Teenage Pregnancy in Ethiopia

Introduction:

According to the United Nation Population Fund (UNFPA), Ethiopia ranks among the top 10 countries with the highest number of women aged 20 to 24 who gave birth by their eighteenth birthday (UNFPA, 2013). The COVID-19 pandemic has exacerbated this issue, further complicating adolescent sexual and reproductive health in a country already struggling with socio-economic, cultural, and religious challenges related to adolescent pregnancy. This report explores the determinants of teenage pregnancy in Ethiopia before, during, and after COVID-19, analyzing rates, trends, and impacts. By understanding these factors, the report addresses the consequences at individual, family, community, and national levels and designs targeted interventions, particularly in Benshangul Gumuz, where the highest rate of adolescent pregnancy occurs. Finally, the report aims to address the gaps in current interventions and proposes context-specific interventions aligned with Ethiopia's national strategy to reduce adolescent pregnancy.

Determinants of Teenage Pregnancy Before COVID-19

Prior to the COVID-19 pandemic, Ethiopia faced substantial challenges regarding teenage pregnancy. According to the 2016 Ethiopian Demographic and Health Survey (EDHS), approximately 13% of adolescent girls were either pregnant or had already become mothers (Central Statistical Agency [Ethiopia] & ICF, 2016). The rates of teenage pregnancy varied significantly between rural and urban areas, with rural areas reporting higher fertility rates among adolescent girls (15%) compared to urban counterparts (3% in cities like Addis Ababa). Specific regions such as Afar, Amhara, Benshangul Gumz, and Sidama exhibited even higher rates, with Afar reaching 23%.

Education plays a crucial role in influencing teenage pregnancy rates. The EDHS highlighted that 28% of pregnant adolescents had no formal education, whereas only 3% of those with secondary education experienced teenage pregnancy. This stark contrast underscores the protective effect of higher education levels against early pregnancy, indicating that improving educational access and retention for girls could be a key strategy in reducing teenage pregnancies (Central Statistical Agency [Ethiopia] & ICF, 2016).

Socioeconomic status has been a major determinant of teenage pregnancy. Girls from lower socioeconomic backgrounds were more likely to become pregnant during adolescence. The study conducted by Kearney and Levine (2015) shows that low income and socio-economic disadvantage are strongly associated with higher rates of teenage pregnancy.

Geographic location significantly influences teenage pregnancy rates in Ethiopia. Adolescents in rural areas are more likely to become pregnant than in urban settings. These rural regions often face barriers such as a lack of healthcare facilities, insufficiently trained healthcare providers, and financial constraints (Seme et al., 2021).

Religion and Cultural factors, such as societal expectations and traditional practices, significantly contribute to teenage pregnancies in Ethiopia. Norms like child marriage are deeply ingrained in many communities, making it difficult to change behaviors and attitudes. Ethiopia has one of the highest rates of early marriage globally, with one in two girls marrying before their 18th birthday and one in five marrying before the age of 15(Kaso et al., 2017). The prevalence of child marriage varies significantly by region and is often higher than national averages. For example, a study in the Gojjam and South Wollo zones of the Amhara region indicated that about 49% of women were married before age 15, and approximately 83% were married before age 18 (Tekile et al., 2020). Religious beliefs often reinforce these practices, as some religious leaders and communities view early marriage as a moral or traditional obligation. Religious doctrines, particularly those of the Orthodox Church, strictly prohibit the use of contraceptives, including birth control pills, deeming them sinful and harmful to the body (Church, 2023).

Determinants of Teenage Pregnancy During COVID-19:

The study of teenage pregnancy during the pandemic was not properly recorded during the pandemic in regions of East Africa including Ethiopia (Musinguzi et al, 2022). However, related factors and determinants can indicate potential trends.

Determinants During Covid:

With schools closed, many adolescents spent more time at home, which for some meant increased exposure to abusive environments, including sexual abuse. This directly leads to higher risks of teenage pregnancy. For example, in the Amhara region there were 203 rape cases (of which 54 are child victims) and 208 Physical assault (of which 192 are women and 8 are child victims). (Mingude, 2020)

With the health system overwhelmed by COVID-19 cases, sexual and reproductive health services were often deprioritized. This resulted in decreased availability of routine antenatal, postnatal, and abortion care, further complicating the landscape of teenage pregnancy management. (UN Women, 2020)

The economic downturn caused by the pandemic increased poverty levels, which is a known risk factor for higher rates of teenage pregnancy. As noted in Kearney and Levine's research (2015), economic hardships can lead to early marriages or transactional sex as survival strategies for families and young girls.

The conflict in the Tigray region began in November 2020 between the Tigray People's Liberation Front (TPLF) and Ethiopian federal forces, alongside their Eritrean allies. This conflict has led to a humanitarian crisis with widespread displacement and violence. The ongoing war has significantly exacerbated vulnerabilities, including sexual violence, which directly contributes to teenage pregnancies. According to regional authorities, at least 120,000 women were raped during the

war in Tigray (Hochet-Bodin, 2024). This persistent conflict has made it even more challenging for young girls, increasing their risk of early pregnancy.

Determinants Post COVID-19:

The determinants discussed pre-COVID-19 and during the pandemic continue to affect adolescent sexual and reproductive health post-COVID-19. The pandemic disrupted healthcare services in Ethiopia, increasing challenges in accessing necessary care. There was a noticeable rise in unmet contraception needs, with an estimated annual increase of 20,738 adolescents lacking access (Seme et al., 2021). This shortfall contributed to a spike in unintended pregnancies among adolescents, increasing by approximately 8,884 cases annually. The economic burden of these health outcomes was substantial, with additional costs amounting to 10.1 million Ethiopian birr (over $250,000) annually for pregnancy-related and newborn care. Moreover, the pandemic led to severe health implications, including 438 cases of major obstetric complications and 14 maternal deaths among adolescents each year (Seme et al., 2021). It is important to understand that these consequences affect not only the teenage mothers but their families, communities and the country.

Consequences/Impacts of Teenage Pregnancy

Individual Level: In Ethiopia, teenage mothers face a higher risk of complications during pregnancy and childbirth such as anemia, obstetric fistula, preterm birth, and low birth weight contributing to the country's leading cause of death among girls aged 15 to 19 in poorer regions. Moreover, the mortality rate for infants born to teenage mothers is 50% higher compared to those born to mothers in their twenties reflecting the critical health vulnerabilities associated with maternal youth and inexperience (Central Statistical Agency [Ethiopia] & ICF, 2016). Additionally, teenage pregnancy drastically alters a girl's life, often disrupting her education with many dropping out of school or experiencing difficulties in completing their education. This can limit their future opportunities for employment and economic stability creating a group of young ladies with limited education and economic options unable to contribute to the country's progress (Zemene et al., 2024).

Family Level: At the family level, teenage pregnancy increases the financial burdens due to additional healthcare, childcare, and education costs for the young mother and her child in Ethiopia (Central Statistical Agency [Ethiopia] & ICF, 2016). There is a higher likelihood of teenage pregnancy among girls who have an older sister who was a teenage mother perpetuating a cycle of early pregnancies within families (Mezmur et al., 2021). Additionally, the family structure plays a significant role; teenagers from divorced parents are more likely to experience teenage pregnancy compared to those from married parents (Mezmur et al., 2021). This can be attributed to a lack of stable parental guidance and communication regarding sexual and reproductive health. More effective communication between parents and children about sexual

education has been shown to reduce the likelihood of teenage pregnancy highlighting the importance of a supportive family environment (Mezmur et al., 2021).

Community Level: The societal implications of teenage pregnancy in Ethiopia are profound. There is a strong correlation between teen motherhood and low educational achievement which negatively impacts the young women's societal position and potential contributions. (Mamo et al., 2021) Teenage pregnancy is often stigmatized within communities leading to social exclusion and limited support for young mothers. Communities with high rates of teenage pregnancy often face challenges in providing comprehensive sexual education and supporting girls to stay in school (Mezmur et al., 2021). The lack of educational attainment and support structures perpetuates a cycle where teenage mothers are unable to contribute effectively to the community's economic and social development. This results in a broader social burden as communities must allocate additional resources to support young mothers and their children, further straining public health and social services (Mezmur et al., 2021).

Country Level: On a national scale, teenage pregnancy in Ethiopia contributes to broader demographic and economic challenges. The prevalence of teenage pregnancy leads to faster population growth which can significantly increase healthcare costs associated with maternal and child health services further straining national resources and impeding socioeconomic development efforts as high teenage pregnancy rates limit the potential contribution of young women to the workforce and economy (Siyoum, M et al,. 2021). The pandemic's impact worsened these conditions by limiting access to healthcare and education, increasing economic pressures, and heightening social isolation. These factors collectively intensified the vulnerabilities of adolescent girls, making the need for effective interventions more urgent.

However, according to a recent study there has been a significant decline in teenage pregnancy from 16.6% to 12.5% during the study period (2005-2016) because of the improvements in several demographic and socio-economic factors. These include increased educational attainment, shifts in religious practices, and better economic conditions as represented by the wealth index. The shift can also be attributed to some of the nation’s effective strategies regarding sexual and reproductive health which have been adopted with international partners in the last few years which are highlighted in the next section.

National Strategy

Currently one of the most prominent aspects of Ethiopia’s national strategy to improve Sexual and Reproductive Health in Ethiopia is the use of Community Health Extension workers. Ethiopia's National Adolescent and Youth Health Strategy (2021-2025) aims to reduce teenage pregnancy from 13% to 7%, reflecting a comprehensive approach to improving

adolescent health. It prioritizes vulnerable and hard-to-reach populations, including those living with HIV, disabilities, and those in fragile contexts (UNFPA, 2021).

The United Nations Population Fund (UNFPA) has been a crucial partner in this initiative, providing both financial and technical support. UNFPA's involvement includes aiding in the development of the strategy, facilitating stakeholder coordination, and ensuring the systematic engagement of young people and other relevant parties. Specifically, UNFPA has supported the training and deployment of community health extension workers (CHEWs), who are vital in delivering reproductive health services and education at the grassroots level. Additionally, UNFPA has played a role in data collection and research to monitor the effectiveness of interventions, ensuring that the programs are evidence-based and targeted to the needs of the population (UNFPA, 2021).

The partnership between Ethiopia and UNFPA has been instrumental in mobilizing resources and aligning international support with national priorities. This collaboration aims to effectively tackle teenage pregnancy and associated health issues, contributing to Ethiopia's emerging success in family planning (Olson & Piller, 2013). This success is partly due to the integrated efforts in improving access to contraception, enhancing health education, and addressing cultural barriers to reproductive health services.

Central to this strategy is the role of community health extension workers (CHEWs), who are essential in providing sexual and reproductive health education, preventing early marriages, and promoting contraceptive use. Since the launch of the Health Extension Program (HEP) in 2003, CHEWs have significantly enhanced access to health services, especially in rural areas with limited healthcare infrastructure. By 2010, over 34,000 CHEWs were deployed across Ethiopia, forming a robust framework for grassroots health service delivery. CHEWs engage communities through home visits and outreach activities, promoting health education and culturally appropriate practices, which has increased the acceptance and utilization of health services among rural populations. (Assefa et al, 2019; Medhaniye et al, 2012))

However, despite some successes in national strategies, challenges persist. Resource constraints, such as the lack of water, electricity, and medical supplies at health posts, limit the ability of CHEWs to provide comprehensive care. Additionally, CHEWs face workload strain and insufficient support from higher-level health facilities, which can affect the quality of care they provide. Moreover, deep-rooted cultural practices and beliefs, particularly in rural areas in Ethiopia, also pose barriers to the adoption of health practices promoted by CHEWs.

To enhance the effectiveness of CHEWs within the national strategy, it is recommended to provide ongoing training and support to CHEWs, involve community leaders in health initiatives, develop targeted interventions to address cultural barriers, and strengthen supervision and coordination between CHEWs and higher-level health facilities. UNFPA

has also encountered difficulties in fully engaging local communities and leaders, which is crucial for the success of health initiatives, especially in areas with higher cultural resistance. The need for continuous training and support for CHEWs is paramount to address the evolving health needs of adolescents.

Gap Analysis:

Despite notable efforts within Ethiopia's national strategies to address teenage pregnancy and improve sexual and reproductive health (SRH), significant challenges persist, particularly in the Benishangul-Gumuz region. Health facility deliveries and postnatal care remain inadequate as many women continue to prefer home births due to deeply rooted cultural beliefs and the perceived inadequacy of health posts. Resource constraints, including the lack of water, electricity, and medical supplies at health posts, severely limit the capacity of community health extension workers (CHEWs) to provide comprehensive care. Additionally, CHEWs face considerable workload strain and insufficient support from higher-level health facilities, affecting the overall quality of care they can deliver. Deep-seated cultural practices and beliefs also act as barriers to the adoption of health practices promoted by CHEWs. Current interventions face difficulties in fully engaging local communities and leaders, which is crucial for the success of health initiatives, especially in rural regions with strong cultural resistance.

To enhance the effectiveness of CHEWs within the national strategy, our intervention will focus on how to narrow down and target the intervention in rural areas that need it more and involve community leaders in health initiatives to address cultural barriers and strengthen supervision and coordination between CHEWs and higher-level health facilities. This can will be done through the formation of an education board that encompasses religious leaders, UNFPA, local leaders, the Ministry of Education (MOE), and the Ministry of Health (MOH). This board will ensure that the intervention is culturally sensitive and gains broad community support, addressing one of the major barriers identified in the gap analysis.

Stakeholders and Potential Threats/Risks:

The program intervention relies on creating a board with five key stakeholders: the UNFPA, the Ministry of Education (MOE), the Ministry of Health (MOH), Local School Board Representatives, and Religious and Cultural Leaders. The UNFPA can significantly contribute by providing funding, training community health extension workers, and designing the Sexual and Reproductive Health (SRH) curriculum based on successful international interventions. However, they could block the project by restricting funding and resources, potentially leading to unprepared workers and poorly researched materials, hence they need to be convinced that the chosen region and intervention has potential. Religious and Cultural Leaders pose the greatest risk of blocking the intervention due to their influence on community perception. Their hesitance to promote SRH education, especially concerning abortion and contraception, necessitates their inclusion in community

discussions to align on common goals like responsible adolescent behavior. Programs like Tostan in Senegal have shown success in engaging religious leaders on reproductive health and family planning. The government, specifically MOH and MOE need to collaborate to appoint community health extension workers and adjust the curriculum to include SRH components, demonstrating how it simultaneously improves health and education outcomes. However, aligning national and local interests poses a challenge. Local School Board Representatives might limit the capacity and access of health-extension workers in schools due to local biases. Aligning local interests is easier if religious communities are involved, given their influence in rural areas. Therefore, integrating all stakeholders into a unified body with a common goal is crucial for successful intervention. As seen in Figure 2, negotiating the nature of SRH education with all the stakeholders is tough but necessary for community acceptance and feasible implementation.

Proposed Intervention:

As seen in Figure 1, our intervention involves using the board to deploy and oversee CHEWs effectively in targeted rural communities. As previously mentioned, considering that sevearal of Ethiopia's regions are experiencing civil conflict, it may be difficult to implement these interventions simultaneously across the country; therefore, the intervention will begin as a pilot project in the Benishangul Gumuz region, and, if yielded positive results, will be scaled up. We decided on Benishangul Gumuz, because it is not involved in civil or political conflict and requires "special reproductive health projects to alleviate reproductive health problems" (Dina, 2021). Benishangul Gumuz is a rural area located in the north-western part of Ethiopia and hosts approximately 1.1 million people (UNICEF Ethiopia Regional Brief, 2022). The two largest religious groups in the region are Islam and Orthodox Christianity and UNICEF reports that Benishangul Gumuz maintains the highest neonatal mortality rate in the region (55 deaths per 1000 births), and the second highest child mortality rate under the age of five (90 deaths per 1000 births) (UNICEF, Ethiopia Regional Brief, 2022). Furthermore, child marriage and sexual violence against girls, prevent them from continuing education; these factors also lead to health deterioration and stunting among teen mothers and their children (UNICEF, Ethiopia Regional Brief, 2022).

The intervention aims to holistically educate children in the region on SHRP to reduce teenage pregnancies and sexual abuses through three primary initiatives: to provide school courses on SHRP, to employ teenage parents to teach SHRP courses, and to establish a connection between teenagers and the program through SHRP hotlines and health extension-workers. Subsequently, the intervention aims to leverage CHEWs to access vulnerable rural areas to teach SRH education through resources and training provided by UNFPA. Recognizing the intensive workload on CHEWs, the intervention also seeks to eventuallytrain teen parents to eventually become facilitators, thus reducing the workload on CHEWs and effectively sustaining peer influence within the community. The first initiative aims to educate teenagers (both

boys and girls seperately) in school on SHRP; specifically, on how to access contraceptives, report sexual assaults and abuses, and negotiate sex. To achieve this, we intend to teach these courses from a primary school level until the end of secondary education; this is because girls may get their period during primary education (making them vulnerable to sexual abuse and child marriages), and because several girls may drop out of school between primary and secondary education. Girls will be instructed on how to avoid sex-related negotiations, through *no-saying-strategies* and social precautionary measures, such as walking in groups.

The second initiative aims to train and employ teen parents (particularly focus on girls) to teach SHRP at local schools. Considering that several teen mothers typically drop out of formal education upon pregnancy, it restricts them from socially climbing and finding occupational opportunities; as a result, girls are forced to heavily depend on their husbands for financial support, and often traps them in an abusive relationship with no means to independently support themselves. Therefore, by training teen parents to teach SHRP at schools, it not only introduces them to the labor force, but also, allows them to share key first-hand experiences related to teen-pregnancy with children in the classroom and increases community involvement with the program to increase student receptivity.

The third initiative relies on community feedback through two channels: hotlines and direct health worker extensions to establish direct communication between the teenagers and the program and townhalls for the local leaders and parents to express their ongoing concerns and thoughts on the program. Several teenagers who want to inquire about SHRP are usually stigmatized by their community; this discourages teenagers from seeking out information on SHRP (Webb, 2023). Therefore, by installing phone booths in each community, teenagers can directly dial the program's SHRP hotline and either inquire about adequate SHRP or report instances of sexual abuse. In addition to this, regular townhalls are an effective way for the education board to hear and understand the community's pulse and concerns about the ongoing intervention. Local leaders and parents have a platform to express concerns, so they are more receptive to the program in the long run. As shown by Figure 3 in the appendix, the health extension workers and townhalls become a means of monitoring and evaluation to receive feedback and collect data for intervention. The CHEWs have a safe channel with the adolescents and teenagers which is independent of parental and community concerns raised in the townhall. Constant community engagement is important to ensure that the local context is receptive to interventions around sensitive subject matters to ensure long term success.

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Appendix:

Figure 1: Logic Framework

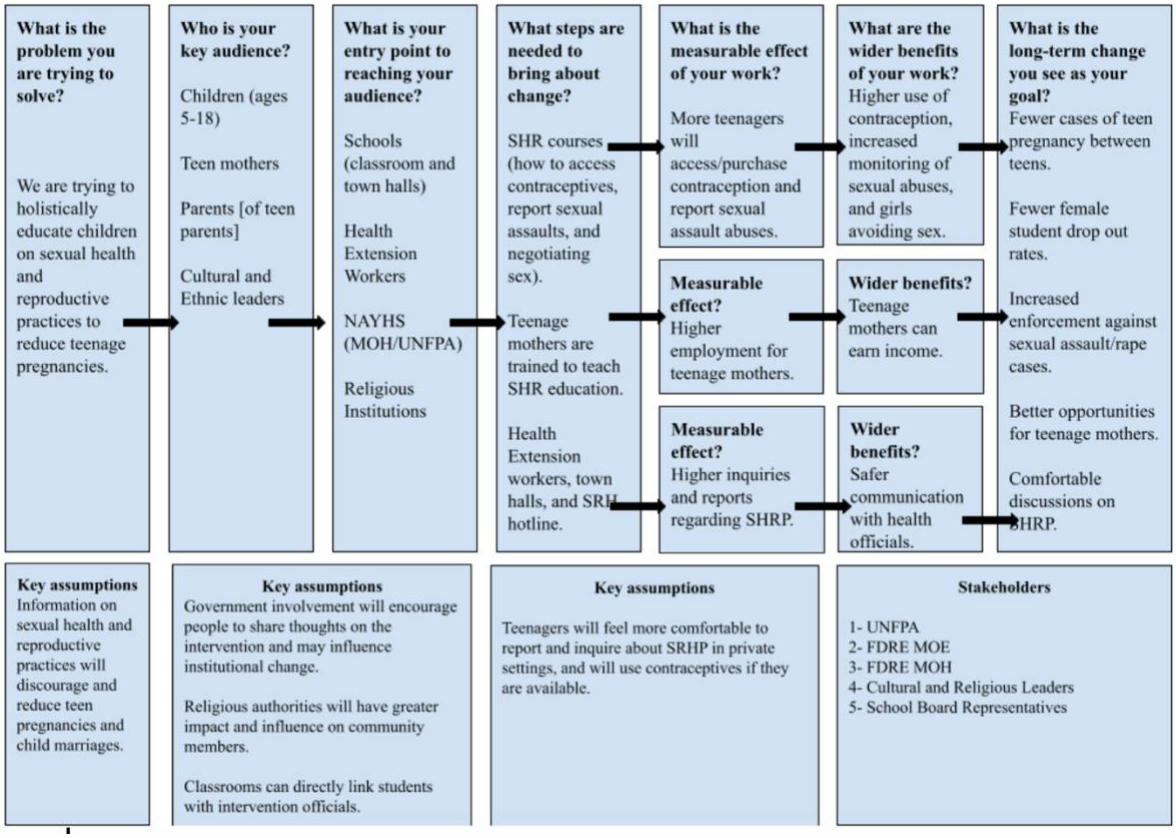

Figure 2: Stakeholder Analysis Matrix

Stakeholder	**What is important to the stakeholder ?**	**How could the stakeholder contribute to the project?**	**How could the stakeholder block the project?**	**Risks and Benefits**	**Strategy for engaging the stakeholder**
United Nations Population Fund (UNFPA)	Increasing quality of Sexual and Reproductive Health Education in vulnerable communities	-Provide funding and training to community health extension workers -Design the SRH curriculum according to effective interventions in other countries	-Restrict funding and resources like training material and access to evidence of past interventions	**Risk:** -Unprepared workers and under-researched material being given in SRH education -Interventions not aligned with international standards likely to fall into national/local barriers **Benefit:** -Access to international resources and best	-Emphasize how the intervention improves upon pre-existing effective interventions in the past and addresses key gaps -Demonstrate how it will make their existing education programs in Ethiopia more robust since SRH is a key educational concern contextually

				practices for SRH education -Funding to train community health workers	
Religious Leaders	Moralistic Values (adolescent abstinence), reducing instances of teenage pregnancy	-Influence community perception and cultural acceptance of SRH education -Encourage members of religious institutions and their children to seek this kind of education	-Object to members of their communities attending or gaining SRH education -Influence government officials to block implementation	**Risks:** Community hesitant to engage in SRH education (children and parents) **Benefit:** Community open to SRH education	-Emphasizing how education leads to outcomes of abstinence and reduced pregnancy -Providing religious leaders with some oversight of material being discussed in SRH sessions -Including moralistic and abstinence components in SRH education
Local School Board Representatives	Providing quality education to Ethiopian children.	Teaching classes specific to sexual health and reproductive practices.	Limit the capacity and access of health-extension workers in schools.	**Risks:** May allow personal biases to influence information taught to children in sexual health and reproductive practices. **Benefit:** Teach boys and girls at early ages about the risks and importance of sexual health and reproductive practices.	Nationally mandate sexual health and reproductive courses at primary schools. Introduce sexual health and reproductive courses as part of a larger education package provided by the MOE, MOH, and UNFPA..
Federal Democratic Republic of Ethiopia (FDRE) Ministry of Education (MOE)	Disseminate quality education to the youth of Ethiopia	-Appointing community health extension workers who will be teaching the SRH curriculum -Adjusting the curriculum to include SRH components	Disallow SRH to be integrated into the official school curriculums	**Risk:** Inability to disseminate SRH education through official channels **Benefit:** Ability to hire personnel, and develop an SRH curriculum combining national demands and international standards	- Use evidence of past interventions to demonstrate how education reduces instances of teenage pregnancy and increases overall SRH outcomes for the youth -Emphasize how the cause of the issue is primarily lack of education, making it an educational responsibility as much as health
Federal Democratic Republic of Ethiopia (FDRE) Ministry of Health (MOH)	Improve sexual reproductive health for adolescents, and enhance family planning strategies.	Leverage the National Adolescent and Youth Health Strategy (NAYHS) to create sexual health	May decide to not amend their NAYHS to include regional education agencies, nor include sexual health and reproductive courses in schools that target	**Benefit:** Introducing new dimensions into an already adequately designed strategy with sufficient funding. **Risk:**	-Emphasize how the intervention improves upon pre-existing effective interventions in the past and addresses key gaps -Demonstrate how it will make their existing education programs in

		strategies for adolescents within different cultural and religious contexts.	resource accessibility and reporting.	Difficulty in regularly amending intervention to fit changing demographics and developments.	Ethiopia more robust since SRH is a key educational concern contextually

Figure 3: Monitoring and Evaluation and Timeline

Expected Outcome	Indicator	Baseline	Target	Data Source	Timeframe	Responsibility
[Short-Term Outcomes] Student Receptivity to SRH Education	% of students demonstrating knowledge in topics Level of student interest in SRH education	Varies regionally 32% Benishangul-Gumuz (Dina, 2021)	70% of students demonstrate comprehensive SRH knowledge (2028)	Pre and post-intervention surveys (Knowledge and Interest)	6 months	Community extension workers and school administration
[Short-Term Outcome] Community Engagement with SRH Education	% of community open to students receiving SRH education	N/A	60%	Focus group discussions Surveys Town hall participation	1 year	Community health extension workers Local leaders
[Short-Term Outcome] Increased Contraceptive/ SRH resource usage	Number of students accessing resources (% of students using contraceptives)	20%	60%	School records Surveys	6 months	School administration
[**Long-Term Outcome**] Reduced Instances of Teenage Pregnancy	% of teenage pregnancy	Early childbearing - 59% (Dina, 2021)	30%	Health clinic records, school reports	5 years	Ministry of Health

[Long-Term Outcomes] Improved Health Outcomes	% decrease in STIs among students Decrease in unsafe abortions	83.9% adolescents underwent unsafe abortions	50%	Health Clinic Records	5 years	Community health extension workers