale trade and other income-generating activities. Young men are also involved as tour guides. The population is primarily Orthodox Christians.

Tach-Meret is a rural community in Amhara that is predominately a crop-growing area but is vulnerable to seasonal food shortages. The population is primarily Orthodox Christians and many poor households depend on the state-run Productive Safety Net Program (PSNP).⁹ The community is close to a town, where many households and young people access services such as schooling, healthcare, tap water and electricity. There is also a market, and there are opportunities for wage labour.

Leki and Lomi are both rural communities situated within the Rift Valley in Oromia, where agriculture, mainly crop production, and some fishing are the main sources of livelihood. Young people can also find work as waged labourers in private irrigated fields. As the communities are food-insecure, households resort to the PSNP state support. In both communities, voluntary abduction and forced abduction (which very often lead to early marriage) are still practised, and some marriages are still arranged.

Timatim is a densely populated, rural community in Gurage Zone of SNNPR. The main livelihood is agriculture, complemented by earnings from small trade and other income-generating activities. Early marriage is also common here. People get basic health services from the health post in the community, and have to travel 6 kilometres to the nearest town to access better healthcare.

Zeytuni is a rural community in Tigray, where the mostly Orthodox Christian households depend on farming for their livelihood. Like most of the rural communities included in the study, Zeytuni is vulnerable to sporadic rain shortage and is therefore a food-insecure area dependent on PSNP support. However, in recent years, young people have been generating additional income through small-scale irrigation activities and waged labour in the fast-growing construction sector in nearby towns. Gomen is a semi-urban community in Tigray of mainly Orthodox Christians. A road crosses the town, stimulating fast urbanisation, and offering opportunities for young people for waged labour in the construction sector and for small businesses and other income-generating activities. There are sufficient primary schools and healthcare services, although, as in the other sites, young people need to travel to larger towns to access higher education and hospitals. Arranged marriage is common in both communities.

⁸ See Tiemelissan and Pankhurst (2013).

⁹ This is a large-scale, social protection intervention aimed at improving food security and stabilising assets.

5. Quantitative findings

This section presents survey results on the prevalence of early marriage and early fertility among the Older Cohort, and the total number of young mothers and young fathers with children at age 22.

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

	Female	%	Male	%	Total	%
Marriage						
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 (Araya, Woldehanna and Pankhurst 2018).

As seen in Table 1, of all the females in the cohort, 15 per cent were married or cohabiting by age 18, while 17 per cent were married or cohabiting after age 18. Of all the males in the cohort, 3 per cent were married or cohabiting by age 18 and 4 per cent were married or cohabiting after age 18. Girls (32 per cent) are more likely to get married early than the boys (28 per cent).

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

	Female	%	Male	%	Total	%
Fertility						
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 (Araya, Woldehanna and Pankhurst 2018).

Almost one-third of the Older Cohort women were already married or cohabiting, and just over a quarter had a child (Table 2). Relatively few of the young men were married or cohabiting, and even fewer had a child. The women tended to marry earlier and have children earlier than the men, and 10.2 per cent of them had had a child by the age of 18.

The prevalence of early marriage and motherhood among women is not necessarily as high as expected from national trends. According to EDHS 2016, the national prevalence of early marriage (of women marrying before age 18) has declined from 63 per cent to 58 per cent (CSA and ICF 2017). Boys marry relatively late, given that they face constraints on early marriage, as they are responsible for saving funds needed for the bridewealth and are also expected to be relatively economically autonomous before marrying.

6. Qualitative findings

Almost all aspects of women’s and men’s lives are touched by decisions about how many children to have and when to have them. Several factors influence how parenthood unfolds, including age at marriage, educational and employment opportunities available to women and men, their access to family planning, gender roles and expectations, and the overall social and economic context in which they live (UN 2015a).

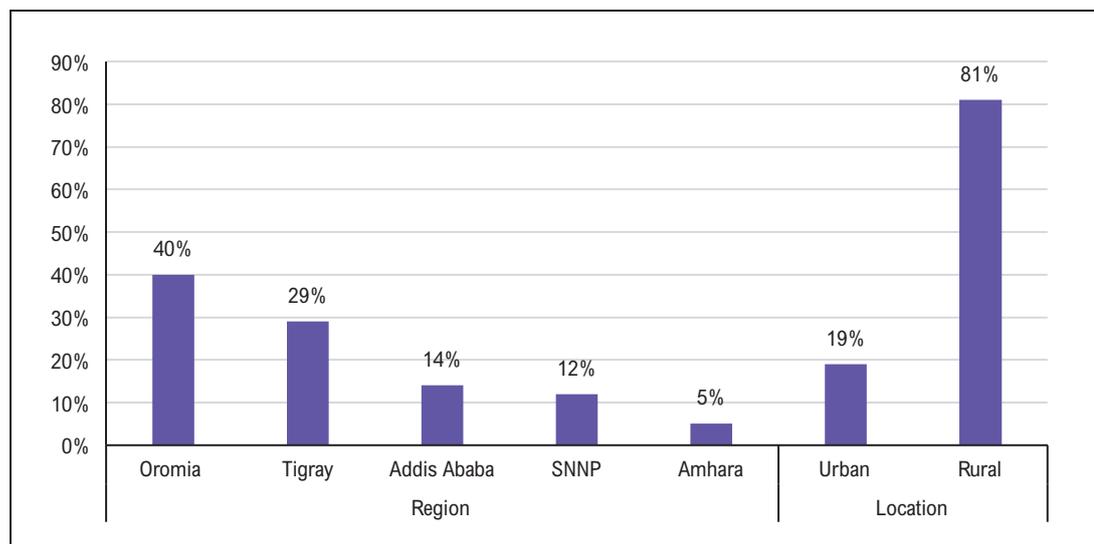
6.1 How young women and men got married

This section gives background information on how young people entered into marriage, including drivers of early marriage such as what influenced their decision to get married, year of marriage and age at marriage, and general trends of early marriage by cohort, gender and location.

In the last five rounds of qualitative and quantitative research, 42 young people who have experienced early marriage were covered in the qualitative study, of which 31 have already become young parents and two were pregnant during the last data-gathering round. The remaining nine were without children or only just married.

In the qualitative sub-sample featured in this paper, Oromia has the highest number of child/early marriages (40 per cent) followed by Tigray (29 per cent) and Addis Ababa (14 per cent). The majority of those who experienced early marriage are from rural areas (81 per cent).

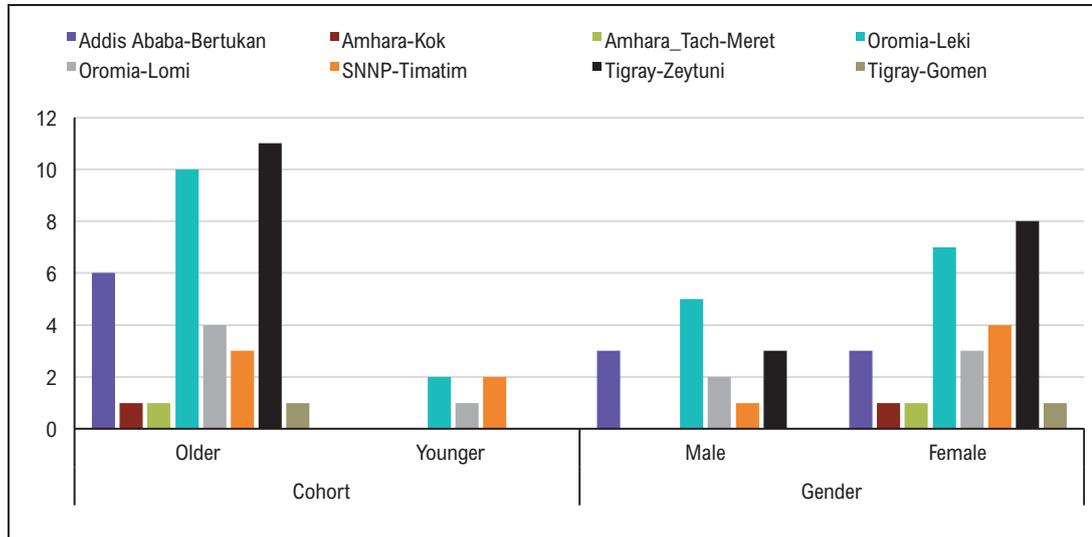
Figure 1. *Early marriage experiences by region and location (n=42)*



Source: Fifth wave qualitative data, and Young Marriage and Parenthood Study data

The qualitative sub-sample featuring in this paper covered young people from both cohorts who had married, with a higher number from the Older Cohort. The Older Cohort (aged 25 in 2019) and females are more likely to have been married early, as is the case with the quantitative data (Figure 2).

Figure 2. Age and gender representation of early marriage (n=42)



Source: Fifth wave qualitative data, and Young Marriage and Parenthood Study data

6.1.1. Marriage forms and drivers

This section discusses the forms of marriage, age at first marriage, the reasons girls marry young, and how marrying young is a driver of early pregnancy. Social pressures force girls to marry young, with marriage at a younger age assumed to ensure a girl’s reproductive capacity and also their marriageability. Women are expected to remain virgins until they marry, and are married off at a young age to prevent them from having sex outside marriage. There may also be economic motives in a society where marriage attracts bridewealth payments by the groom to his bride’s family.

Young parents sought various family formation mechanisms. Those in urban areas usually established a family through informal mechanisms, such as cohabitation, while the majority of those in rural areas resorted to love marriage and to some degree to forced or voluntary abduction or parental arranged marriage. Informal cohabitation usually happens in response to unintended pregnancy or the desire to maintain a sexual relationship while temporarily bypassing the costs of formal marriage. Forced abduction is rarely practised, while voluntary abduction (similar to elopement) is initiated by the couple (Tafere et al. 2020; Boyden, Pankhurst and Tafere 2013). Parental arranged marriage is where parents select the marriage partner and arrange the marriage.

Rural young married people seem to form a family at a younger age than their urban counterparts. Berhan and Buzunesh both live in rural Leki. Berhan was married through forced abduction and Buzunesh through *Aseenaa*¹⁰ at age 15, without her family’s knowledge. Berhan attended school only up to Grade 3 and Buzunesh until Grade 6: although they aspired to pursue their education further, they had to leave school after getting married, even though they were not really interested in getting married at the time. Berhan’s father reported that his daughter married when she was 14 while Berhan indicated that she was 11:

¹⁰ A local practice whereby an unmarried girl attempts to compel an unmarried man into marriage by secretly entering into his home, uninvited; the custom requires his family to accept her and their marriage.

I married at the age of 10 or 11, no, I was even younger. I don't remember the exact time since I was a kid, but we have already celebrated our fourth marriage anniversary.

She reported this in 2018 when she was age 17 (according to Young Lives data), meaning she married when she was 13. Berhan's story illustrates that girls in rural areas marry before their 15th birthday and that the practice of early/child marriage is still present. Early marriage in Ethiopia is still common and happens despite efforts to reduce the practice. Girls from poorer socio-economic backgrounds are more likely to marry early, and societal norms and family pressures sometimes influence marital decisions. Some couples feel compelled to marry after having sex because of the stigmatisation of girls who have sex outside marriage. These marriages are undertaken without planning.

Marriage because of a sexual encounter

According to Moha (Buzunesh's husband), his marriage happened when his wife was sent away from her natal house following their secret get-together the night before. She then came to his parents' house and did not want to leave, and was also being insulted by community members for having been seen with him. Once a girl has been seen with a boy, it is taboo for her to go back and live with her parents. The girl then consents to the marriage by admitting what she did and staying at the boy's parents' house. In the culture of the community, the man has to accept and marry her once she has entered the family's house through *Aseenna*. Similarly, Kenna said his marriage was unexpected and the result of a one-off sexual encounter. He recounted:

While I was attending school, I saw a girl who became my [now] divorced wife, I talked to her, she said OK, and we had sex. That day she went home late in the evening, and her family asked her where she had been. The next morning, her family arrived at our home early in the morning, with a machete, hammer, and different tools. When we saw them standing at our gate, I said that they had come to kill me. After a day, I fled my home, but my father was jailed. My family told me that my father was in jail in place of me. I returned to Leki to get my father out of jail and I was imprisoned instead for five weeks. Then I agreed to marry her after giving *gaaddissa* [reconciliatory] money. (Kenna, Leki, 2018)

From this, it is clear that Kenna had had a one-off sexual encounter that angered the girl's parents and led to his imprisonment. For the girl's family this was shameful, as girls are not expected to practise sex before marriage. Under such circumstances, marriage is a means through which parents ensure their reputation and preserve their honour within the community.

Marriage due to unplanned pregnancy

Unplanned pregnancies also influence early marriage decisions. Bereket, from urban Bertukan, married through an informal cohabitation that led to marriage. His friendship with a girl developed into a romantic relationship over time and later his girlfriend conceived when he was 20:

The way I entered into marriage is full of accidental situations. I didn't have any plans 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.

Beauty is another driver of early marriage. For Mina from Timatim, it is a significant contributor to the early marriage of girls:

There are girls who get married aged 15 and 16. Especially if the girl is good-looking, no one allows her to be alone even if she is not old enough for marriage. Besides, as the culture of the community, the parents also want to marry her off early.

Arranged marriages

There are also marriages arranged primarily with the interests of the parents in mind. In Zeytuni, some young married girls had had their marriages arranged. Letish was married at age 19 to a man she had never met before. She said, "His parents came to ask my parents and then my father agreed to give me off in marriage and then arranged everything." Though Letish's marriage was arranged by her parents, to a certain degree she was interested in the marriage as she was bored of the labouring work she was doing.

It is not uncommon for many child brides in rural Ethiopia to see their prospective husbands for the first time on their wedding day. Letish reported meeting her current husband when she had to go with him for an HIV/AIDS test at a health facility a few days before her wedding. Young people enter into early marriage as a result of decisions initiated by their own interests, their families, or unprecedented situations beyond their control.

6.2 Experiences of fertility and childbearing

Parenthood is viewed as an important marker of transition to adulthood (Arnett 1998). With parenthood, the focus of concern shifts inexorably from responsibility for one's self to responsibility for others (Arnett 2000). Parenthood is also a period whereby adults in many societies have to comply with social norms and experience the roles of becoming parents and setting up independent households.

Nowadays, young people's transitions are not linear and are more diverse, including their parenthood transitions. The following section covers young people's knowledge about SRH generally, their use of contraceptives, their perceptions of and attitudes towards contraceptive use, and their experiences of ante- and postnatal care.

6.2.1. Knowledge about sexual reproductive health

The majority of Ethiopian women live in rural areas largely untouched by modern technology, education and communication. Access to SRH information is still a challenge (Coast et al. 2019). Young married women's needs for SRH information are still unmet or they receive inaccurate or partial information from other people around them.

Both married young women and young men in the study areas face exceptional challenges in the transition to parenthood. Many young mothers are not prepared for motherhood and early childbearing. Although some of these young mothers and fathers have a tertiary level of education, they still know very little about SRH. Almost all mentioned that they got SRH knowledge from peers, older siblings or neighbours, while a few reported getting it from schools, media (television and radio) and health extension workers.

Informal sources are the main sources of knowledge and information for many young married couples, who have little knowledge of reproductive health and childbearing upon their transition to marriage.

Compared to their rural counterparts, those in urban areas appear to have better knowledge about contraceptives. Fatuma lives in urban Bertukan and has completed Grade 10. She got knowledge about SRH from the media and to a certain extent at school. She said, “I got the awareness from the media and people were coming to our school to increase our awareness about it.” Similarly, Lemlem from semi-urban Kok, who had attended college, reported that she was using a three-monthly injection and had learned about sexual relationships, pregnancy, and about the position of the foetus in a biology class.

At the institutional level, although health extension workers are expected to play a role in disseminating information about SRH, little is done in practice. Information and discussions about SRH are almost entirely absent both before and after marriage, either from families or health institutions.

6.2.2. *Contraceptive use*

The contraceptive use experiences of young parents are diverse and are influenced by knowledge, perception and access to available contraceptives. Implants and injectable contraceptives are commonly used types of contraceptives in all the study areas.¹¹ Across the sites, young couples usually start using contraceptives after having their first child, and change from one form of contraceptive to another if they experience adverse side-effects. Some of those who did not know about contraceptives at all become familiar with them when they went for the antenatal healthcare associated with their first pregnancy.

Fatuma lives in urban Bertukan. She married at age 18 and has two children aged 2 and 4. She used contraceptives for some time after marriage and then stopped them to become pregnant and gave birth to her first child when she was 19. She mentioned her first pregnancy was good, yet was a very new experience in her life:

I became shy and shameful as it was my first time ... pregnant. I feared to go out in front of people, even though my belly was small and people could hardly notice my pregnancy until the day I gave birth.

Fatuma has tried three types of contraceptives and found all of them to have adverse side-effects:

I have tried the implant, oral contraceptive, and injectable and none of them is comfortable to me. Sometimes I was staying in menstruation for continuously one or two months. I was suffering from stomach pain because of oral pills. Then the health professionals advised me to use the natural calendar method to avoid pregnancy and that is what we are using now.

Some couples do not use modern contraceptives, but instead give birth naturally at certain intervals. Medi is a mother of two residing in the same community as Fatuma. She married at age 16 and gave birth to her first child when she was 17, and to her second child two years later, but was not using any form of contraceptive: “I have not used any form of family planning methods. I got pregnant with the second baby after two years because I was breastfeeding.”

11 Modern contraceptives in Ethiopia are available in every health facility free of charge. These are: male and female condom, diaphragm and other barrier methods, vaginal contraceptives (foam, tablet and jelly), emergency contraceptives, progestin-only pill, combined oral contraceptive, injectable contraceptive, implant and intrauterine contraceptive device (IUCD).

Medi doesn't believe in planning the number of children because, for her, children are gifts from God. By contrast, some other young parents worry about the well-being of their children and hence want to plan intervals between births. Lemlem from Kok believes in the importance of family planning:

I think family planning is vital for the better development of a child. The second child will be born after seven years and now I should nurture my new-born.

The experiences of pregnancies and contraceptive use vary from one couple to another. Some start using contraceptives soon after their marriage, others delay until after the first birth, and still others never use contraceptives and instead delay pregnancy by breastfeeding. Though breastfeeding significantly contributes to overall fertility reduction, it is not reliable for individual fertility suppression. Studies indicate that women who are partially breastfeeding are at higher risk of conceiving than fully breastfeeding women (Guz and Hobcraft 1991; Lethbridge 1989). Individual women are cautioned not to rely on breastfeeding alone if they wish to avoid conceiving (Labbok 2008).

Fertility is also seen as a way of cementing and preserving relationships. Husbands and other extended family members sometimes want the wife to prove her fertility immediately after marriage. However, some young couples fail to give birth after some years of marriage even if not using contraceptives, and are therefore suspected of being infertile. Hewan from Leki was unable to conceive for two years, even though she and her husband did not use any form of contraceptive until the birth of the second child. She recounted the blame she received from her in-laws:

My husband's family were considering as if I was using contraceptives. In our culture, once you got married and could not give birth immediately, families from the husband's side may suspect your fertility. His families were assuming ... I was applying birth control.

On the other hand, educated and professional parents are quite helpful in advising their early married daughters about early pregnancy. Yalem lives in Lomi and was married at age 17 while attending Grade 7. She and her family wanted her to delay pregnancy so she could pursue her education. Her mother, a health professional, encouraged her and advised her to use contraceptives. Yalem said:

[My mother] asked me if I had taken contraceptives and I told her so. And I gave her the piece of medical paper that I received when I obtained the contraceptives. For the next time, I think that she is going to give me the contraceptive herself from the health post she works at. She will support me by selecting the contraceptive that fits me best.
(Yalem, Lomi, 2019)

Young couples' childbearing experiences are also influenced by the availability of contraception. Some young couples in urban and rural areas mentioned that they could not get their preferred contraception in their locality and then opted for other types, which decreased their interest in using any contraceptives in the future. This is mostly a problem in government-owned health centres, while accessibility is better in private health facilities. Government health centres are where most young people in the urban and rural sites accessed contraceptives, though options in these centres are very limited. Accessing contraceptives in private health facilities is very difficult for young parents as they cannot afford the associated costs.

6.2.3. *Perceptions of and attitudes towards contraceptive use*

Young couples' experiences of contraceptives are also influenced by attitudes revolving around their use. Although some tend to use contraceptives, others hold negative perceptions, with contraception seen as causing infertility and distorting the woman's health, or considered a crime and equivalent to killing children through abortion. Ayehu, a young man in Bertukan, said:

I don't like using contraceptives. I don't recommend her to use any because it is considered [to be the same] as killing children through abortion.

Religion influences the perception young married couples have of contraceptive use. Muslim couples both in urban and rural areas share a strong aversion to the use of modern contraceptives and instead use the calendar method. Samir is a young Muslim man who had his first child at age 21, a year after his marriage. He mentioned that the health extension worker denied contraceptives to his wife when she went to access them. His wife stated:

They say medicine is not good for the Muslims; they say 'Allah yazezewn mwled nw lemuslim' [Muslim women should give birth if Allah allows]. After I gave birth to my first child, I went to the health centre to get birth control because I didn't want to have the second one soon, but one of the Muslim health workers said, 'You are a Muslim, and the child you give birth grows by Allah's will, so you shouldn't use it.' Two other health workers – a man and a woman – advised me seriously to avoid demanding family planning. Then I stopped visiting them again. But thanks to God, 'Alhamdulillah', I didn't get pregnant right away! (Samir's wife, Timatim, 2019)

The effect of religion on childbearing is stronger among some couples in urban and rural areas. Being a Muslim affects contraceptive use and timing, and the number of children. As seen in Samir's case, starting from the use of contraceptives to the number of children couples want, Muslim health professionals oppose couples' decisions to use family planning, both for limiting the number of children and for child spacing.

Poor living conditions also decrease couples' interest in using contraceptives. Some young married women who only had one meal a day wanted to abstain from using certain types of contraception. Many thought that it had side-effects and was not good for their health, especially if they were poor and did not get enough to eat. Mina from Timatim is a mother of four. She indicated that she preferred injectable contraceptives:

It is the three-month contraception that I want to use because I may not have dinner sometimes if there is a shortage of food in the house. Under such a situation, I give priority to my children. So, I may not eat food often. My spouse also says 'if you take contraception that is for three or five years' period, you will be hurt as we are not in a good situation economically.' It is because of this I take the injectable contraceptives.

Young women who have barely begun their childbearing years fear that their fertility might be impaired by the use of modern contraception and prefer abstinence. Some assume that using contraceptives for the first time before getting pregnant causes infertility, and so want to have at least one baby before starting to use contraceptives. Lielti is a divorced young mother in Zeytuni. She said:

Had I have used contraceptives before having one baby, I would have probably missed to have it in the future. So, I just wanted to have a baby at the age of 23.

The wariness of young women about using contraceptives is somewhat similar in urban and rural sites. This is explained by the low educational attainment of the young parents, their economic status, and deep-rooted cultural beliefs in both rural and urban areas, with the latter slightly stronger in rural areas.

6.2.4. *Antenatal and postnatal healthcare*

Pregnant mothers are expected to attend antenatal healthcare appointments following conception. Antenatal healthcare includes a blood test, urine test, foetus position check-ups, vitamin supplements, nutritional advice, and other pregnancy-related treatment. Before pregnancy, advice on contraceptives and the provision of contraceptives are available at the health facilities. Ayu outlined the types of antenatal healthcare she received during her two pregnancies in Leki.

Interviewer: How would you follow-up on antenatal care?

Ayu: I would visit the facility [once a] month.

Interviewer: Would the workers appoint the day you visit them or you would do it on the day you want?

Ayu: They would give me an appointment.

Interviewer: You mentioned that they would check up the positioning of the baby. What other antenatal services would they give you?

Ayu: They also would do an HIV blood test for me every time I visit them.

In urban and rural areas, there is a home-to-home visit service that started in 2004, where a team of health extension workers work on general maternal and child health, delivering health packages that include family planning. According to a health extension worker in Bertukan, this includes taking the anthropometric measurements of pregnant mothers and referring them to the health centre, and if there are malnourished children, ensuring that they get supplementary food. Young mothers indicated that they go to the nearest health facility for antenatal care and for postnatal healthcare services.

Delivery services are carried out at health facilities and health extension workers are doing a lot of work highlighting the benefits of facility delivery in all the study areas. Almost all of the young mothers in the qualitative study reported giving birth at health facilities, with a small number giving birth at home with the support of traditional birth attendants, mostly in remote rural areas. For those who were giving birth at home, institutional delivery was encouraged only in cases where the woman faced birth complications. Though facility-based childbirth is highly encouraged, studies indicate that home delivery is still common and the main cause of maternal mortality and morbidity among rural women in Ethiopia (Amano, Gebeyehu and Birhanu 2012; Fikre and Demissie 2012). EDHS 2016 indicates that only 26 per cent of births occurred in a health facility, with 73 per cent of births occurring at home (CSA and ICF 2017), but facility delivery had increased to 48 per cent in 2019 (EPHI and ICF 2019).

Beletech from Leki gave birth to her first child, who died shortly after birth, at a health centre, but three of her children were born at home. Like Beletech, Haymanot, a rural remarried mother of two, has experience of home delivery. She explained:

Haymanot: I gave birth to my first child at home just because I was afraid of going to a health facility and first birth is assumed to be done at home.

Interviewer: Is it the culture?

Haymanot: Yes, first birth must be done at the mother's house. But later it may be with the husband or his family.

Interviewer: Do other young mothers also give birth at home like you did or do they call for an ambulance?

Haymanot: They call an ambulance only if they face some problems during delivery.

In remote rural areas, some pregnant women give birth at home because of a lack of adequate infrastructure or roads to go to health facilities. Young couples whose first child is born at a health centre are more likely to space their births and have fewer children overall, as they are likely to start using contraception after the first birth.

Postnatal healthcare, where women attend follow-up services and receive advice after giving birth, is done at the same health facility. Services given include child vaccination, weight examinations and advice on Infant diet regulation, including exclusive breastfeeding for the first six months and complementary feeding after that. Health extension workers explain to the women about the need for child spacing and recommend that they begin to use contraceptives after pregnancy.

6.3. Factors influencing decisions about fertility

This section presents the factors and/or actors influencing motherhood and fatherhood among young married couples and examines how fertility decisions are made and changed over time. Couples' fertility desire is directly linked with their desire for children: both how many and what gender they would like them to be, as well as the birth intervals. Yet often the desire is not the same for woman and man in the couple. Sometimes couples decide collectively through open discussions about family planning methods, while at other times, the partners decide on their own without the knowledge of the other partner.

There are a few cases where husbands may make fertility decisions without telling their wives. Kasahun lives in Leki and married when he was 22. He and his wife have not had a child in the last four years. He wants to have four children in the future, but he decided to wait four years before having their first baby and started using the calendar method of birth control. When asked why he wanted to delay having a child, he replied:

I want to have a child after four years because I will not be stressed then. Now, we are two and rely on my income for a living. And if we added another life it would be very challenging since I could not fulfil the needs of my child.

In some Ethiopian communities, children are believed to be God's gifts and it is thought that fate decrees whether they grow or not. This traditional belief leads some couples to have many children regardless of their economic capacity. For Kasahun, this is unacceptable:

I know the dates within which she gets pregnant. It is from the fourteenth to the twenty-sixth day. Between these days, I don't want to have sex with her; rather I try to distance myself. Since I do my job on a shift system, during these days, I try to change my shift to night shift.

This is his clandestine contraceptive plan, though his wife wants to have children and does not want to delay her first pregnancy. Kasahun is doing this after seeing his married friends with children suffering from raising their children. He is still expected to pay a pending

bridewealth (*Gabbaarra*) and wants to continue with his education (which he left in Grade 9) before bringing children into the world.

In some other couples, the husband's involvement in and knowledge about reproductive health are very limited. Even in decisions made jointly on the use of contraceptives, the decision about what type of contraceptive to use is left to the wife. In such cases, it is usually the health professionals who choose contraceptives for the couple, based on their availability. Other husbands are reluctant and do not know if their wives are using contraceptives. They consider this issue to be only the woman's business and leave it to her. Hadush, a young man from Zeytuni, recounted an instance of this.

Interviewer: Haven't you discussed how long she should use the contraceptives?

Hadush: The man does not know anything. This belongs to the women; so they decide by themselves.

Interviewer: If you do not discuss it, how does she know?

Hadush: OK, when the child gets older, I tell her to stop the contraceptive and become pregnant. It is OK if she fell pregnant when the child is two years old.

Hadush has an 8-month-old baby who was born after two years of marriage. He seems to be unaware of contraception, owing to a lack of knowledge, as he and his wife have never been to a formal school and do not know anything about contraceptives. He confirmed recently that his wife had started using contraceptives after health extension workers came to their house and recommended that they use contraception.

However, there is wider variation in knowledge, attitudes, norms and practice in the larger qualitative data regarding husbands' experiences of making decisions about fertility. Across the sites, husbands are usually the dominant decision-makers on fertility and childbearing issues. Whether couples have children soon or allow enough child spacing is largely left to the men to decide, especially in rural areas, although wives are generally consulted. Meselech is a mother of one child, living in Tach-Meret. Her grandmother told her to delay her first pregnancy, even though her husband wished to have a baby soon after marriage. She said, "My grandmother advised me to extend the time for childbearing [but] my husband was very eager to have a child immediately after marriage." By contrast, in Leki, Ayu's husband wanted some spacing between the children. Ayu gave birth to their first child after three years of marriage. Currently, she has two children born three years apart. In total, she aspires to have four children and send them to school so that they have a better life than she does. During the last study round Ayu explained this.

Interviewer: There is three years' space between your two children. What is your reason for this?

Ayu: We discussed and decided to have children with wider spacing.

Interviewer: Why did you make such a decision?

Ayu: My spouse told me that having children one after the other may hurt my health. He told me to take contraceptives and then I accepted his idea.

Interviewer: Imagine he says that you better give birth after two years but you say it is better if we have it after three years. Whose interest will be entertained?

Ayu: His preference will be implemented but he should also listen to my point.

Interviewer: He may listen to your point. But, will his idea be the final decision?

Ayu: Yes.

It is clear that though there are discussions between a husband and a wife about contraceptive use and child spacing, practically, men's decisions are final, giving women little autonomy. Sometimes couples decide to wait for some time before having a baby and then change their minds. Usually, it is the husbands who change their minds and then ask their wives to withdraw contraception. In most situations, men tend to make all the decisions about a family at home, including decisions about childbearing (Chuta 2017). The health extension worker in urban Bertukan said:

Whenever the wife is willing to take [contraceptives], the husband refuses. When we ask them the reason, they say our husbands do not agree.

Similarly, in their study of rural pastoralist areas of Afar, Jackson et al. (2017) reported that gender roles were strictly defined and that men were dominant, even when it came to the immunisation of children and women's access to health services for delivery. Husbands' roles as household heads and providers also constrain women's decision-making ability about fertility. Husbands with little or insecure sources of income were less likely to have children early, mainly due to men's obligations to act as breadwinners and support the children financially. Generally, the husband was dominant in the household, and the wife was usually under his control. In terms of couples' communication and decision-making, the husband made the final decision, including on family planning methods, and the woman needed her husband's permission to use family planning (Geleta, 2018).

Women's and men's roles in fertility and reproduction are also influenced by a combination of other factors. Friends, neighbours, relatives, in-laws, parents, health extension workers, and, to a certain extent, grandparents, may reinforce the parenthood decisions of young couples. Sometimes these actors interfere in the reproductive health decision-making capacity of the couples.

6.3.1. *Economic determinants*

For young married couples, many of the reasons for delaying pregnancy are economic. Those who have been delaying birth either for the first or second time reported that they needed an independent source of livelihood before having children. Regardless of this, some families pressurised couples to have a child. Kuru is a young husband from rural Leki, who married at age 19. They did not have a child in the five years of marriage but his wife has just fallen pregnant.

Since I dropped out of school, I had no other hope but wanted to marry and have a child. I hoped to have a child at the age of 20 or 21. However, when you don't have someone to help you, it is difficult to follow your plan.

He has a strong desire to have a child but has been held back by his limited economic capacity and had to delay starting a family. However, his mother and in-laws have nagged him to have a child for the last five years. Family pressure is present to a certain extent in the fertility desires of couples, though some mothers and grandparents want young couples to delay pregnancy.

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, Leki, 2018)

There are also men like Wende, who are determined to take charge of their own lives and act autonomously, and are therefore delaying pregnancy for two or three years despite external pressures.

Interviewer: Don't your parents and other people around you insist that you have waited too long without having a baby?

Wende: They do! A lot of them say so! But people do not know our family's reality. It is we who know about it. We did not believe in having a baby because of external pressure. It will be a challenge to us and our child if we give birth without having confidence in our living conditions. We should give priority to our ideas and not to the external ones. I will do that after developing confidence in my economic status.

Interviewer: How long after your marriage did people begin to ask you to start a family?

Wende: They did not even wait until I'd been married for five or six months. They pushed me to start a family.

Interviewer: Who are they? Are they friends or family members?

Wende: The first one is friends [then] neighbours ... They say that it is not good if a wife stays for a longer time without giving birth. They explain that a wife that stays longer without giving birth does not stay in the wedlock ... that such a wife will engage in adultery, but I am not bothered with such assumptions. I believe that she will stay with me faithfully if she is convinced and decline the marriage otherwise. This is my standpoint. Above all, I should fulfil my family's needs and settle the condition in which I raise my children. There should be a balance between family needs and fulfilments. I have to acquire important resources before having a child. I have to develop the capacity to fulfil the things that other parents do. I can randomly have two or three children in a row. But I have to consider my capacity. (Wende, Lomi, 2019)

This conversation illustrates many points. First, the determination of the couple, despite efforts to criticise their marital relationship just because they hadn't had a baby. Community perceptions towards a woman with no child are highly negative and a relationship under such circumstances is thought to be unstable. Meki, in Bertukan, said, "My husband convinced me that our happiness will be complete if we have a child." Children are assumed to play a role in making a relationship sustainable, with a marriage without children seen as very fragile and creating less love among couples. People believe that children, like assets, help sustain the relationship and keep the woman in marriage.

Second, the transition to marriage is made early without prior economic and psychological preparation. Many couples who enter into marriage, both in rural and urban areas, do so without the required knowledge and understanding of marital life, including any knowledge of childbearing. Young couples get married without advice about parenting and children, some as a result of the influence of their friends and parents.

Third, although some parents wish to have children even if they are poor and cannot provide for the children's basic needs, this couple seem to be very much concerned about the well-being of their future children. The traditional belief that 'children grow by fortune' does not apply for this couple and they have a strong understanding that they have to increase their economic resources before becoming parents. The life chances of children depend heavily on the resources of the family that they are born into (Comeau and Boyle 2018). Meki's spouse explained what he thought his parental responsibility meant:

A father should provide the necessary things for his wife and his baby and administer the household. It is similar to what the mother does to her baby when giving love and care.

Growing up in poverty generally creates another cycle of poverty and hampers children's development (Odgers 2015). All of the young couples in the study said they wanted their children to have better schooling and living conditions than they did. Hence, for Wende and his wife, parenting is carrying out the responsibilities of raising and relating to children so that the child is able to realise their full potential.

Having many children is also a sign of prestige and economic status in some Ethiopian communities. As agriculture is the major economic sector, most families want to have a large number of children for their labour contribution.

6.3.2. *Socio-cultural determinants*

The community, consisting of friends, relatives and neighbours, can also influence the decision-making ability of couples over fertility and childbearing more than parents, grandparents or mothers-in-law. In some rural communities, couples are encouraged to give birth immediately after marriage, regardless of their age. The community's influence over the dynamics of couples' decisions gets stronger over time and across subsequent births, including in cases where women planned to delay the next births. This was the case with Sessen, the mother of a 5-year-old and living in Zeytuni, who delayed her second pregnancy for five years:

Let alone delaying the first birth, people are gossiping about me even now because I delayed the second birth. They think that I am still on contraceptives and delayed the second pregnancy.

This is more the case in the rural areas, where the community adheres more strictly to social norms, even though some of its more educated members accept the need for family planning. Being a mother or father also gives high social status within the community. After having a baby, the man is called the father of 'x' and the woman, the mother of 'x', and they are not called by their names: this is considered to be a large degree of respect conferred on the couple by the community. Having many children is also considered an advantage and a gift of God in some Ethiopian rural communities. Couples who do not have siblings and are the only child aspire to more children.

6.3.3. *Gender preference determinants*

Gender preference also impacts decision-making over fertility. Some couples keep having children until they get their preferred gender. Wives usually prefer girls, for practical reasons such as getting support with household chores. A mother of one, Letish in Zeytuni, said, "I want to have more girls than boys because girls help me at home more than the boys."

Husbands reported preferring boys to girls within the nuclear family, mainly as their labour can support farming activities. Heissler and Porter (2013), in their study of Young Lives children in Ethiopia, indicated that some families may want a balance of sons and daughters because both their contributions to domestic, family farm and unpaid work are important. However, for Berhan from Leki, who was married through forced abduction, her preference is to have a boy.

Berhan: I believe starting with myself, girls cannot complete their education.

Interviewer: Are there no girls in your kebele who have completed their education?

Berhan: You will not find successful girls in their education. Even if you come across some who have completed school, you may not see them becoming employed.

Although girls are sent to school, it is less likely that they will enter into paid employment. This is slightly at odds with what Boyden et al. (2016) found in their study of Young Lives children's gendered time use, which indicated that boys in the sample generally started school later than girls, did less well at school, and left school earlier. In rural areas, girls are destined to marry and undertake domestic work and not paid work. Especially once girls are married at a very young age, they seldom go back to school. So Berhan fears having girls may expose them to early marriage and make them abandon their education, something she experienced. On the other hand, others like Sefria in Timatim, preferred three girls over two boys for their labour contribution. She said:

I like female children. Male children do not work all domestic chores. For example, they do not clean animal dungs and for that reason, I prefer female children. Female children will help me in doing domestic chores when I get sick.

Most rural Ethiopian women tend to work longer hours and shoulder larger responsibilities than men (CSA 2014a). As a result, they require support from their children. Apart from this, as a health extension worker from Timatim explained, children, especially girls, are also seen as future financial prospects for the family:

Most of the time women who have low income have many children because they believe that when the children become adults, they would support them economically. In the community, girls are economically more active, and migrate to Middle East countries and send money for their family, and because of this, parents in our community prefer to have girls rather than boys.

Labour migration is a source of remittance for some families in the study communities, although boys also migrate for work in other Ethiopian communities.

7. Discussion

This working paper has investigated the fertility and childbearing experiences of young mothers and fathers, as well as the factors that affect the dynamics of their decisions on fertility and childbearing over time. Overall, the decision-making capacities of young couples are affected by different factors in differing contexts.

Fertility is the most important factor in population dynamics as it contributes to changes in the structure of a population. Patriarchal gender norms influence many aspects of family planning and contraception use, as well as the age at marriage.

The study findings show there is gender inequality in determining fertility decisions and contraceptive use. First, there is limited communication and unequal bargaining power between husbands and wives on issues of contraceptives and child spacing, with husbands tending to dominate. Contraception use is considered one of the important determinants of fertility, yet it is dominated by the decisions that husbands make. Husbands generally make these decisions alone or, if they do decide jointly with the wives, the husband's view is the final one. Husbands also have limited involvement in SRH, either because they lack knowledge or because they consider this to be purely a woman's issue. Some husbands are involved, but this is usually in secret without their wife's knowledge. Traditional gender norms hold girls and women back from exercising their rights. Gender inequality persists and prevents young women challenging of their subordinate position within the household and the authority of their husbands over them (Crivello, Boyden and Pankhurst 2019).

Poverty impacts young married couples' fertility and childbearing decisions in two contrasting ways, with it both impeding and enabling childbirth and child spacing. First, young women living in poverty are more likely than young women from wealthier households to become pregnant or give birth before the age of 18 (UNFPA 2013). Among the Young Lives Older Cohort sample, about 10 per cent of the young women have had a child either at or before the age of 18 (Araya, Woldehanna and Pankhurst 2018). All of these young women are from poor households, and poverty is constraining their capacity to make decisions about their fertility. Both early marriage prevalence and poverty are strongly linked to low contraceptive use and high fertility rates (Raj et al. 2009). Young women who do not receive enough to eat, especially in the rural study communities, prefer not to use contraceptives or else choose other options they assume have less impact on their health.

Second, some couples actively delay the first pregnancy because they do not have the resources to start a family. As children's life trajectories are largely determined by the family they are born into, some couples do not want to perpetuate the cycle of poverty and wish for better economic standing for their unborn children, while others want to have more children because of their future economic contribution. In rural areas, women marry and bear children early, yet because early marriage and childbearing among young people are considered 'normal', the later negative outcomes are given little attention.

Young mothers are highly constrained in their ability to navigate and negotiate fertility and SRH across a broad range of domains. The current use of contraception varies with ease of access, religion, social norms and economic status, and to a certain extent with education. Access to contraceptives affects their use by young couples, and couples struggle to get the contraceptives they prefer. While private health facilities provide a wide range of

contraceptive options, young couples from poor households cannot afford these. These young couples mostly seek contraceptives from government-owned health facilities, usually health centres and health posts which have very limited choice. The Government should therefore widen the choices of contraceptives, especially for those living in poverty, who cannot afford to buy them from private health facilities.

Negative perceptions of contraception use obstruct contraception uptake among young women in urban and rural settings, and this is exacerbated by a lack of knowledge and underlying social and religious norms. It has been seen even with educated health extension workers who were supposed to be educating and encouraging fellow women about family planning methods and encouraging them to use them.

Parents also influence the use of contraceptives. The study has shown how educated parents encourage their early married girls to use contraceptives, while parents with little education push young girls to fall pregnant soon after marriage. Similarly, husbands with better education encourage the use of contraceptives while those who have never been educated seem to know little about the use of contraceptives. There are also differences regarding decision-making over fertility and childbearing depending on location, with young women in the urban areas of Bertukan and Kok and those with better education more knowledgeable about contraceptive use and experiences of contraceptives.

Knowledge and information about SRH are very important in childbearing and fertility decisions. Since most of the young couples had either been to school up to the primary level or dropped out at lower secondary grades, they had gained little knowledge about SRH while at school. As a result, they had very limited knowledge about contraception and childbearing, and were therefore at greater risk of the associated disadvantages than were urban couples.

Young couples' decision-making capacity is influenced by a wide range of factors. Couples are assumed to have little or no say about the timing of the first birth, yet their interest in delaying the second and third births is also constrained. Normally couples need to demonstrate their fertility and give birth to a child soon after marriage, yet family pressure does not seem to stop even after the first birth. Community and family expectations play a key role here. Children are regarded as status symbols and sources of economic gain in rural areas, and hence families and the community keep pushing couples to have a large family.

8. Policy implications

Ethiopia's ability to meet the SDGs requires policymakers to pay greater attention to the underlying causes affecting women's decision-making over fertility and childbearing, especially for poor young couples. SDG 5 on gender equality in sexual and reproductive health is far from being realised in the country, as patriarchal values suppress women within both the community and the marriage. Gaining access to health services, including to SRH services, and obtaining the required knowledge and information about SRH are equally important. Some key policy recommendations and suggested further interventions are given below.

8.1. Gender inequality regarding decisions about fertility and childbearing

Men's dominance is often widespread at the household level, including in SRH and childbearing issues, perceptions of which are influenced by a strong tradition of patriarchy. In patriarchal societies, ideas of masculinity often perpetuate inequality between men and women, granting men control and authority over decisions about fertility and childbearing. Many reproductive health approaches overlook the role of masculinity in their programmes. This should be addressed by engaging men in SRH and other health initiatives in the following ways:

- Devise stronger gender perspective approaches in family planning policies and programmes that aim to address the health needs and rights of both men and women. This can be done by designing reproductive health programmes that address men's behaviour in their roles as sexual partners, husbands, fathers, household members, community leaders, and gatekeepers to health information and services.
- Increase men's knowledge of services to change their attitudes and behaviour regarding SRH.

The fact that men play breadwinning roles within a family makes women adhere to the needs of their husbands. Policies to promote gender parity in fertility and childbearing should therefore aim to do the following:

- empower women both economically and educationally so that they have room to negotiate equally with men about fertility and childbearing. The concept of women's empowerment here is generally associated with delayed marriage, smaller families, access to accurate information, and the ability to discuss freely their family planning needs with spouses and other household members and the community. It also needs to influence norms that confine women to unpaid domestic work and low-paid productive work.
- work with men and boys to challenge traditional ideas around masculinity.

8.2. Knowledge and information gap

Inaccurate information, and a lack of information, about family planning methods create prejudices among young women regarding what contraceptives to choose, when to start using them, and where to give birth, as they usually receive this information from unreliable informal sources. Therefore, we conclude as follows:

- Formal communication interventions, including media, are needed, targeting different actors such as friends, families and neighbours, at different levels within households, schools and the community.
- Offering age-appropriate comprehensive sex education by ensuring that young people have the appropriate information before their first sexual experience is vital. Sex education with specific content and pedagogy, taught by trained teachers, can affect behaviour and increases the use of contraceptives.
- Effective mass media interventions should be used to increase communication about contraception and reproductive health education.

8.3. Gender norms

The persistence of deep-rooted gender norms remains the key driver of child marriage and early fertility. Actions are needed to influence family and community norms related to early marriage and early childbearing. To delay the age at first marriage and the birth of the first child, adequate laws are the first step, but interventions are also needed. The following interventions have proved to be promising in improving SRH, enabling the partners to have an equal say in decisions, and encouraging gender-equitable norms and behaviours:

- including the wider community, especially mothers-in-law, as well as religious leaders, officials and others in programmes;
- devising integrated intervention approaches that combine group education for men and boys, mass media activities, and community mobilisation and outreach.

8.4. Sexual and reproductive health rights

Sexual and reproductive health rights and services are critical to young women's ability to lead healthy lives themselves and enable their children to do so too. Policies that aim to promote the SRH rights of women should aim to consider wider social norm approaches by doing the following:

- involving key community gatekeepers, including religious leaders, in SRH rights education at the community level to enforce changes in power relations, economic inequalities, and the persistent ideologies, and cultural and religious norms;
- promoting school-based information services for both boys and girls.

8.5. Poverty and contraceptives

Access to contraception and contraceptive advice, as well as SRH services, is much more difficult for women and men from poor, rural households. The Government needs to promote better information and access and widen the choices for contraceptives, especially for poor people, who cannot afford to buy these from private health facilities. The Government, with the support of development partners, should therefore do the following:

- increase knowledge about the choice of contraceptives at the community and kebele levels;
- ensure contraception is genuinely affordable to the poorest families;
- ensure the supply of contraceptives by making family planning a permanent line item in the budgets of healthcare systems.

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Who Decides? Fertility and Childbearing Experiences of Young Married Couples in Ethiopia

This working paper explores the way young couples in Ethiopia make decisions about fertility and childbearing, and examines their experiences of contraceptive use. It draws on longitudinal qualitative data and quantitative information from young mothers and fathers, spouses, caregivers, community representatives and service providers in eight communities. The paper focuses on the following research questions: (1) What is the relationship between early marriage and young parenthood? (2) What are the experiences of fertility and childbearing among young married couples? (3) What factors affect the decision-making powers of young married people?

The findings show that early marriage is associated with early fertility, and that women's autonomy over fertility and childbearing is constrained by poverty, with social and religious norms widening the gender gap. It also reveals that there are negative perceptions of contraception use, stemming from a lack of knowledge, and that social and religious norms and expectations obstruct contraception uptake among young women in urban and rural settings. Couples in rural areas have limited knowledge and information about contraception and childbearing, while their urban counterparts are better informed.

The paper recommends the implementation of existing gender equality policies (related to Sustainable Development Goal 5) regarding fertility and childbearing, through the creation of stronger and more gendered approaches to family planning policies and programmes to address the health needs and rights of both men and women. Formal communication interventions targeting different actors at different levels with increased reproductive health education need to be strengthened, to address the knowledge and information gap in fertility and childbearing. Finally, adequate laws and interventions that consider encouraging social norms that delay the age of first marriage and childbearing should be in place to address the persistence of deep-rooted gender norms regarding early marriage and early fertility.



An International Study of Childhood Poverty

About Young Lives

Young Lives is an international study of childhood poverty and transitions to adulthood, following the lives of 12,000 children in four countries (Ethiopia, India, Peru and Vietnam). Young Lives is a collaborative research programme led by a team in the Department of International Development at the University of Oxford in association with research and policy partners in the four study countries.

Through researching different aspects of children's lives across time, we seek to improve policies and programmes for children and young people.

Young Lives Research and Policy Partners

Ethiopia

- *Policy Studies Institute*
- *Pankhurst Development Research and Consulting plc*

India (Andhra Pradesh and Telangana)

- *Centre for Economic and Social Studies, Hyderabad (CESS)*
- *Sri Padmavati Mahila Visvavidyalam (Women's University), Tirupati (SPMVV)*

Peru

- *Grupo de Análisis para el Desarrollo (GRADE)*
- *Instituto de Investigación Nutricional (IIN)*

Vietnam

- *Centre for Analysis and Forecast, Viet Nam Academy of Social Sciences (CAF-VASS)*
- *General Statistics Office of Viet Nam (GSO)*

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