Young Lives Preliminary Country Report: Ethiopia

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September 2003

Young Lives
An International Study of Childhood Poverty

The Young Lives Partners

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Contents

List of tables

List of figures

List of boxes

Abbreviations

ADLI	Agricultural Development-Led Industrialization
ASSC	Absolute Structural Social Capital
BCG	Anti-TB vaccination (Bacille Calmette-Guérin)
CBO	Community-based Organisation
CDC	Centre for Disease Control
CIT	Citizenship
CSA	Central Statistical Authority
CSC	Cognitive Social Capital
CSO	Civil Society Organisation
DFID	Department for International Development
DHS	Demographic and Health Survey
DPPC	Disaster Preparedness and Prevention Commission
EDRI	Ethiopian Development Research Institute
EHNRI	Ethiopian Health and Nutrition Research Institute
EPRDF	Ethiopian Peoples' Revolutionary Democratic Front
ESDP	Education Sector Development Program
HDI	Human Development Index
HIPC	Heavily Indebted Poor Countries
HIV/AIDS	Human Immuno-deficiency Virus /Acquired Immuno-Deficiency Syndrome
HSDP	Health Sector Development Program
IDA	International Development Association
IFI	International Financial Institutions
ILO	International Labour Organisation
IMF	International Monetary Fund
MDG	Millennium Development Goal
MOE	Ministry of Education (Ethiopia)
MOFED	Ministry of Finance and Economic Development (Ethiopia)
MOH	Ministry of Health (Ethiopia)

MOLSA	Ministry of Labour and Social Affairs (Ethiopia)
NGO	Non-governmental Organisation
NOE	National Organisation for Examinations
RAU	RAU University
RSSC	Relative Structural Social Capital
SAC	Structural Adjustment Credit
SAF	Structural Adjustment Facility
SAMRC	South African Medical Research Council
SC-UK	Save the Children Fund-United Kingdom
SDPRP	Sustainable Development and Poverty Reduction Program
SDQ	Strengths and Difficulties Questionnaire
SNNP	Southern Nations, Nationalities and Peoples
SOE	State-owned Enterprises
SPSS	Statistical Package for Social Scientists
SS	Social Support
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Emergency Fund
WB	World Bank
WHO	World Health Organization
WI	Wealth Index
YL	Young Lives

Preface

The Young Lives Project is a longitudinal study in Ethiopia, India, Peru and Vietnam. The research is co-ordinated by an academic consortium involving the University of Reading, the London School of Hygiene and Tropical Medicine, London's South Bank University, the University of Sussex, the South African Medical Research Council, and Save the Children UK, which is also the dissemination and advocacy partner. The UK Government Department for International Development (DFID) funded the first phase of the project.

In each of the countries, this included the first survey of 2,000 index children aged around one year and a survey of 1,000 children aged around eight years, evenly spread across 20 sentinel sites per country. The Young Lives Project is unique in measuring child well-being in a holistic and consistent way across several developing countries, including economic, social, physical and demographic aspects. Data collection finished in 2003 and an important priority has been the early production of a preliminary report from each country, each report following a similar structure.

This preliminary report covers only a small selection of the explanatory and outcome variables. Data are mainly presented for the entire sample of an age group, in most cases separated into wealth groups or by urban/rural location. The full richness of the data is not reflected in this preliminary report, but we hope that it contains enough information to prompt interest in the project and its data. It will be of great value if it prompts academics, practitioners, policy-makers and other stakeholders to provide ideas, comments and questions to the Young Lives team.

These will feed into further analysis plans, which will include work on the three main 'story lines' of the project: the effects on child well-being of (i), access to and use of services, (ii), social relations, and (iii), livelihoods. As in any longitudinal research, the most interesting and important results will come after several rounds of data collection – we hope to survey our index children approximately every three years until they are fifteen. However, an examination of this first round – like a single snapshot, cross-sectional study – can produce notable results even at this early stage.

For further information on the Ethiopian component of the Young Lives Project, please contact Bekele Tefera, Save the Children UK–Ethiopia, Addis Ababa, Ethiopia (yl-scethiopia@telecom.net.et) or Tekie Alemu, Department of Economics, Addis Ababa University, P.O. Box 1176, Addis Ababa, Ethiopia (tekie_a@econ.aau.edu.et). For further information on the international dimension of the project, please visit the Young Lives website http://www.younglives.org.uk/

Acknowledgements

This study was made possible with the kind assistance of a number of people and institutions.

The UK Department for International Development (DFID) supports policies, programmes and projects to promote international development. DFID provided funds for the first phase of Young Lives 2001-2004 as part of that objective although the views and opinions expressed in this report are those of the authors alone.

Preliminary analyses have been carried out using Statistical Package for Social Scientists (SPSS) statistical software and we are grateful to SPSS UK Ltd for allowing us free use of the software for the Young Lives Project. We also benefited from a visit by Carlos Barahona of the Statistical Services Centre (SSC), University of Reading, in co-ordinating our data entry. Cathy Garlick, also of SSC, prepared the SPSS syntax used to produce the initial tabulation plan. We would like to record our appreciation for Cathy Garlick's efforts and her capacity for understanding our problems and her patience in addressing them.

The Ethiopian team of the Young Lives Project would like to thank the Disaster Preparedness and Prevention Commission (DPPC) and the Ministry of Labour and Social Affairs of the Federal Democratic Republic of Ethiopia (MOLSA) for their co-operation. The team would also like to thank members of the Advisory Panel of the Project and the institutions they represent (see Appendix B) for their very useful contributions at various stages of the project and the Ethiopian Development Research Institute for its support. The team would like to thank administrators at different levels of government for facilitating the fieldwork and supervisors and enumerators for their useful contributions. Last but not least, the team would like to thank all the respondents (families and children) and community informants for their cooperation.

Executive summary

Young Lives is an international longitudinal study aimed at improving our understanding of the causes and consequences of childhood poverty in four developing countries (Ethiopia, India, Peru and Vietnam). The research is based on a panel survey which will track two thousand children, and their households, from each of the four countries over a fifteen-year period. The findings of the research, based on surveys to be conducted every three years, are expected to provide a better understanding of the problem of child poverty and to help in the formulation of policy to alleviate child poverty.

The Ethiopian part of the project is jointly implemented by the Ethiopian Development Research Institute (with researchers from Addis Ababa University) and Save the Children UK in Ethiopia.

This preliminary national report has the following objectives: to briefly present what is known about child poverty in Ethiopia; to review policies expected to have an impact on child poverty; to identify key stakeholders for this study; to describe the methods used in the study; to present preliminary results from surveys of 2,000 households with one-year-old children, and 1,000 households with eight-year-old children; and to present some provisional conclusions and policy implications. Twenty sentinel sites were selected from five regions of the country for the survey. A summary of the main results of the surveys is presented below.

Index (one-year old) children: Fifty-three per cent are male and 47 per cent female; 82 per cent live with both parents and 17 per cent live with single parents; 85 per cent live in male-headed households; 97 per cent are cared for by their biological mother.

Caregivers of index children: Ninety-seven per cent of caregivers are biological mothers of the index child; 85 per cent of caregivers have permanent partners; 82 per cent of caregivers' partners live in the household; 89 per cent of caregivers have not completed primary school.

Households of index children: Thirty-five per cent of households live in urban areas and 65 per cent in rural areas; 63 per cent are very poor, 24 per cent poor and 12 per cent less poor households; average household size is 5.7 people; 87 per cent of household heads have not completed primary school; female-headed households are more common in urban areas (22 per cent) than rural areas (12 per cent); 53 per cent of household members are below 15 years of age, 26 per cent are children below 5 years of age, only 2 per cent are over 60 years of age.

Socio-economic status of households of index children: Eighty-six per cent of children living in very poor households are in rural areas, while 88 per cent of the less poor are in urban households. Water piped into dwellings is almost exclusively found in urban areas, with 29 per cent of study households having access to this. Only 3 per cent of urban households and about 1 per cent of rural households have access to water-borne toilet facilities; 87 per cent of the poorest households have no toilet facilities, whereas 50 per cent of the less poor households use household pit latrines. Earth is a widely used flooring material and is more likely to be used by very poor (99 per cent) and poor (85 per cent) households.

Pregnancy, vaccination and delivery (index child): Antenatal visits were undertaken by 71 per cent of urban biological mothers and 40 per cent of rural biological mothers, with wealthier households having better antenatal care. The majority of rural mothers (96 per cent) give birth at home, without the assistance of a medically trained person. In wealthier urban areas this figure falls to 57 per cent. About 40 per cent of children in very poor households had low birth weights compared to 15 per cent in less poor households; 42 per cent of rural households reported low weight of the child at birth compared with 20 per cent for urban households. Around 21 per cent of the children do not receive vaccinations against both tuberculosis (BCG) and measles. About 78 per cent of the respondents had two or more children and the remainder had only one child, a larger proportion of rural households (83 per cent) having more than one child compared with urban households (69 per cent). The death of a child under five years of age was reported in 25 per cent of the households.

Childcare (index child): Twelve per cent of urban households make use of non-household members for childcare while the corresponding figure for rural areas is 21 per cent. Very poor households (21 per cent) tend to allow non-household members to take care of their child more than the poor (12 per cent) and less poor (15 per cent), possibly because the relatively rich ones have sufficient resources to be able to allocate a household member to this task. A larger percentage of very poor households (15 per cent) allow children younger than five years of age to take care of the index child, compared to less poor households (4 per cent).

Health of index child: Twenty-seven per cent of rural caregivers perceive their child's health to be worse than other children of their age, whilst in urban areas this drops to 19 per cent. In less poor households, 64 per cent of caregivers perceive their child to be healthier than other children of their age. The corresponding figure for the very poor is 28 per cent. 10 per cent of the index children have long-term health problems and these are more likely to be living in the poorer rural areas (12 per cent) than in wealthier urban areas (7 per cent). About 30 per cent of caregivers reported their child had been so sick that they feared she/he might die, with 34 per cent of the very poor reporting such cases compared with 22 per cent for the less poor category. Of these caregivers, 75 per cent sought medical help with less poor households appearing to be more likely to seek medical help than very poor ones.

Twelve per cent of the index children have suffered a severe injury and 36 per cent of children experienced illness in the 24 hours before the interview. Rural children (39 per cent) and children born into very poor households (40 per cent) seem to be more vulnerable to illness than children from less poor households (23 per cent).

Livelihoods, diversification and debts (households of index children): The three most frequent activities undertaken by household members were agriculture, hunting, forestry and fishing (60 per cent); community, social and personal services (27 per cent), and wholesale and retail trade (20 per cent). The three least frequent activities are working with electricity, gas and water (0.1 per cent); mining and quarrying (1.1 per cent) and not being involved in any activity (2.1 per cent). For very poor and rural household members the most important activity is agriculture, hunting, forestry and fishing, followed by community, social and personal services. On the other hand, the largest percentage of urban household members were involved in finance, insurance, real estate and business services followed by

wholesale and retail trade. In terms of diversification of households, 56.7 per cent of the households were involved in activities in only one sector. A larger percentage of households in rural areas (47 per cent) were involved in more than one sector, compared with urban areas (32 per cent). These figures are higher for the very poor than for the less poor. A smaller percentage of households reported having not been involved in any activity in rural areas (0.7 per cent) than those in urban areas (4.0 per cent). About a third of the households reported having serious debts, of which 33 per cent thought they would be able to repay on time. A larger proportion of households in the rural areas had serious debts (39 per cent) compared with those in urban areas (20 per cent). The percentage of those who had serious debts appears to decrease with wealth.

Economic changes and events (households of index children): Most families faced up to five events or shocks (since the biological mother was pregnant with the index child), with the proportion experiencing shocks being higher in rural areas (72 per cent) than in urban areas (60 per cent), and higher amongst very poor and poor households than less poor households. The most common event was 'decrease in food availability' followed by 'failure or theft of crops' (noting, however, that the latter event can cause the former). Shocks related to agricultural failures (crop failure, natural disaster, death of livestock) are naturally more prevalent in rural areas. However, people in both rural and urban areas seem to face similar problems regarding food availability. Job loss, birth or new household members, paying for children's education, illness and injury were more common in urban areas. The problems of theft or death of livestock, crop failure, natural disaster and decrease in food availability are the highest among the very poor households. Most households did nothing when confronted with negative events. However, some of the families responded to negative events by selling assets, eating less and/or the use of credit. The response 'doing nothing' is often an indication of perceived helplessness and may suggest an almost complete lack of resources.

Social capital (households of index children): The majority of households (58.3 per cent) have medium absolute structural social capital, medium social support (49.6 per cent), and high cognitive social capital (88 per cent). Of the caregivers, 56 per cent had zero citizenship, indicating that they neither join together to address common issues nor do they talk with the local authority on problems in the community. The proportion of households who have medium and high absolute structural social capital, medium and high social support, and high cognitive social capital is higher for the very poor than the less poor. The results suggest that poorer households who have little or no financial and physical capital have higher levels of social connectedness in order to reduce their vulnerability.

Psychosocial well-being of caregiver: About 33 per cent of caregivers reported having had some level of depression within the past 30 days, with little variation across location and poverty status.

Nutritional status of index children: Thirty-eight per cent of the index children are malnourished and 14 per cent are wasted. Rural children and children born in very poor households tend to be more wasted, or (chronically) malnourished, than urban children and children born into less poor households.

Nutritional status of eight-year-olds: Thirty-three per cent of the children are stunted and 14 per cent are wasted. Rural children and children born in very poor households tend to be more wasted than urban children and children born into less poor households.

Health of eight-year-olds: Forty-eight per cent of the children's caregivers' feel that the health of their child is the same as their peers; a larger proportion of caregivers in less poor families (compared to very poor households) see their children as being healthier than their peers. Ten per cent of the children have had long-term illness, while 20 per cent of caregivers reported their child so ill that they thought she/he might die – with the percentage being higher for children born into very poor households (21 per cent) than for the less poor (11 per cent). Seventy-five per cent of these sought medical treatment. Severe toothache is more common in urban than rural children, and in the less poor than very poor children. Some 20 per cent of the children had been ill in the two weeks preceding the interview.

Literacy and numeracy of eight-year-olds: Fifty-four per cent of the children cannot read or write anything. Only 20 per cent can read letters and 57 per cent are unable to write. Children in urban areas, and less poor households, appear to be better in literacy and numeracy than those in rural areas and poorer households.

Child's schooling and feelings about school: Sixty-seven per cent of the children had attended school prior to, or during the time of, the survey year. School attendance is higher in urban areas (86 per cent) compared to rural (56 per cent), and for children from less poor households (95 per cent) than from very poor ones (53 per cent).

In 30 per cent of the households, the child did not go to school because she/he was needed to help the family in various work activities. The other two main reasons were the school being too far away (24 per cent), and it being too expensive to send the child to school (22 per cent). Over half (59 per cent) of the children felt that 'teachers or pupils beating' them is what they do not like about their school. A similar proportion (58 per cent) felt the thing they most liked was learning.

Child development – Raven's test: For the simplest set of tests, 67 per cent of children obtained average scores and 27 per cent obtained high scores. Children from less poor families appear to have scored better than others. In the next levels of testing all children obtained low scores.

Child's work and feelings about work: About 9 per cent of the children have worked for money (or goods) with a larger percentage of rural children working (11 per cent) than urban (4 per cent), and more children from very poor households (12 per cent) than from poor and less poor ones (3 per cent each). For almost 75 per cent of the respondents, the main reason the child is working is to supplement household income. Bonded labour was the second most frequent response for urban households (about 8 per cent), while for rural households it was what the children like to do (about 14 per cent). About 5 per cent of working children are reported to have been seriously hurt whilst working, with a larger percentage of cases reported in urban than in rural areas. More than half of 94 children responded that they like working. About 41 per cent of 39 children said that they do not like working because it is too tiring. About 28 per cent of 80 children said they have missed school because of being at work.

Child's perception of well-being: Most of the children felt the water people drink (82 per cent) and the air people breathe (67 per cent) to be good, and the area they live in to be safe for children (76 per cent). However, only 33 per cent felt good about the rubbish on their street. Of those who feel bad about the rubbish, the proportion is higher for urban than for rural children. The child's perception regarding the quality of water is better in urban areas, and among poor and less poor households, than in rural areas and among very poor households.

Most of the children want to become teachers (41 per cent) or doctors (26 per cent) with urban children having a stronger ambition to be a doctor than rural children. Buying clothes is the most preferred activity of the majority of the children. Rural children feel happier than urban children when bought clothes and playing with friends. The desire to be bought clothes declines as the family becomes less poor. Forty-five per cent of the children dislike the area they live in because they are being beaten.

Child's social capital: Seventy-five per cent of the children play with children daily. For 90 per cent of the children, there will always be someone who helps them when they have a problem, usually their mother – though in rural areas nearly double the number of children will be helped by a brother/sister.

1 Introduction

Young Lives is an international study of childhood poverty. It is aimed at improving our understanding of the causes and consequences of childhood poverty in four developing countries (Ethiopia, India, Peru and Vietnam). The research is based on surveys which will track 2,000 children, and their households, from each of the four countries over a fifteen-year period. The findings of the research, based on surveys to be conducted every three years, are expected to provide a better understanding of the problem of child poverty and to help in the formulation of policy to alleviate child poverty.

The Ethiopian part of the project is jointly implemented by the Ethiopian Development Research Institute (with researchers from Addis Ababa University) and Save the Children UK (SC UK) in Ethiopia. This preliminary report presents, among others, some of the descriptive results from the first-round survey of 2,000 one-year-old children[1] and their households, and 1,000 eight-year-old children[2] and their households. A more rigorous analysis of the data will follow.

The report has the following objectives: to briefly present what is known about child poverty in Ethiopia; to review policies expected to have an impact on child poverty; to identify key stakeholders for this study; to describe the methods used in the study; to present preliminary results from surveys of 2,000 households with one-year-old children, and 1,000 households with eight-year-old children; and present some tentative conclusions and policy implications. The remaining part of Section 1 of this report tries to achieve the first three objectives.

1.1 Background

Childhood is a period of formation and development. Many children in the world are denied their natural right to development. They grow up with no access to the different types of resources vital for their well-being and the fulfilment of their potential. Growing up in poverty deprives children of basic needs such as shelter, water, food calories, education, health and all aspects of needs for psychosocial development (SC UK, 2000). The United Nations Children's Fund (UNICEF) argues that poverty is often understood in terms of income, ignoring the many human faces of childhood poverty. According to this argument, a definition of poverty should include material 'capabilities' and 'basic characteristics' such as frequent illness, low birth weight, low education, social and political marginalisation, or discrimination based on gender, age or another ground (UNICEF, 2000, p.6). It further argues that child poverty does not only include lack of basic services but also lack of protection for the disadvantaged from man-made and natural disasters, child labour, and disabilities. Therefore, child poverty should be measured in terms of 'outcomes' and not 'inputs' required for buying a minimum basket of food and services (ibid).

Child poverty is even more complex because children's well-being, and the values linked to that, is related not only to level of income, but also to education of parents and their beliefs, priorities of policy-makers and the overall political and socio-economic condition of a country.

Child poverty is becoming a concern for governments, donors and civil society. This concern arose from a recognition that in most developing countries: (1), children make up one-third to half of the population; (2), the future of a nation depends on today's children, and that investing in children today ensures a better world for themselves, their people and their country (Young Lives, 2000); and

1 The results for this report are given for 1,999 one-year-old children due to one missing observation.

2 The results for the eight-year-old children are reported for 1,001 households as there was one more observation in one of the sites.

(3), that conflicts, natural disasters, population growth, poor governance, failed economic strategies, social and economic inequalities and a whole array of other problems continue to have an impact on the life chances of children (SC UK, 2000).

In the last few years of the twentieth century, the focus of donors on reducing and eradicating world poverty strengthened. Ranges of bilateral donors, as well as the UN system, the World Bank (WB) and International Monetary Fund (IMF), have all adopted a set of international development goals, mostly to be met by the year 2015. Some of the goals directly relate to children, including reduction in infant and child mortality, and ensuring universal primary education.

However, while international policy interest in improving child welfare in developing countries has been growing, it is increasingly recognised that the data and evidence base for making policy in these areas is limited. Data on children is often fragmented, and rarely based on long-term studies, which are essential for an understanding of how early experiences affect future life-chances.

Whilst there are child-development studies in the UK, USA and other developed countries, no such studies exist in the developing world. Young Lives is an international innovative, longitudinal and multi-dimensional study of childhood poverty, aiming at making panel data available for decision and policy-makers and other users. The project will also disseminate evidence–based information on the changing nature of childhood poverty using the media, the website and other channels.

The specific objectives of this project are to:

Produce good quality, long-term panel data about the changing nature of the lives of children living in poverty.

Attempt to trace links between key events and policy changes on the one hand, and child welfare on the other.

Ensure that the research results inform and respond to the needs of policy-makers and planners.

The remainder of this section examines the socio-economic and poverty situation in Ethiopia (with emphasis on childhood poverty), and briefly analyses the policy environment and implementation processes to identify issues for follow-up and advocacy. Finally, an attempt is made to analyse potential stakeholders and partners for advocacy.

1.2 The socio-economic context in Ethiopia

In 1991, when the new Government took power after ousting the socialist military regime, Ethiopia had been in a deep socio-economic crisis. It was characterised by macroeconomic imbalances, indebtedness, vulnerability to external shocks, severe food deficits, worsening social conditions (especially for those displaced by war) and demoralised civil servants (IMF, 1999). Quality of social services was deteriorating at all levels. Since 1991, the Government has taken drastic measures to restructure the political and economic systems, and institutions, as the groundwork for ensuring that peace and stability is created in the country and that the democratisation process has taken effect. In this regard, the adoption of new constitutions and the formation of a new decentralised federal system of government were landmarks for democratisation and the creation of "the foundation for participatory development and empowerment" (Ministry of Finance and Education [MOFED], 2002a, p. 2).

From late 1991, the Government of Ethiopia chose to implement structural adjustment programmes. Supported by WB/IMF structural adjustment facility (SAF) and International Development Association (IDA) structural adjustment credit (SAC), the Government entered upon a path of post-war economic reconstruction aimed at putting the country back on its feet (IMF & IDA, 2001). During the period 1992-96, Ethiopia continued stabilising its economy with continued support from the donor community coupled with good harvest in the country.

BOX 1 THE MILLENNIUM DEVELOPMENT GOALS

The *United Nations Millennium Declaration* was adopted by 149 world leaders in September 2000. The Declaration commits UN Member States to achieving the following Millennium Development Goals by 2015:

- To halve the proportion of the world's people whose income is <$1 per day and the proportion of people who suffer from hunger and the proportion of people who lack safe drinking water.
- To ensure equal access to all levels of schooling for girls and boys – preferably by 2005 for primary and secondary education – and primary schooling for all children everywhere.
- To reduce maternal mortality by three-quarters and under-five mortality by two-thirds.
- To halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases.
- To provide special assistance to children orphaned by HIV/AIDS.
- And by the year 2020, to achieve a significant improvement in the lives of at least 100 million slum dwellers.
- The baseline (except for drinking water) is 1990.

Source: Boulton and others, (2001)

Committed to alleviating poverty and achieving rapid development, the Ethiopian Government has been investing substantially in the public sector for the last decade. During the post-reform period, the budgets for education, health and infrastructure have all increased as a share of total public expenditure (MOFED, 2002a). In 2002, the Government finalised its Sustainable Development and Poverty Reduction Programme (SDPRP), which laid out the strategy for achieving the Millennium Development Goals (MDGs) within the scarce resources the country can afford and with support from the donor community. In order to alleviate poverty the Government designed a broad-based development strategy, called agricultural-development led industrialisation (ADLI). ADLI is taken as the primary strategy for rapid development and for lifting up the living standard of the poor (ibid).

In spite of the major efforts made at all fronts, achievements over the last ten years or so have been modest for a number of reasons. The two-year conflict with Eritrea, and the subsequent drought that occurred in many parts of the country, coincided with and negatively impacted on economic development. The war forced the Government to spend scarce resources on defence and scale back ambitious development plans. For example, defence outlays increased from 19.3 per cent public expenditure in 1997/98 to 39.8 per cent in 1999/00. On the other hand, poverty-related expenditure was reduced from 38.9 per cent in 1997/98 to 5.3 per cent in 1999/00 (IMF & IDA, 2001). The war had another repercussion. Donors withdrew development aid they committed or pledged, or made tactical delays in transfers. The most affected were sector development programmes for health and education (Ministry of Education [MOE] 2001, Ministry of Health [MOH] 2003a).

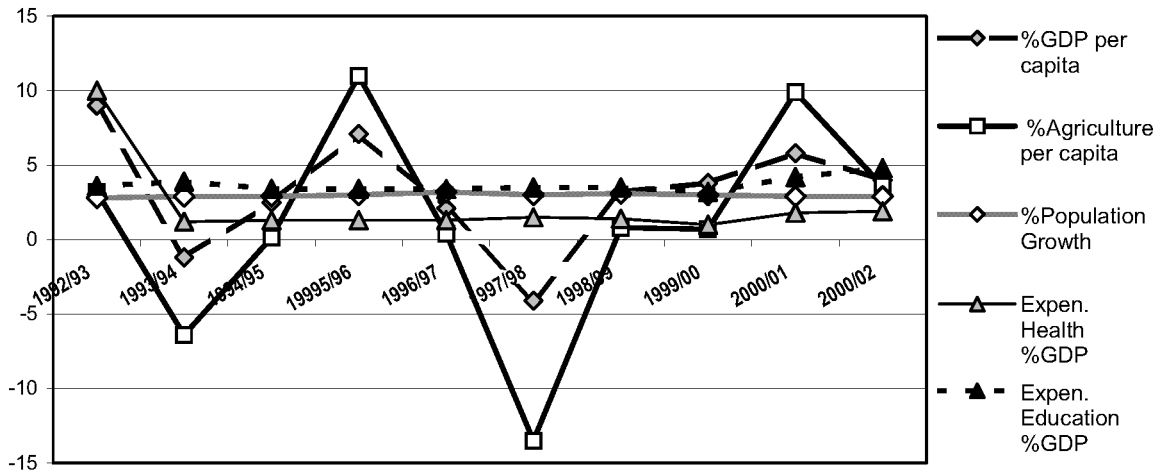
Repeatedly affected by recurrent drought, war, falling prices of agricultural products (particularly coffee)[3], and foreign trade imbalance and debt[4], the Ethiopian economy became volatile (*see* Figure

3 Producer price for coffee fell by 44.6 per cent in 2001/2002 while at the same time prices of cereals fell by 22.2 per cent (IMF and IDA, 2001).

4 The net present value (NPV) of debt to export ratio at the end of June 2001 was 284 per cent, which is 42.6 per cent of GDP (IMF&IDA, 2001).

1.1). However, against all odds, the economy has shown a positive change during the last decade. Real gross domestic product (GDP) per capita increased by an annual average of 2.4 per cent between 1992 and 2002 while, at the same time, real agriculture value added per capita grew by an annual average of 0.2 per cent (MOFED, 2002a). This shows that although, on average, agriculture (which also contributes more than 45 per cent of GDP) has shown positive growth, it has failed to match the annual population growth of 2.9 per cent. Similarly, expenditure for health and education did not show corresponding growth with population growth – but at least it was maintained throughout the decade. Nevertheless, there have also been improvements in the social sector since 1992. For example, infant mortality has declined by 25 per cent over the last ten years, to 97 per 1,000 live births, while at the same time under-five mortality declined by 21 per cent, to 116 per 1,000 live births in 2000 (Central Statistical Authority (CSA, 2000a).[5] Gross primary school enrolment increased from 37.4 per cent in 1996 to 61.1 per cent in 2000 (CSA, 2001b).

FIGURE 1.1 SOCIO-ECONOMIC TRENDS (1992/3 - 2001/2)

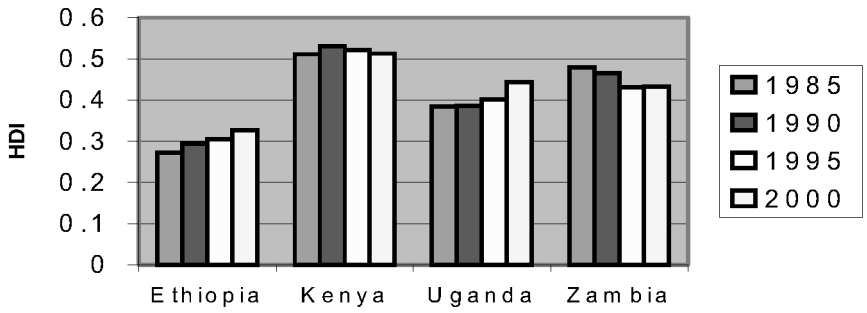


Source: MOFED (2002a)

Throughout the last decade, Ethiopia continued to be one of the poorest countries in the world, ranked 168th in the Human Development Index (HDI) out of 173 countries in 2000 (United Nations Development Programme [UNDP], 2002). Even then, Ethiopia has shown some modest improvement on the HDI in the fifteen-year period, 1985-2000, compared to Zambia (where the HDI is on a downward trend) and Kenya (where it is levelling off). Figure 1.2 shows that Ethiopia had the lowest development base, even in 1985, compared to Kenya, Uganda or Zambia. Catching up with the rest would require a significant growth.

5 Infant mortality 5-9 years before the DHS 2000 was 130 per 1000 live births and 133 per 1000 live births 10-14 years before the survey.

FIGURE 1.2 HUMAN DEVELOPMENT TRENDS FOR FOUR AFRICAN COUNTRIES



Source: UNDP (2002)

In 2000/2001, Ethiopia had the second lowest per capita income, down from US$110 to US$100 (IMF, 2001). On the Human Poverty Index (HPI)[6], Ethiopia ranked 87th out of the 88 developing countries. Kenya ranked 49th followed by Zambia (66th) and Uganda (67th). Life expectancy, which is 43 years, is one of the lowest in Sub-Saharan Africa (UNDP, 2002).

In 1999/2000, 44 per cent (27 million people) of Ethiopia's population lived in absolute poverty[7]. At the same time, a further 15 per cent of the population lived in extreme poverty (MOFED, 2002c). A Government Welfare Monitoring Survey conducted in 2000 shows that the majority of the population has seen little improvement in their living standards in recent years. Whilst the standard of living has improved for about 32 per cent of the population, it has stagnated for about 27 per cent, and became worse for 41 per cent (CSA, 2001b). A recent study conducted by SC UK and the Institute of Development Studies (IDS), University of Sussex, in the highland areas of north-east Amhara, shows that destitution has increased by 14.6 per cent over the last ten years (SC UK & IDS, 2002).

Eighty-nine per cent of all children under five, and eighty-eight per cent of all children under fourteen, live where life is precarious and access to basic services either limited or non-existent (CSA, 2001a). Poverty in Ethiopia is a rural phenomenon. And, with a diverse topography, an average population density of 50.2 persons per square kilometre and over 85 per cent of the population (55.4 million people, 25 million of whom are children under-fifteen) living in rural areas (CSA, 2001c), reaching the poorest children (about 11 million in the rural areas) and their families is one of the key challenges in tackling poverty in Ethiopia[8]. Childhood poverty in Ethiopia is appalling. Deprivation of children of all sorts of basic needs is one of the highest in the world.

6 HPI-1 measures human poverty (deprivation). It considers life expectancy, adult literacy, access to health, access to water and sanitation, and nutrition.

7 Absolute poverty is defined as inability to meet the minimum required calorie intake or 2200 kcal per adult per day, and extreme poverty is defined as <1650 kcal per adult per day (MOFED, 2002b)

8 Population of children in poverty is calculated from the total population and the MOFED poverty figure in rural areas (45 per cent).

1.3 Childhood poverty in Ethiopia[9]

In this section, the state of child poverty will be examined using selected indicators (food and nutrition, health, water and sanitation, education and work) for which information is readily available. Comparisons will be made between rural and urban areas and among regions.

1.3.1 Food security and malnutrition

Food security is a key concern for rural households. Recurrent drought and famine, instability and bad policies have, for decades, severely affected the viability of rural livelihoods throughout Ethiopia. The majority of households in rural areas are not able to produce enough food to last 12 months. In 2001, only 2 per cent of peasant farmers had produced enough food to feed their family for more than 12 months (CSA, 2001a).

TABLE 1.3.1 COMPARISON OF UNDER-NUTRITION INDICATORS IN FOUR COUNTRIES (%)

	UNDERWEIGHT (<-2 SD)	STUNTING (<-2 SD)	WASTING (<-2 SD)
Ethiopia	47	51	10
Kenya	22	37	6
Uganda	25	38	5
Zambia	25	59	4

Source: UNICEF (2002)

Ethiopia has one of the highest malnutrition rates in Africa (Table 1.3.1). Fifty-one per cent of children in Ethiopia are stunted or chronically malnourished (height-for-age) (CSA, 2000a). Stunting is an effect brought about by inadequate intake of food for a long period of time during childhood.

Nationally, about 10 per cent of children in Ethiopia are suffering from wasting (weight-for-height), caused by temporary shortage of food or acute illnesses or bad child-feeding practice – all of which are related to poverty, directly or indirectly.

1.3.2 Water and sanitation

Another key area of concern in Ethiopia is the lack of adequate water and sanitation. In 2000, about 72 per cent and 83 per cent had no access to safe drinking water and appropriate sanitation facilities respectively (CSA, 2001a). National averages hide the wide difference between rural and urban areas: 83 per cent of the rural population had no access to safe drinking water compared to 8 per cent of the urban population *(ibid)*. Unsafe drinking water and inappropriate sanitation facilities expose children to diarrhoea and parasitic diseases. The demographic and health survey (DHS) report (CSA, 2000a) shows that 24 per cent of children under five, nationally, had experienced episodes of diarrhoea within two weeks before the survey was conducted: 25 per cent in rural and 17 per cent in urban areas. The difference in the episodes of diarrhoea between urban and rural can be explained by the fact that households living in urban areas have better access to a safe drinking water supply, mothers are better educated and have better access to professional advice on how to manage diarrhoea at home or can access services at health institutions *(ibid)*.

9 Data from the Central Statistical Authority (CSA) and the reviews and evaluation of the Health and Education Sector Development Programmes are extensively used in this analysis.

1.3.3 Health services

Government investment in the health sector in the last five or more years has led to an expansion of healthcare services through the construction of healthcare facilities, and the training of more health workers and junior nurses. There has been some improvement of access to maternal and child healthcare, but many children are still not receiving the vaccinations they require. Vaccination coverage for DPT3 (Diphtheria, Pertussis and Tetanus) in 2001/2002 was 51.5 per cent, measles 41.5 per cent and fully immunised children 29.8 per cent – or 711,368 children against a target of 2,545,924. This means 1,834,556, or 70 per cent of, children under one year have not been immunised against preventable childhood diseases. There were also serious regional disparities, which the national data had possibly masked. For example, 0.8 per cent of the children under one year in Somali region, and 1.73 per cent of the children in Afar, were fully immunised in 2001/2002 compared to 62 per cent in Addis Ababa and 68 per cent in Tigray (MOH, 2002a). The disparity among regions is mainly due to lack of infrastructure and the capacity (in terms of human resources) to deliver services in what are called 'the emerging regional states'. While infant mortality is 97 per 1,000 live births in urban areas, it is 115 per 1,000 in rural areas (see Table 1.3.2). There are also wide differences in infant and child mortality rates between urban and rural areas as well as among regions.

The leading causes of morbidity (as seen in outpatient visits not disaggregated by age) are malaria (10.4 per cent), parasitic diseases (6.7 per cent), acute respiratory infections (6.5 per cent), bronchopneumonia (5.5 per cent) and dysentery (3.5 per cent) (MOH, 2003b). The causes of morbidity listed above are related to poverty. They are all preventable with the proper diet, proper hygiene and environmental sanitation, housing and with access to preventive and curative health care.

TABLE 1.3.2 EARLY CHILDHOOD MORTALITY BY GEOGRAPHICAL LOCATION AND REGIONS FOR TEN YEARS PERIOD PRECEEDING 2000

	INFANT MORTALITY (PER 1,000 LIVE BIRTHS)	UNDER-FIVE MORTALITY (PER 1,000 LIVE BIRTHS)
Urban	96.5	148.6
Rural	114.7	192.5
Tigray	103.6	169.0
Amhara	112.4	183.4
Oromia	116.2	193.8
SNNP	113.4	181.5

Source: Adapted from CSA (2000a)

1.3.4 Education

Education is one sector in which Ethiopia has experienced considerable improvement in recent years. Investment in improving physical access to schools has resulted in an increase in net primary enrolment of more than 60 per cent during the period 1996-2000 (MOE, 2001). However, although overall net primary enrolment has increased substantially, it is still not satisfactory. Only 34 per cent of children aged between 7 and 12 were enrolled in primary school in 2000, showing that about 66 per cent of children of this age group were out of school. The net primary-enrolment ratio is 36 per cent

for boys and 32 per cent for girls. The disparity between rural and urban areas is great. Of the 34 per cent of children enrolled in primary school, 74.5 per cent were urban and 28 per cent rural (CSA, 2001a).

Retaining enrolled children until they complete primary education is another challenge for the school system as the drop-out rate is 15 per cent (CSA, 2001a). The major reasons for drop out from primary schools (and even from secondary schools) are identified as 'sickness', and the need to work (ibid, p.38). Although primary schools could be found within a 10-km radius for more than 80 per cent in all regions, distance is one of the reasons for under-utilisation of schools. In 2000, it was discovered that 5.4 per cent of households in rural areas were not sending their children to school because they thought the school was too far away. In 2000, 24 per cent of primary school students lived within a 5-9 km distance from school compared to only 0.3 km in urban areas. Female students are particularly affected by the lack of school facilities near to their community, as parents may be reluctant to send them far from home for fear of harassment and abduction (ibid).

The quality of education is another factor needing to be addressed. The mid-term review of the education sector in 2000 shows that the education system in Ethiopia is characterised by low quality teaching, inefficiency, scarce resources and poorly qualified teachers (MOE, 2001). There is some evidence that cognitive performance of children in school is below average. An assessment conducted by the National Organisation for Examinations (NOE) on Grade 4 pupils in English test performance found a mean score of 40.5 per cent, in mathematics 39.3 per cent and in environmental science 48.3 per cent (ibid).

As mentioned earlier, one of the reasons for drop out is that children had to work. Children work for a variety of reasons including supplementing household income, to pay family debt, and assist in household enterprises (CSA, 2001c). On the other hand, these children are deprived of their continued primary education because of work and illness. About 87 per cent of children in the country are engaged in productive activities or housekeeping – or both. Out of these, 34 per cent are working whilst at the same time going to school. Depending on the significance of their contribution to household income and the depth of poverty in the household, the likelihood of these children leaving school to work could be significant.

1.4 Policy context in Ethiopia

This subsection will look at the major policy changes during the last ten years, strategies for implementation and the challenges of implementing the polices, and then analyses of the potential partners for advocacy.

The history of policy-making processes has not been known for its participatory nature – rather, the opposite. In the post-reform period, policies were formulated as a matter of urgency to ensure that economic and social services continued, but at the same time transforming the policies in ways that reflected the new ideology: globalisation and market economy. However, experiences of other countries' policies were adopted for both economic and social sectors.

Sector policies in Ethiopia are geared towards achievement of the economic development goals of the country. For example, cost-sharing in education and cost-recovery in healthcare has been included in the health and education policies. These policies also stress economic returns on investment, for

instance, investing in healthcare and education will enhance people's productivity. Likewise, a number of strategies, programmes and approaches have been developed to achieve rapid development in the country. The SDPRP and sector development programmes (SDPs) are discussed here since they encompass all sector policies.

The SDPRP has been developed in wider consultation with representatives of rural and urban communities, civil society organisations (CSOs), interest groups, non-governmental organisations (NGOs), international organisations, researchers and professional associations. Suggestions and recommendations from different groups were presented at the national consultation conference and then publicly debated.

The main thrusts of the SDPRP (MOFED, 2002a, p.i) are:

- focus on agriculture to stimulate growth in the other sectors of the economy;
- strengthen the growth and development of the private sector to achieve off-farm employment and output growth;
- rapid export growth through production of high-value agricultural products, and increase support to export-oriented manufacturing;
- strengthen the decentralisation process;
- improve governance, and
- agricultural research, water-harvesting and small-scale irrigation.

TABLE 1.4.1 ETHIOPIAN MID-TERM CHILD-SPECIFIC TARGETS TOWARDS ACHIEVING THE MILLENIUM DEVELOPMENT GOALS (MDGS)

COMPONENTS	INTERMEDIATE / OUTCOME INDICATORS	MDGS	CURRENT STATUS	SDPRP TARGETS
Health	Under-five mortality	Reduce by two-thirds by 2015	167 per 1,000 live births	160/1,000 by 2005
Education	Gross Enrolment	Ensure that, by 2015, children, boys and girls alike, will be able to complete a full course of primary schooling	57.4% by 2000/2001	
	Girls/Boys Ratio	Eliminate gender disparity in primary and secondary schools – preferably by 2005 – and to all levels by 2015	Ratio of girls to boys in 2000/01 was 40.6 per cent	Ratio of girl to boy students 0.45-2004/2005

Source: MOFED (2002a)

With the above in focus, the Government hopes to reduce poverty and maintain economic stability, achieve the required growth and meet the MDGs.

By formulating health and education policies and strategies, the Government developed a step-by-step sector development approach, particularly for health and education. The implementation of the sector development programmes is a joint venture among the sector Ministries of Health and Education, Regional Governments and donors. Central and Regional Joint Steering Committees have been formed to guide and co-ordinate the implementation of the programmes by the regional and city administrations. For example, in the health sector, the committee consists of Health Bureaux of the region and city administrations, Federal Ministries of Health, Education, and Finance, a representative from the Prime Minister's Office and donor representatives. The first SDPs helped to look at the sectors' components in an integrated way and move away from piecemeal project implementation. It was instrumental to focus on delivery but also on required inputs, management and governance of the systems (MOH, 2003a). In regard to financing, the sector development programmes are funded by the Government and donors. For example, donors pledged 27 per cent of the fund for education.

The objectives of the health SDP (HSDP) include increased access to, and use of, services; improved service quality through training, and improvement of necessary inputs; strengthened management of health services and more participation by the private sector (MOH, 2003a). The evaluation of the first phase of the HSDP has come up with problems faced by the health service system including poor quality of service, low level of utilisation and low level of vaccination coverage in pastoralist areas (MOH, 2003a). In addition, it is reported that human development planning is ad hoc and policy-makers did not see the Expanded Programme on Immunisation (EPI) as a priority (ibid, p.viii).

The objectives of the education SDP (ESDP) include increased access to primary school, increased equity in rural areas and increased girls' share of enrolment, improved quality of education, improved relevance (through reform of the curriculum), increased efficiency (by reducing drop-out and repetition rates), and raised government spending on education to 19 per cent of public expenditure (MOE, 2001). A key issue arising from the ESDP is the expansion of schools while increasing the access to schools. There is a mismatch between resource allocation and opening of new schools, thereby adversely affecting the quality of education. Furthermore, drop-out and repetition rates are increasing. An overloaded curriculum in lower grades is one of the problems identified in the mid-term review of the ESDP.

One of the democratisation and service delivery strategies of the Government is decentralisation and good governance. In the first phase of decentralisation, power was devolved to the regions and implementation of economic and social sector policies also shifted to them. In the second phase, further decentralisation put *Weredas* (districts) at the centre of socio-economic development. They have the responsibility of delivering basic services including health, primary education, water supply and sanitation, extension services for farmers, small-scale irrigation, rural roads and market development (MOFED, 2002a). On the implementation side however, there is a long way to go to effectively devolve power to the district level (being implemented in four regions).

The benefits of decentralisation are thought to be: (1), financial and human resources are better allocated according to local priorities; (2), planning for basic services could be streamlined to meet specific goals (WB, 2001).

In a *Wereda* study conducted by the WB (2001), it was shown that "regional governments still rely on a system of administrative and social hierarchy, vis-à-vis *Weredas* in the delivery of essential services", and, that "planning at the local level is largely subordinated to national and regional priorities" (ibid, p.ii).

In addition to the indicators used by the different sectors to monitor successes and challenges, the SDPRP has overall targets and indicators, classified as indicative and performance targets and indicators of achievement, which vary by category. Certain donors require the achievement of specific indicators as a condition for funding, while indicators related to 'HIPC (heavily indebted poor country) triggers' are required for debt relief. Therefore, performance indicators are set on this condition and are binding, while the indicative indicators and targets may not be binding for different reasons (MOFED, 2002a, pp.158-159). The examples given are: (1), demand and supply factors in increasing enrolment to public schools; (2), decisions on public expenditure depend on agreement with regions (regional states); (3), linkage between government outputs and outcomes are not precisely known; and (4), resources available for future years are not certain, either of domestic revenue or foreign assistance.

1.5 Stakeholder analysis

One of the key changes, albeit slow, in Ethiopian policy-making in recent years has been increased consultation with groups outside government. Immediately following the change of government in 1991, the most visible civil society stakeholders in Ethiopia were international and local NGOs engaged in emergency and development operations. The role of community-based organisations (CBOs) was to develop social support mechanisms (eg, funeral services). Neither group played a key role in influencing the policy agenda.

Potentially, there is now a growing number of CSOs, CBOs, NGOs (local and international) and interest groups able to influence policy. The following are some of the key stakeholders:

- the government (federal and local level)
- political parties (Ethiopian Peoples' Revolutionary Democratic Front [EPRDF] and other groups)
- the private sector
- civil society organisations (CBOs and NGOs)
- donors (international financial institutions and other donors)
- workers' associations
- youth and women's associations
- professional associations (medical associations, lawyers' associations, economic associations, etc.)
- peasant associations and farmers' co-operatives.

By working with communities at the grassroots level, NGOs try to make an upward policy influence. However, their credibility depends on the extent of their financial contribution to development at community level. CSOs, on the other hand, are urban based and their influence is usually at the federal level. There are encouraging signs that the Government is recognising the role of NGOs and

CSOs in the poverty reduction programme. Representatives of CSOs are invited to important seminars, policy discourses and workshops. For example CSOs and NGO umbrella organisations were able to present what they believed should be included in the SDPRP.

In spite of these positive signs, however, the influence of CSOs in policy-making is limited due to different factors. For example: (1), the capacity of CSOs to establish a strong and cohesive constituency is low; (2), there is no institutionalised mechanism for accessing information and engaging in dialogue and (3), mutual mistrust. However, in a gradual process, CSOs are now building their organisational strength to analyse and sensitise their constituency. The most common approaches used by CSOs to sensitise their constituencies and policy-makers are through research reports, organising public debates, publications and using the media. Peaceful demonstrations are rare but possible. For example, demonstrations on child rights, gender issues, HIV/AIDS are the commonest.

The emerging private sector in Ethiopia has the potential to be in a much stronger position than national CSOs to engage in dialogue with government. There are already a number of key institutions, which represent the interests of the private sector, including the National and City Chambers, and exporters' associations.

The Young Lives Project will endeavour to work with government, CSOs, researchers and research institutions, and international organisations. It will also continue to work with the media, households and communities.

2 Methods

In this section, we present the study design and instruments used, sampling strategy and the methodologies applied in the field by the Ethiopian group of the Young Lives Project. Four questionnaires were developed with the help of our international partners. These are: one community questionnaire, two household questionnaires (targeting households with a one-year-old and an eight-year-old child[10]) and one questionnaire for the eight-year-old child. The main contents of these questionnaires are presented in Section 2.1. Section 2.2 discusses the sampling procedure used while Section 2.3 presents the organisation and implementation of the fieldwork. Section 2.4 presents data entry and methods used for the analysis while Section 2.5 describes the process and procedures followed in the approval of the project in Ethiopia.

2.1 The questionnaires

2.1.1 The community questionnaire

The community questionnaire collects information that is common to most or all members of the community. In the context of Young Lives, 'community' is defined in terms of administrative areas. This is because these are geographically well-defined and recognised. In addition, administrative areas are often the level of policy allocation and, sometimes, the level at which secondary data is broken down.

In practice, the community can be smaller, larger or the same size as the sentinel sites and might include a whole village or a suburb in a city. In sites where children were recruited from several small villages or very scattered dwellings that have no clear community centre, the community questionnaire covered the entire district, rather than the individual communities. The method recognises that not all children sampled had directly correspondent community information.

The questionnaire has six different sections enquiring about the physical environment, social environment, infrastructure and access, the economy, health and education, and prices.

The **physical environment** section enquires about the total population and land area of the chosen community. It also asks representatives of the community about the available resources in the locality; whether the community is located in a town and the sub-ecological zone that best describes the locality. There are also questions about natural calamities which may have occurred, and whether the communities received any assistance. The section concludes by asking about the main type of houses in the community.

The **social environment** section identifies the main ethnic and religious affiliations of the community. It then enquires about the forms of political and cultural leadership and representation. It concludes by enquiring about the main social problems prevailing in the community.

The **infrastructure and access** section identifies the various social and economic infrastructures available in the community; the distance of main facilities from the community and the existence of development programmes.

10 When we refer to a one-year-old child, we mean one who was between 6 and 18 months old at the time of the survey. Similarly, an eight-year-old child means one who was between 7.5 and 8.5 years old when the survey was conducted.

The **economy** section asks about the average wages earned in the community for both agricultural and industrial activities, and classifies them in male, female and child categories. The section also enquires about the main forms of acquisition of land in the community, the availability of credit institutions and the prices of selected commodities.

The **health and education** section asks about the types of schools and health facilities available within the community.

Finally, there is a section asking for information on prices of selected education and health-related items, including common drugs, and staple foods.

2.1.2 The one-year-old (index) child household questionnaire

This questionnaire has 13 sections, including the tracking section. As has been the practice in all Young Lives Project countries, the questionnaire was adapted for local conditions: for example, the tracking questions, which are based on locations for the rural areas and nomenclatures used for locating places in urban areas. The remaining 12 sections are similar to the international questionnaire except for the inclusion of codes for country-specific items, when the need arises.

The first two pages contain the **enrolment form**, which is followed by **locating information,** including a sketch map of the position of the household. Section 2 enumerates the **composition and basic characteristics of the household.** A section which identifies **pregnancy, delivery and breast-feeding** history of the mother of the index child follows. Sections 4 and 5 deal with **childcare** and the **child's health status** since birth. Section 6 collects information about the background of the **caregiver,** who could, in principle, be different from the mother.

Sections 7 and 8 enquire about the household's means of **livelihood** and **economic changes** that may have occurred in the three-years before the survey. Section 9 is about **socio-economic status** of the household, and Section 10 deals with the **psychosocial well-being** of the caregiver. Section 11 deals with the **social capital** available to the caregiver in the community. Finally, Section 12 contains **tracking details** (address of another family member and friend) and the **anthropometric** measures of the index child.

2.1.3 The eight-year-old child household and child questionnaires

This questionnaire is largely the same as the one-year-old household questionnaire. It, however, replaces sections not applicable to eight-year-old children's conditions with additional questions where necessary. In particular, Section 3 deals with **births and deaths** of children (rather than pregnancy, delivery and breastfeeding conditions). Similarly, Section 4 is concerned with the child's **education** status rather than childcare. Section 7 also includes questions on **work** done by the eight-year-old child in addition to the questions about household livelihoods. Section 10 was adapted to assess the **mental health of the child** (as opposed to the caregiver). However, owing to difficulties in the translation of the proposed mental health instrument (the Strengths and Difficulties Questionnaire, Goodman, 1999), as discussed below, this part of the questionnaire was not analysed.

A **child questionnaire**, administered to the eight-year-old children themselves, was also used. This questionnaire asks the children some simple questions about what they like and dislike in their vicinity

and what they would like to be when they grow up. The Raven's test (with coloured progressive matrices), an instrument which assesses child development, was also administered in five sentinel sites (only urban areas) (Raven, Raven & Court, 1998).

2.1.4 Translation

The household and child questionnaires were translated into three main Ethiopian languages (Amharic, Oromiffa and Tigrigna). There was no need, however, to translate the community questionnaires as the supervisors, who are fluent in English, filled them out. Two rounds of translation, using different translators, were completed and this allowed possible discrepancies in translation to be identified. Formal translation and back-translation was not carried out but each question's translation was verified during the training of supervisors.

The Strengths and Difficulties Questionnaire (SDQ) for child mental health was translated into the three main languages and back-translated. Many problems appeared in the process of translation and back-translation of this part. For example, the distinction between 'many' and 'often' is very blurred in the Ethiopian languages and some concepts, such as 'temper-tantrums' or 'hot tempers' have no direct translation. Despite numerous attempts to arrive at acceptable translations and back-translations of the SDQ, final approval by the author and copyright holder of the questionnaire (Dr Robert Goodman) could not be obtained. Further work on translations of the SDQ for use in Ethiopia is now being undertaken by an Ethiopian consultant working with Dr Robert Goodman in the UK. It is hoped that the instrument will be available for further testing and use in future survey rounds.

Each enumerator and supervisor received a working copy of the translated questionnaire but filled in questionnaires in English. This procedure, we believe, has an advantage over having to fill translated questionnaires, in that all enumerators would fill out an identical questionnaire which, among other issues, facilitates data entry.

2.2 Sampling

The sampling framework adopted in the Young Lives Project is known as the Sentinel Site Surveillance system. A Sentinel Site Surveillance system is a system whereby sites are selected intelligently and mainly based on qualitatively determined variables. In other words, sentinel sites are selected by considering multi-dimensional policy variables and other factors relevant to the project.

The selection of sentinel sites and households within sites eligible for enumeration involved a number of stages. The selections were undertaken on the basis of predetermined criteria consistent with the objectives of the project along with consultations with relevant officials, policy-makers and experts at all levels. The stages included selection of specific regions in the country, selection of Weredas (districts) in each of the selected regions, selection of peasant associations (in rural areas) or Kebeles (the lowest level of administration in urban areas) within Weredas and, finally, the selection of households eligible for the fieldwork (See the completed version of the Sampling procedures on the website, www.younglives.org.uk). Table 2.2.1 gives the regions and names and brief description of the sentinel sites covered in the survey.

TABLE 2.2.1 REGIONS, SENTINEL SITES, AND THEIR CHARACTERISTICS

REGION	SENTINEL SITE CODE	*WEREDA*	SELECTION CRITERIA (TARGET)	SITE DESCRIPTION
Addis Ababa	1	*Wereda* 1	Urban[11] poor	Community mainly dependent on petty trade and daily labour, a number of settlements with plastic sheeting; serious problems of theft, robbery, prostitution, sewage and garbage; close to the main market area of the city; crowded; education, health and development programmes undertaken by an NGO; health and education facilities available in relatively short distance; piped water, roads, electricity available.
	2	*Wereda* 27	Urban poor	Industrial area; air and water pollution, sewage, noise from factories and flooding are problems; rape and robbery are also problems; piped water, roads, electricity available; factory work and daily labour important; education facilities, public and private health centres easily accessible but is far from government hospitals; located in the southern outskirts of Addis Ababa.
	3	*Wereda* 21	Urban less poor	Crowded; vulnerable to disasters such as fire and flooding; piped water, roads, electricity available; theft, robbery, and prostitution are problems; there is a project on family planning and reproductive health, and child feeding; wage earning and petty trading are common; air and water pollution, garbage and sewage are problems.
Amhara	4	Lalibela	Urban	Lalibela is a town known for its tourism, but the area is environmentally degraded with little tree cover and high soil erosion; the people in Lalibela town and its surroundings are very poor; the streets in the town are full of beggars.
	5	Bugina	Rural[9]	The site is about 25 kilometres from Lalibela town; the people are very poor; the soil is shallow and infertile; people live from crop livestock mixed farming; people in the area are dependent on food aid
	6	Libokemkem	Rural less poor	An area surrounding Addis Zemen town and the vicinity of Lake Tana, this is the closest site to the capital city of the Administrative Region, Bahir Dar; the village is known for its malaria; the area is less poor compared to the other sites chosen in Amhara Region.
	7	Lay-Gayint	Rural	The *Wereda* is located in South Gonder Zone and is found on the Woreta-Woldiya main road; the site selected for the survey is within 10 kilometres radius of the town called Gaint; the area is characterised as a food deficit area and people are subject to frequent droughts and hence depend on food aid. Table 2.2.1 Regions, sentinel sites, and their characteristics (Continued)
Oromia	8	Adamitulu	Rural	Located within the Rift valley, closer to Lake Ziway, about 8 km from the Addis-Awassa road; sparsely populated; only one primary school exists and no health centre in the sentinel; highly affected by the current drought; agriculture, fishing and handicrafts are important activities.
	9	Dodota Sire	Rural	Located within the Rift Valley in Arsi Zone; relatively sparsely populated; water, postal, and health service centres are available at a distance of about 6 km outside the sentinel; one of the areas highly affected by the current drought; agriculture is the main source of livelihood.

11 For the purposes of Young Lives Ethiopia, 'urban' areas are classified as such according to official government criteria, which are based on factors such as population size and infrastructure. Conversely, 'rural' areas have smaller populations and less infrastructure.

TABLE 2.2.1 REGIONS, SENTINEL SITES, AND THEIR CHARACTERISTICS (CONTINUED)

REGION	SENTINEL SITE CODE	*WEREDA*	SELECTION CRITERIA (TARGET)	SITE DESCRIPTION
	10	Wuchale fi Jiddaa	Urban	A town located about 80 km on the Addis-Debre Markos road; electric supply, piped water and all-weather road are available; trade and handicrafts are main activities; government primary and secondary school; a public health centre and drugstores also available.
	11	Sirbana Godeti	Rural	Located along the Addis-Awassa road about 60 km south of Addis; relatively densely populated; police station, piped water, and basic commodities providing shops are available at a distance of less than 0.5 km; health services operating within the community include a private clinic and drugstore as well as family planning service; though the area is not characterized by natural vagaries, households have a hand-to-mouth standard of living.
SNNP	12	Maskan	Rural	A densely populated area with distinct linguistic and cultural practices of the Gurage community.
	13	Damot Gale	Urban	A highly densely populated small town on the main road from Awassa to Sodo.
	14	Awassa	Intermediate Urban	A site in a rapidly growing city and multicultural society.
	15	Dale/Yirgalem	Rural less poor	Coffee growing area with a close proximity to the regional capital.
	16	Lemu	Rural	An area with high environmental degradation and dependence on food aid.
Tigray	17	Enderta	Rural less poor	Though reported as relatively less poor, the area was affected by the recent drought; densely populated due to population growth and returnees from previous resettlement schemes.
	18	Saese Tsaeda Emba	Rural	Located mainly on an inland plain with only a few hills; much of the farmland in the area is depleted of its agricultural soil, and is in a state of continuing environmental degradation and loss of vegetation cover.
	19	Saese Tsaeda Emba	Urban	Small town on the main road from the regional to the zonal capital; little economic activity.
	20	Wukro	Rural	Poor area vulnerable to recurring drought; hilly landscape and climate with sandy soils, known to be unsuitable for agriculture.

FIGURE 2.1 MAP OF ETHIOPIA SHOWING WEREDAS CONTAINING SENTINEL SITES.

2.3 Organisation and implementation of fieldwork

2.3.1 Supervisors' training and pilot survey

Supervisors were recruited in Addis Ababa. They were recruited on criteria that included proficiency in the languages in which the interviews were to be undertaken. Most of them had a first degree and some had senior level university education in the social sciences or related fields. We encountered a problem with only one supervisor, who did not meet up to our expectations. However, this was discovered early in the fieldwork and appropriate action was taken. Thus, we succeeded in completing 19 sentinel sites in the first round: between October 20, 2002 and December 5, 2002. We had to send one of the 19 supervisors to the twentieth sentinel site after finishing the first round (between December 10, 2002 and January 31, 2003).

There were two layers of training: one for the supervisors and the other for the enumerators. Our team of researchers in Addis Ababa trained the supervisors for 10 days. We each took turns and participated in the training. Colleagues from SC UK in Addis Ababa also participated in training supervisors on anthropometrics and ethical requirements for interviewing children.

The supervisors' training took 15 days including the pilot study. Using the fieldworkers' manual, which was prepared by the international team and modified for local use, and from other experiences of the researchers, issues raised included: the responsibilities of the supervisors; ethical considerations; management of financial resources and field materials; the recruitment criteria and procedures of the enumerators; compensation to supervisors and incentive provision to interviewees. After consensus had

been reached concerning the administrative aspects of the survey, the sampling procedure to be followed once the supervisors reached the selected sites was explained by the researchers.

Supervisors raised many questions, most of which were related to the clarity of the questions to be addressed and the problem of addressing some of the questions from the point of view of the culture of Ethiopian society. For example, there were lengthy discussions on the section dealing with psychosocial well-being of the caregiver as well as the eight-year-old child. This was due to certain questions not being the type of question usually asked and discussed openly in this society. Another issue was the difficulty of gaining signed consent of illiterate interviewees. Other problems related to whether certain concepts had been exactly translated from the English language to the languages in which the questionnaires were administered. However, through discussion, adjustments were made wherever necessary, based on consensus.

After training, the supervisors were sent out to complete a pilot survey in order to identify practical problems which might be encountered during the main survey. The most frequent problem reported by the supervisors was that the questionnaires were too large and hence boring for the interviewees.

2.3.2 Training of enumerators

In each region, except for Oromia, one member of the research team accompanied the supervisors to the respective region's capital. We recruited a field manager for Oromia for two reasons. First, we needed a person who speaks the language spoken in the region and second, we are only four in the research team, whereas we covered five regions and wanted to start in all regions simultaneously.

In Addis Ababa, Tigray and Amhara the enumerators were recruited in their respective capitals, which enabled us to train all of them in one place. This also enabled members of the research team assigned to each of these regions to participate in training of enumerators.

In Oromia and Southern Nations, Nationalities and Peoples (SNNP) regions, however, the enumerators were recruited from the *Weredas* of the respective sentinel site. This forced us to let the supervisors take care of the training of enumerators. The field manager for Oromia, as well as the National Co-ordinator, Ato Bekele Tefera, shuttled between sentinel sites during the training period in this region.

Both researchers and supervisors did not see problems in the training process. However, although the training duration of five to seven days was explicitly stated, a few supervisors finished training in fewer days. The majority of the supervisors gave the training for seven days, including piloting.

2.3.3 Supervisor and enumerator selection: Researchers' accounts and supervisors' comments

The research team and the National Co-ordinator organised a debriefing meeting for the field supervisors in December 2002. The main lessons to be drawn included experience in selecting and training fieldworkers (supervisors and enumerators), transportation and logistic arrangements, clarity and follow-up of guidelines, co-operation with and support from the Regional Governments and *Weredas,* identification and registration of households, filling out consent forms, trust and willingness of households to participate in the survey, clarity and accessibility of translated questionnaires, as well

as problems of finance, culture, tradition and seasonal constraints. The main issues and lessons drawn are discussed below.

Generally, researchers felt that the selection process of supervisors went well. Yet there were disappointing cases. Although the researchers knew most of the supervisors from their participation in previous research work, there were a few who were selected just on the merits of their CVs. It happened that some of these had a poor track record though this was unknown to the researchers. However, the weak supervisors were identified early in the fieldwork and support was given to those who were believed to be able to improve their work, while one supervisor was dismissed before the fieldwork started.

Enumerator selection went well, but there were problems similar to those encountered in the selection of supervisors. The effort to have a majority of female enumerators was not successful as there were relatively few female applicants, and not all those who applied had sufficient experience. In spite of these difficulties, some female enumerators were employed. However, there were problems with the performance of most of them, as a result of which supervisors had to spend a lot of time assisting them. An important added value of the female enumerators was that they were better at managing children and mothers during anthropometrics measurements than their male counterparts.

Some enumerators left in the middle of the fieldwork for reasons ranging from being unhappy with supervisors to low remuneration. According to the supervisors, the expectation of most of the enumerators about remuneration was very high from the beginning. This was reflected at the debriefing meeting. The supervisors expressed their dissatisfaction about payment, particularly per diem.

Whilst the majority of the supervisors did very well, others were rather overbearing and their relationship with enumerators was, in some cases, harsh. The researchers and the National Co-ordinator intervened wherever relationships between enumerators and supervisors were found to be poor. The general feeling was that more time given to the selection process would have helped ensure better selection of more experienced and trustworthy supervisors and enumerators.

2.3.4 Transportation and logistics

SC UK deployed six vehicles for the fieldwork at a very low cost. Each regional site obtained one car, except for the Amhara region where the sentinel sites were far apart geographically. Supervisors felt that transport was not sufficient for some sites, as vehicles had to cover a wide distance between the different sites. Alternatives were discussed for repeat surveys when we do it again. One alternative was for supervisors and enumerators to be allocated with a transport allowance, the other was to assign at least one vehicle per region for the whole period of the survey. It was felt that the use of these alternatives depended on access to public transport since there are substantial differences across sites.

The supervisors reported that the weighing scales distributed to the sentinel sites had problems: the type and quality of the scales was such that they were either not manageable by the supervisors or were faulty. Where this problem has been observed supervisors reported that they used Salter Scales from the Local Health Centre and clinics. Some supervisors said that they had to use public transport in order to carry the questionnaires.

2.3.5 Clarity of guidelines

The supervisors felt that the guidelines were clear, readable and a very useful tool for the fieldwork. They thought it would have been better had they been given the guidelines well before the training started so as to have sufficient time to read them thoroughly.

2.3.6 Co-operation and support from the Regional States

The researchers felt that they were given enough co-operation and support from the Regional States – except in places where officials were involved in long regional meetings, mainly in Addis Ababa City Council. It took the researchers and supervisors quite some time to get authorisation letters sent from the City Council to the *Weredas* and *Kebeles*. Nevertheless, all the regional governments, and zonal and *Wereda* administration offices expressed their interest in the research and supported the research team including, in some cases, the provision of halls for training.

At the *Kebele* level, the administrators were also supportive. However, it was necessary to employ guides who led fieldworkers through the villages and towns. This was anticipated from the beginning by the research team and provision was made for it within the budget.

2.3.7 Identification, registration and willingness of households to register

Identification and registration: There were no major problems in identifying and registering households. However, there were some refusals and changes of mind during the second visit and such households were replaced by another eligible one using the standard procedure. The reasons for refusals and changes of mind were similar in most sentinel sites and included:

1. Parents felt that supervisors were registering children so that the government will take them away on the pretext that they (the parents) were too poor to take care of their children.
2. Fear that the fieldworkers had a different religion. This was reflected in some places where parents refused to accept the incentive (Birr 15[12]), thinking that the money was being used as bait. However, no such problems were observed in the majority of the sites.
3. In some sites, expectations were very high so, despite the enumerators' explanations about the project, a lot of people came forward with their children to be registered. This caused some difficulties as those who were not included accused enumerators of being inconsiderate.

The manual states that identification and registration is the job of the supervisor. However, supervisors felt this was a difficult task for them to achieve on their own and they had to involve enumerators in this activity. There was no problem reported in this regard.

Consent: As anticipated by the research team earlier on, getting signed consent was not very successful. Households were reluctant and in some cases cautious about being asked to sign the consent forms. In some places however, caregivers signed the consent after they had gone through the content of the interview. But in most cases it was the enumerators who signed the forms, confirming that they had informed the respondent and that the latter had agreed to participate in the survey.

12 At the time of the survey US$1 = Ethiopian Birr 8.5

Questionnaire: Some cultural and other constraints were observed in administering the questionnaire.

1. Maternal health and mental health questions were difficult for respondents to understand. In some sentinel sites, even the enumerators were not comfortable asking the questions and supervisors had to intervene.
2. Some eight-year-olds were shy about answering the open-ended questions. Finding a 'quieter' place to conduct the interview was problematic, particularly in Addis where people live in crowded quarters.
3. Spelling names correctly in English was another problem and, in this case, enumerators were asked to write the name in Amharic, Tigrigna or Oromiffa, whichever was appropriate.
4. Activity and occupation codes were difficult as these were, in most cases, completely different from those in the international activity code list. Country- specific codes will need to be developed for the activities which are completely different from the international norms.
5. Translations were in some cases not consistent with the English version. Supervisors, therefore, had to use the English version where such inconsistencies were observed.

2.3.8 Seasonal constraints

Although the survey intended to avoid seasons when agricultural work was at its peak, the fieldwork period was, in some of the sentinel sites, a prime harvesting time owing to delays in getting into the field. This caused some difficulties in getting to respondents in time. Thus, enumerators and supervisors had to work early in the morning, before respondents left for work and in the evening when they returned.

2.3.9 Quality control

We employed two strategies to ensure the quality of interview. First, the supervisor immediately checked each questionnaire that had been filled out by an enumerator. Whenever there were inconsistencies, the supervisor sent the enumerator to clarify and correct such points. Secondly, parts of the questionnaires were reproduced and given to the supervisor. Each supervisor had to re-interview one household among the households interviewed by each enumerator under his supervision, representing a re-interview of approximately 10 per cent of the sample. Awareness of this process of random checking is expected to have contributed positively towards improvement of the quality of the data.

2.3.10 Other issues

In some sentinel sites there was malaria. One of the drivers had malaria and was critically ill and had to be evacuated to the regional capital. Others had typhoid and other illnesses.

There was no case reported where the fieldworkers were asked to help with a sick child. There was one case where fieldworkers reported that a child was locked in the house when he returns from school and his mother leaves her home for work and other business. This has been reported to SC UK.

2.4 Data entry and analyses

The data was entered using the Microsoft ACCESS programme developed by Cathy Garlick of the Statistical Services Centre (SSC), University of Reading.

The analyses presented in the following sections were made using Statistical Package for Social Scientists (SPSS) syntax prepared by Cathy Garlick, adapted and revised to accommodate unique categories included in the Ethiopian questionnaires. The discussion of the results in the report is based on frequencies and percentages. Some of the concepts and methods used in the analysis are discussed below.

2.4.1 Wealth index

The wealth index was constructed from (1), the number of rooms per person as a continuous variable; (2), a set of eleven consumer durable dummy variables, each equal to one if a household member owned a radio, fridge, bicycle, TV, motorbike/scooter, motor vehicle, mobile phone, landline phone, modern bed, table or chair, and sofa; (3), a set of three dummy variables equal to one if the house had electricity, brick or plastered wall, or a sturdy roof (such as corrugated iron, tiles or concrete); (4), a dummy variable equal to one if the dwelling floor was made of a finished material (such as cement, tile or a laminated material); (5), a dummy variable equal to one if the household's source of drinking water was piped into the dwelling or yard; (6,) a dummy variable equal to one if the household had a flushed toilet or pit latrine; (7), a dummy variable equal to one if the household used electricity, gas or kerosene.

The wealth index captures variables that are broader than production assets, such as home ownership and the durability of that home, plus access to infrastructure such as water and sanitation.

TABLE 2.4.1 DEFINING A WEALTH INDEX

COMPONENTS OF INDEX AND SCORE	CONTRIBUTING VARIABLES
H = Housing quality (/4)	Rooms/person, wall, roof, floor durability.
CD = Consumer Durables (/11)	Radio, fridge, bicycle, TV, motorbike/scooter, motor car/truck, mobile phone, landline phone, modern bed, table or chair and sofa.
S = Services (/4)	Electricity, water, sanitation, cooking fuel.
Wealth Index = (H+CD+S)/3	**Range = 0.0 – 1.0**

All variables were scaled for scale equivalence, ie, 0.0 to 1.0, and weights are arbitrary because the weighting makes little difference when the contributing variables of the index are highly correlated, as they are here (housing, consumer durables, services).

The determination of poverty status of a household in summarized in Table 2.4.2. Poverty status of a household is determined based on the value of the wealth index. Households with a wealth index less than 0.2 are considered very poor, those with index value greater than or equal to 0.2, but less than 0.4 are considered poor. Households with index value greater than or equal to 0.4 are named less poor.

TABLE 2.4.2. DETERMINATION OF POVERTY STATUS

VALUE OF WEALTH INDEX	POVERTY STATUS
<0.2	Very poor
Between 0.2 and 0.4	Poor
>= 0.4	Less poor

2.4.2 Social capital

Current theory of social capital recognizes several types, including structural social capital (connectedness or networks) and cognitive social capital. Although the theory suggests distinguishing between bridging and bonding social capital, the Young Lives questionnaire focused on the bonding aspect of social capital (relationship within community), not the bridging (relationship between communities) because bridging requires questions regarding the relationship among communities which were not feasible given the time and budget. Hence, the frame of reference for social capital in this report is the community and it was the caregiver's perception of their own social capital in their respective communities that was measured. The caregiver was chosen because she or he has a direct influence on the index child.

Specifically, the following types of social capital are defined as follows.

Absolute structural social capital is defined based on the number of groups to which the caregiver belongs.

Relative structural social capital depends on the number of groups available in the community and the proportion of these groups to which the caregiver belongs.

Social support type of social capital is based on whether or not the caregiver has received support (emotional, economic or other) from either groups, or individuals, in the year before the survey.

Cognitive social capital is based on the caregiver's perceptions of the local community.

Citizenship is based on whether or not the caregiver has worked with others in the community to address a common issue.

Absolute structural social capital is categorized as high if the number of groups to which the caregiver belongs is three or more; as medium if the number of groups is one to two, and zero if the caregiver is not a member of any group.

The categories of relative structural social capital are deemed high if the proportion of groups (among groups available in the community) to which the caregiver belongs is greater than 40 per cent; medium if the proportion is from 10 to 40 per cent, low if the proportion is from 1 to 10 per cent, and zero if the caregiver is not a member of any of the available groups.

Social support is based on the number of groups from which the caregiver has received support in the year before the survey. It is considered high if a caregiver gets help from five or more groups. If the caregiver gets help from one to four groups, it is considered as medium social support.

The index of cognitive social capital is a combination of the responses to the questions on whether the

caregiver feels she/he is part of the community, whether she/he feels people in general can be trusted, whether she/he feels people would try and take advantage of her/him if they could, and whether she/he feels people generally get along with each other. If the caregiver's response is positive for at least three of these they have high cognitive social capital, medium they give only one or two positive answers and if all questions are answered negatively, we categorized them as having no cognitive social capital.

The last type of social capital is a citizenship index, which looks at the questions about joining together to address common issues and/or talks with the local authority on problems of the community. This index is a dichotomous (0 or 1) variable. The index is given a value '1' if the caregiver either joins together with others to address common issues or talks with the local authority about problems in the community. Otherwise '0' was given.

2.4.3 Nutritional status

The survey included weighing all the children and measuring their height. Child weight was measured using calibrated child scales and recorded to the nearest 0.1 kg. Child height was measured to the nearest 0.1 cm using height boards made for the purpose. These measures coupled with the age of the child, measured in days based on the birth and interview date, enabled us to obtain the three measures of nutritional status: height for age (stunting), weight for height (wasting) and weight for age (indicator of underweight). These measures were used to compare the sampled children with an international standard population using the Centre for Disease Control/World Health Organisation (CDC/WHO 1978) reference points using the Epi-Info statistical package (Dibley and others, 1987).

Stunting is one of the indicators used to measure chronic under-nutrition. This measure is obtained by dividing the height of children by their age and standardising the variables using international reference points. Another measure of nutritional attainment of children is wasting, or the weight for height measure. Here, weight is divided by height and standardized using international standards. The third measure of nutritional status is the weight for age or an indicator of underweight, which is obtained by dividing weight by age and standardised using the international standards. Children scoring low z-scores (less than -2) are then classified as chronically malnourished using all the three measures.

We were able to obtain complete and useable child weight and height measurements only for 1836 (92 per cent) of the one-year-olds, and 857 (86 per cent) of the eight-year-olds. Though we had to discard a few observations because of probable measurement errors, the largest part of this low figure is accounted for by the inability of the enumerators to measure all the children in one sentinel site because of a malaria epidemic at the time. We advised the team to evacuate as early as possible, thinking about the welfare of our team and the difficulty for families affected by malaria to allow us take measurements of their children.

2.5 Ethics

The project development and approval has involved consultations with relevant ministries, colleges and universities as well as research institutes in Ethiopia. The consultation process helped SC UK and the Academic Consortium to identify research partners and a National Co-ordinator for the Project. As a second step, partner institutions were sought for implementation for the following two sets of activities: (1), the research part of the project, ie, questionnaire design, data collection, analysis and

report writing, and (2), for co-ordination, facilitation and dissemination of the results. Agreements were signed with the Ethiopian Development Research Institute (EDRI) for the former, and the Disaster Preparedness and Prevention Commission (DPPC) and Ministry of Labour and Social Affairs (MOLSA) for the latter.

The third step was to form an advisory panel for the research and dissemination components. The panel discusses technical, communication and relational issues. The issue of ethical clearance has been discussed extensively. Enquires as to who gives ethical clearance in Ethiopia have been made. There is no ethical clearance required for or provided to research in the social sciences. MOLSA, the Ministry responsible for children and women affairs is not aware of the existence of ethical clearance requirements for such projects. In addition, SC UK's legal advisors have been consulted on the issue.

Major achievements towards addressing ethical issues are:

- Official agreements have been signed with government bodies.
- The advisory panel members did not see any unethical questions included in the questionnaire.
- SC UK in Ethiopia trained supervisors on SC UK child-abuse reporting system[13].
- The Fieldworker Guideline provided clear instruction of how fieldworkers behave in the field, how they approach households/respondents and how they administer questions.
- All these precautions have provided the ethical ground for the research.

13 Save the Children Child Protection Policy is available on SC website (http://www.SCuk.org.uk/functions/aboutus/pdfs/Child_prot00.pdf) and in every country and field office across the globe. Within the child abuse reporting system in Ethiopia are included the Ministry of Labour and Social Affairs and the Police.

3 Results — One-year-old survey

3.1 Introduction

This section of the report presents a description of the information collected from households with one-year-old children. The characteristics of the index children, their caregivers and their households are presented below. Section 3.2 discusses socio-economic status of the households. Although wealth is discussed in terms of housing, access to services such as electricity, water and sanitation, it should be borne in mind that these commodities form part of the wealth index itself. In subsequent (multivariate) analyses the sample can be stratified by, for example, electricity, etc, to allow for the absence of some commodities in certain areas. The rest of this report focuses on description of the results by poverty status (wealth categories) and by location (rural and urban). Boxes 2, 3 and 4 show the characteristics of the index children, their caregivers and their households.

BOX 2. CHARACTERISTICS OF THE INDEX CHILDREN (ONE-YEAR-OLDS) N = 1999

- 53 per cent male and 47 per cent female
- 35 per cent live in urban households and 65 per cent in rural households
- 63 per cent are from very poor households, 24 per cent from poor households and 12 per cent are from less poor households
- 82 per cent live with both parents and 17 per cent live with one parent
- 98 per cent see their mother on a daily basis
- 82 per cent see their father on a daily basis
- 85 per cent live in male-headed households
- 97 per cent are cared for by their biological mother

BOX 3. CHARACTERISTICS OF THE CAREGIVERS (ONE-YEAR-OLDS) N = 1999

- 97 per cent of caregivers are biological mothers of the index child
- 85 per cent of caregivers have permanent partners
- 82 per cent of caregivers' partners live in the household
- Only 10 fathers considered themselves the caregiver
- 89 per cent of caregivers have not completed primary school
- 53 per cent are aged between 20 and 29 years, 29 per cent between 30 and 39

BOX 4. CHARACTERISTICS OF THE HOUSEHOLD (ONE-YEAR-OLDS) N = 1999

- 87 per cent of very poor households are rural; 13 per cent are urban
- Average size of household is 5.7 people
- 87 per cent of household heads have not completed primary school
- Female-headed households are more common in urban areas (22 per cent) than rural areas (12 per cent)
- 53 per cent of household members are below 15 years of age, 26 per cent are children below 5 years of age and only 2 per cent are over 60 years of age.

3.2 Socio-economic status of households

The wealth index, described in section 2.4, is used to determine the poverty status of a household. A household is considered very poor if the wealth index is less than 0.2, poor if the wealth index is between 0.2 and 0.4 and less poor if the wealth index is greater than, or equal to, 0.4.

Tables 3.2.1 and 3.2.2 present the wealth status of families in the Young Lives sample by location. According to these results, the majority of children (63 per cent) live in very poor households (WI <0.2). Twenty-four percent of them live in poor households (WI between 0.2 & 0.4) whilst 12 per cent live in less poor households.

TABLE 3.2.1. POVERTY STATUS BY LOCATION (ROW PERCENTAGES)

LOCATION	POVERTY STATUS		
	VERY POOR	POOR	LESS POOR
Urban %	24.2	45.1	30.7
Rural %	84.6	13.2	2.2
Total %	**63.4**	**24.4**	**12.2**
Number of observations	**1,268**	**487**	**244**

Young Lives shows that poverty is more concentrated in rural areas than in urban areas. This is similar to data published by the Ethiopian Ministry of Finance and Economic Development (MOFED) in 2002. Eighty-six per cent of children living in very poor households are in rural areas while 88 per cent of children living in less poor households are in urban areas (Table 3.2.2).

TABLE 3.2.2 POVERTY STATUS BY LOCATION (COLUMN PERCENTAGES)

LOCATION	TOTAL SAMPLE	POVERTY STATUS		
		VERY POOR	POOR	LESS POOR
Urban %	35	13.3	64.9	88.1
Rural %	65	86.7	35.1	11.9
Number of observations	**1,999**	**1,268**	**487**	**244**

The regional distribution of the wealth index is presented in Table 3.2.3. The sample sizes of the five regions (Addis Ababa, SNNP, Oromia, Tigray and Amhara) are sufficiently large to compare poverty across regions. Amhara has the highest proportion of very poor households (81 per cent) followed by Oromia (76 per cent). Tigray and SNNP have similar proportions of 69 per cent and 68 per cent respectively, whereas Addis Ababa has the highest proportion of poor households (54 per cent) and less poor households (40 per cent).

TABLE 3.2.3 REGIONS BY POVERTY STATUS (COUNT AND COLUMN PERCENTAGE)

Poverty status	Total sample	Addis Ababa	Amhara	Oromia	SNNP	Tigray
Very poor %	63.4	5.7	81.3	76.7	68.6	69.3
Poor %	24.4	54.0	12.0	18.8	19.6	26.0
Less Poor %	12.2	40.3	6.8	4.5	11.8	4.8
Number of observations	1,999	300	400	399	500	400

A limited number of households in the Young Lives study have access to electricity, safe drinking water and toilet facilities. Households in urban areas have better access to these facilities than those in rural areas (Table 3.2.4). The less poor are more likely to have access to and use of electricity (99 per cent).

In rural areas the main source of drinking water is the public standpipe and a tube well in dwelling in urban areas. The safest form of drinking water is water piped into a dwelling. This is found almost exclusively in urban areas, where 29 per cent of the study households had access to such a facility. The proportion of people who have piped water and tube well in their dwelling increases with wealth – implying that poor peoples' access to safe drinking water is very limited.

Water-borne toilet facilities in both urban and rural areas are scarce. Only three per cent of urban households and about one per cent of rural households have access to these. The vast majority of the poorest households (87 per cent) have no toilet facilities, whereas 50 per cent of the less poor households use household pit latrines.

TABLE 3.2.4 HOUSING AND SERVICES BY LOCATION AND POVERTY STATUS

CHARACTERISTIC	TOTAL SAMPLE		LOCATION %		POVERTY STATUS %		
	N	%	URBAN	RURAL	VERY POOR	POOR	LESS POOR
Electricity							
Yes	709	36	81	11	6	81	99
No	1,290	65	19	90	94	19	<1
Cooking fuel							
Not electricity	1,989	99	99	99.9	100	99.6	100
Electricity	10	1	>1	<1	0	<1	<1
Source of drinking water							
Piped into dwelling/yard/plot	242	12	29	3	1	13	70
Tube well in dwelling	825	41	55	34	37	62	23
Public standpipe	840	42	8	60	60	15	2
Unprotected well/spring/ pond/ river/ stream	92	5	8	3	3	9	5
Toilet facility							
Flush toilet/septic tank	23	1	3	>1	>1	>1	8
Pit latrine household	407	20	21	20	8	38	50
Pit latrine communal	328	16	39	4	5	36	37
None/other	1,241	62	38	75	87	25	6
Floor material							
Earth	1,735	87	69	97	99	85	28
Wood	53	3	6	<1	1	4	12
Stone/brick	19	1	1	1	>1	2	3
Cement/tile	178	9	22	1.8	>1	9	55
Laminated material	14	1	2	-	-	1	4
Roofing material							
Straw/thatch	794	40	11	55	62	2	-
Earth/mud	118	6	3	7	8	4	-
Wood/planks	185	9	4	12	13	4	2
Galvanized iron	895	45	81	25	18	89	97
Concrete/cement/tiles/slates	7	<1	1	<1	-	1	1
Wall material							
Brick/concrete	386	19	18	20	19	20	18
Mud	589	30	41	23	26	31	46
Wood/branches	982	49	39	54	52	48	35
Galvanized iron	14	1	1	1	1	1	-
Matting/other	28	2	1	2	2	<1	1

In rural areas, 75 per cent of households have no toilet facilities and where there are facilities, they are likely to be household pit latrines (20 per cent). These are probably self-made, low-cost latrines.

Earth is a widely used flooring material in both urban (69 per cent) and rural (97 per cent) areas but is more likely to be used by very poor (99 per cent) and poor (85 per cent) households. Fifty-five per cent of the wealthiest households are more likely to use cement and/or tiles for flooring. The use of earth as a flooring material has a negative relationship with wealth.

Straw and thatch are commonly used as a roofing material by both rural (55 per cent) and very poor households (62 per cent). Wealthier and urban households are more likely to use galvanised iron. The use of other materials for roofing such as earth/mud, wood/planks, concrete/cement, and tiles/slates is very limited.

Owing to large variations in wall materials in Ethiopian houses, the housing component of the wealth index did not work as well as expected. For example, 20 per cent of rural and 19 per cent of very poor households (mainly in the northern part of the country) use stone, whilst several urban households (which are generally wealthier) use wood/branches (39 per cent) and mud (41 per cent). There is also a concern that galvanised iron may be misleading as an indicator of wealth in some contexts. A typical rural house with a high quality thatched roof and good mud walls may be indicative of better wealth status than an old iron roof on an urban house with crumbling walls.

3.3 Pregnancy, vaccination and delivery

This section of Young Lives looks at antenatal care of the biological mother, and the circumstances prior to and at the birth of the index child. Antenatal visits were undertaken by 71 per cent of urban biological mothers and 40 per cent of rural biological mothers. Of these mothers, 86 per cent reported having at least two injections for tetanus (Table 3.3.1). The Young Lives data clearly indicates that biological mothers from wealthier households are more likely to have better antenatal care than those from very poor households.

TABLE 3.3.1 ANTENATAL CARE BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Any visits for antenatal care? Yes (%)	50.7	71.3	40	38.6	68.1	81.4
Number of observations	1,917	651	1,266	1,235	461	221
At least two injections for tetanus during antenatal visits? Yes (%)	85.8	87.8	84	83.8	87.1	89.2
Number of observations	**960**	**459**	**501**	**474**	**310**	**176**

Table 3.3.2 shows the results in terms of birthplace of the index child and assistance at delivery by location and poverty status. The majority of rural mothers (96 per cent) give birth at home, without the assistance of a medically-trained person (defined as a doctor, nurse or midwife). In wealthier urban areas this figure falls to 57 per cent. As would be expected, Young Lives shows that the proportion of those born at home decreases with wealth while the proportion of those born in hospitals increases with wealth.

TABLE 3.3.2 BIRTHPLACE AND ASSISTANCE AT DELIVERY BY LOCATION AND POVERTY STATUS

		TOTAL SAMPLE	LOCATION		POVERTY STATUS		
			URBAN	RURAL	VERY POOR	POOR	LESS POOR
Birth place	*Home (%)*	82.4	57.4	95.8	96.1	67.5	41
	Hospital (%)	11.3	26.9	2.9	2.8	18.5	40.6
	Other health facility (%)	6.3	15.6	1.3	1.1	13.8	18.4
	Other (%)	0.1	0.1	-	-	0.2	-
Number of observations		**1,996**	**699**	**1,297**	**1,266**	**486**	**244**
Assistance At delivery	*Medically trained person (%)*	19.4	39.9	8.3	6.9	34.1	54.9
	Non-medically- trained person (%)	80.6	60.1	91.7	93.1	65.9	45.1
Number of observations		**1,999**	**700**	**1,299**	**1,268**	**487**	**244**

In Table 3.3.3 the birth weight and vaccination status of index children is presented. With so many home births, it is not surprising that only 391 caregivers knew the birth weight of their child. Forty per cent of these responses indicated that children in very poor households had low birth weights compared to 15 per cent in less poor households. Although 59 per cent of urban and 53 per cent of rural children were vaccinated against both BCG and measles, Young Lives shows that a large proportion of children (21 per cent) did not receive these vaccinations. This percentage is lowest (6 per cent) in less poor households and highest (27 per cent) in very poor households.

TABLE 3.3.3 VACCINATION STATUS AND WEIGHT OF ALL INDEX CHILDREN AT BIRTH BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Vaccination status BCG only (%)	20.3	21.3	19.8	20	19.6	23.7
Measles only (%)	5.3	4	5.9	5.9	4.6	3.3
Both BCG & measles (%)	53	8.5	50	47	61.3	67.2
Neither BCG nor measles (%)	21.4	16.1	24.3	27.1	14.6	5.8
Number of observations	1,961	694	1,267	1,240	480	241
Low birth weight baby *Yes (%)*	26.9	20	42.1	40.5	25.3	15.3
Number of Observations	**391**	**270**	**121**	**121**	**146**	**124**

The differences between urban and rural households in terms of vaccination status do not seem to be great, since about 59 per cent of the urban households received both BCG vaccination and vaccination against measles with about 16 per cent having had neither, while the corresponding figures for rural households are about 50 and 24 per cent, respectively. A larger proportion of rural households reported low weight of the child at birth (about 42 per cent) compared with the urban households (20 per cent) (Table 3.3.3).

The vaccination status of children between 1 and 1.5 years of age is also reported in Table 3.3.4. The results show that 65 per cent received both the BCG vaccination and the vaccination against measles, compared to 53 per cent of the 6 to 18-month-old children. Nineteen per cent had neither of the two, compared to 21 per cent for the 6 to 18-month-old children.

The results indicate that the proportion of children between 1 and 1.5 years of age who received both vaccinations is higher in both rural and urban areas compared with the corresponding figure for 6 to 18-month-old children in the sample (Tables 3.3.3 and 3.3.4). This result is consistent with the expectation that not all vaccinations are required until after 9 months, eg, measles.

TABLE 3.3.4. VACCINATION STATUS FOR CHILDREN BETWEEN 1 AND 1.5 YEARS OLD BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Vaccination status						
BCG only (%)	10.2	7.1	12.1	12.4	8.6	2.4
Measles only (%)	5.6	5	5.9	6.4	4.9	2.4
Both BCG & measles (%)	65.1	73.5	60	56.5	75	89.5
Neither BCG nor measles (%)	19.1	4.3	22	24.6	11.5	5.6
Number of observations	**1,005**	**378**	**627**	**637**	**244**	**124**

These results also indicate that the proportion of those who received both vaccinations is more common in wealthier households (Table 3.3.4).

Respondents were also asked about the number of their children and the results indicate that about 78 per cent of the respondents had two or more children. A larger proportion of rural households (83 per cent) had more than one child compared with urban households (69 per cent). Moreover, the percentage of households who have more than one child decreases with wealth (Table 3.3.5).

TABLE 3.3.5 CHILD'S POSITION IN HOUSEHOLD BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Only child (%)	22.4	31.4	17.5	16.4	30.5	37
Two or more children (%)	77.6	68.6	82.5	83.6	69.5	63
Number of observations	**1,994**	**698**	**1,296**	**1,265**	**486**	**243**

The death of a child under five years of age was reported in 25 per cent of Young Lives households (Table 3.3.6). It should be noted that 446 households reported that they had only one child and therefore are not included in Table 3.3.6. Differences across location (urban-rural) do not appear large in terms of previous child deaths. However, differences are apparent across wealth categories. The percentage of households reporting no previous child deaths clearly increases with wealth.

TABLE 3.3.6. PREVIOUS CHILD DEATHS BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Death of child less than 5 years old (%)	24.9	22.7	25.9	27.6	21.9	12.6
Death of older child (%)	8.1	8	8.2	9.8	5.1	3.3
No previous child deaths (%)	67	69.3	66	62.7	73.1	84.1
Number of observations	**1,531**	**476**	**1,055**	**1,046**	**334**	**151**

3.4. Childcare

Generally, members of the household assume childcare in Ethiopia (82 per cent). This is even truer in the urban areas where only 12 per cent make use of non-household members for childcare. In rural areas, this figure increases to 21 per cent of households (Table 3.4.1).

It is also interesting to note that very poor households (21 per cent) tend to allow non-household members to take care of their child more than those in poor (12 per cent) and less poor households (15 per cent) This implies that wealthier households do not make as much use of outside caregivers for their children, possibly because they have sufficient resources to be able to allocate a household member to this task.

TABLE 3.4.1 CHILDREN AND OTHERS OUTSIDE THE HOUSEHOLD CARING FOR THE CHILD BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Others outside household caring for child? Yes (%)	18	12	21	21	12	16
Number of valid observations	1,999	700	1,299	1,268	487	244
Child caregivers? Yes (%)	12	7	15	15	9	4
Number of valid observations	**1,999**	**700**	**1,299**	**1,268**	**487**	**244**

It is also evident from the data that a larger percentage of very poor households (15 per cent) allow children younger than five years of age to take care of the index child, compared to less poor households (4 per cent).

3.5. Child health

The questionnaire enquired about child health both as to the caregivers' perceptions, and occurrences, of health problems. There is a difference in caregivers' perceptions about the health of the child across location and poverty status. Twenty-seven per cent of rural caregivers perceive their child's health to be worse than other children of their age, whilst in urban areas this drops to 19 per cent. A large number of caregivers in less poor households (62 per cent) perceive their child to be healthier than other children of their age. This perception is held by only 30 per cent of caregivers in very poor households (Table 3.5.1).

TABLE 3.5.1 PHYSICAL MORBIDITY OF INDEX CHILD BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Health compared to others						
Same (%)	38	35	40	42	35	28
Better (%)	38	46	33	30	46	62
Worse (%)	24	19	27	28	20	11
Number of valid observations	**1,996**	**700**	**1,296**	**1,265**	**487**	**244**
Long-term health problems? Yes (%)	10	7	12	12	7	7
Number of valid observations	**1,997**	**699**	**1,298**	**1,266**	**487**	**244**
Has child been so ill you thought he/she might die? Yes (%)	30	25	33	34	24	21
Number of valid observations	**1,994**	**699**	**1,295**	**1,263**	**487**	**244**
Treatment sought for illness that could have killed Yes (%)	75	83	72	71	85	87
Number of valid observations	**604**	**174**	**430**	**433**	**119**	**52**
Suffered severe injuries Yes (%)	12	14	10	11	13	14
Number of valid observations	**1,999**	**700**	**1,299**	**1,268**	**487**	**244**
Illness in last 24 hours Yes (%)	36	31	39	40	31	23
Number of valid observations	**1,999**	**700**	**1,299**	**1,268**	**487**	**244**

Ten per cent of the index children have long-term health problems. Children living with long-term health problems are more likely to be living in the rural areas (12 per cent) than in urban areas (7 per cent). A larger proportion of children in very poor households have long-term health problems (12 per cent) compared to those in poor and less poor households (7 per cent)

Thirty per cent of caregivers in our sample reported that their child had been so sick that they feared she/he might die. Rural children (33 per cent) appear more vulnerable to sickness compared to urban children (25 per cent).

The poverty status categories, too, seem to show a negative relationship between wealth and serious illness. Thus, while 34 per cent of caregivers from very poor households indicated that their child had been sick to the extent they felt the child might die, only about 21 per cent of caregivers from the less poor category felt so.

Seventy-five per cent of caregivers who reported that their child was so ill they thought she/he might die sought medical help. The figures vary by location (urban-rural) with a higher proportion of urban caregivers seeking medical help (83 per cent) compared to rural caregivers (72 per cent). Less poor households appear to be more likely to seek medical help than very poor households.

Twelve per cent of the index children have suffered a severe injury. Urban children (14 per cent) appear to be more vulnerable to injuries than rural children (10 per cent). There does not seem, however, to be a difference of such incidence in terms of poverty status.

Young Lives shows that 36 per cent of children experienced illness in the 24 hours before the interview. Rural children (39 per cent) and children born into very poor households (40 per cent) seem to be more vulnerable to illness than children from urban (31 per cent) and less poor households (23 per cent), respectively.

The indicators of physical morbidity of children indicate two important relationships. The first being that children born to rural households tend to be ill more frequently, and have less access to medical facilities than children born to urban households. Yet injuries to urban children appear more common. The second being that children born into poverty appear to fall sick more, and their access to medical help is very limited compared to children born to less poor households.

3.6 Livelihoods, diversification and debt

This section covers livelihood activities of household members over the 12 months before the survey, in terms of earning money or goods produced for the household. This section included money and goods sent to and received from household members or others. Moreover, the section enquired whether the household had any serious debts and to whom these debts were owed, and whether the respondent thought the household would be able to repay all of the debts on time.

Table 3.6.1 shows the frequency distribution of household members involved in different activities. The three most frequent activities were agriculture, hunting, forestry and fishing (60 per cent), community, social and personal services (27 per cent) and wholesale and retail trade (20 per cent). The three least important activities are working in electricity, gas and water (0.1 per cent), mining and quarrying (1.1 per cent) and not being involved in any activity (2.1 per cent) (Table 3.6.1).

TABLE 3.6.1 HOUSEHOLDS INVOLVED IN DIFFERENT SECTORS BY LOCATION AND POVERTY STATUS +

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Agriculture, hunting, forestry and fishing	60.4	18.0	83.3	86.8	19.5	4.9
Mining and quarrying	1.1	0.4	1.4	1.4	0.2	
Manufacturing	17.5	22.9	14.6	14.3	24.4	20.5
Electricity, gas and water	0.1	0.1				0.4
Construction	2.7	4.3	1.8	1.3	5.5	3.7
Wholesale and retail trade	20.0	26.0	16.8	14.9	27.9	30.7
Transport, storage and communications	2.8	6.0	1.0	0.5	5.1	9.8
Finance, insurance, real estate and business services	16.3	28.7	9.5	11.1	25.1	25.4
Community, social and personal services	27.0	25.8	27.6	25.4	26.9	35.7
Household has no activities	2.1	4.4	0.8	0.9	4.3	4.1
Total (%)	**149.80**	**136.70**	**156.90**	**156.60**	**139.00**	**136.10**

+ Percentages do not add up to 100 due to multiple answers (responses).

The distribution of involvement of household members in activities by poverty status shows that for very poor households the most important activity is agriculture, hunting, forestry and fishing (86.8 per cent) followed by community, social and personal services (25.4 per cent) and wholesale and retail trade (14.9 per cent). For poor, and less poor, households the most important activity was community, social and personal services followed by wholesale and retail trade and finance, insurance, real estate and business services. Agriculture, hunting, forestry and fishing appears to be inversely related to wealth whereas wholesale and retail trade; transport, storage and communications; finance, insurance, real estate and business services and community, social and personal services appear to be positively related to wealth (Table 3.6.1).

The largest percentage of rural household members were involved in agriculture, hunting, forestry and fishing (83.3 per cent) followed by community, social and personal services (27.6 per cent), and wholesale and retail trade (16.8 per cent). On the other hand, the largest percentage of urban households members were involved in finance, insurance, real estate and business services (28.7 per cent) followed by wholesale and retail trade (26 per cent) and community, social and personal services (25.8 per cent) (Table 3.6.1).

In terms of diversification of economic activities, 57 per cent of the households were involved in activities in only one sector, while 41 per cent were involved in activities in more than one sector, the rest having no recorded activity. The distribution of diversification by location indicates that a larger percentage of households in rural areas (47 per cent) were involved in more than one sector, compared with urban areas (32 per cent). A smaller percentage of households reported having not been involved in any activity in rural areas (1 per cent) than those in urban areas (4 per cent). Cross-tabulation of diversification and poverty status indicates that the most frequent case for each group is household involvement in activities in one sector (between 53 and 66 per cent). The percentage of the very poor involved in more than one sector is higher than that of the poor and the less poor (Table 3.6.2). We may also note that some of the households with no recorded activity may depend on remittances, since our data show that more than 10 per cent of the households have received money or goods from others.

Results of responses to questions on household debts are also reported in Table 3.6.2. 32 per cent reported having serious debts, of whom 33 per cent thought they would be able to repay on time. In terms of location, a larger proportion of households in the rural areas had serious debts (39 per cent) compared with those in urban areas (20 per cent). Thirty-four per cent of those in rural areas said that they expected to be able to repay their debts and in urban areas this was 31 per cent. In terms of poverty status, the percentage of those who had serious debts decreases with wealth (from 39 to 18 per cent), as would generally be expected. The percentages for ability to pay on time did not, however, follow a similar trend, the range for those who said yes being between 32.6 and 33.6 per cent (Table 3.6.2).

TABLE 3.6.2 DIVERSIFICATION AND HOUSEHOLD DEBTS BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
No recorded activity %	2	4	1	1	4	4
Activities in one sector %	57	64	53	53	63	66
Activities in more than one sector %	41	32	47	46	33	30
Number of observations	**1,999**	**700**	**1,299**	**1,268**	**487**	**244**
Any serious debts? Yes (%)	32	20	39	39	23	18
Number of observations	**1,997**	**700**	**1,297**	**1,266**	**487**	**244**
Able to repay on time? Yes (%)	33	31	34	33	34	33
Do not know (%)	14	15	13	14	7	23
Number of observations	**640**	**137**	**503**	**487**	**110**	**43**

3.7 Economic changes and events

The questionnaire also collected information on events likely to produce economic shocks for households, and the coping mechanisms employed in response to these, since the biological mother's pregnancy with the index child.

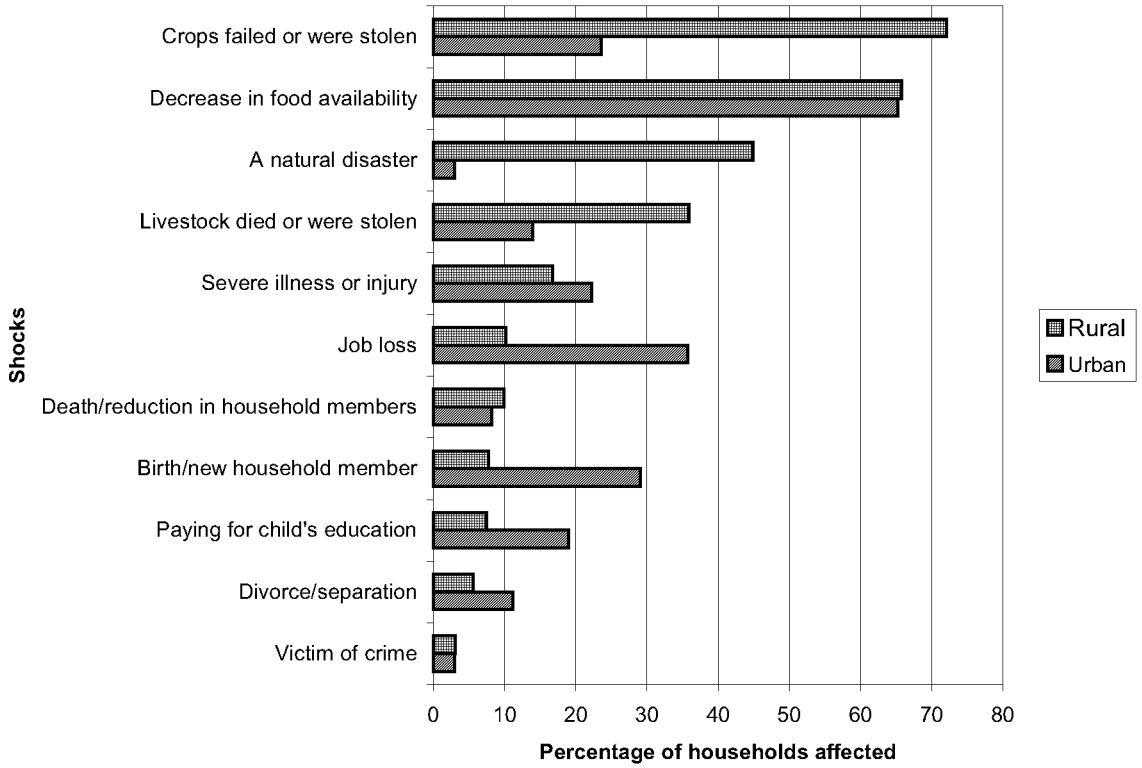
The number and types of events are described in Tables 3.7.1 to 3.7.4. Most families faced up to five events or shocks, with the proportion experiencing shocks being higher in rural areas (72 per cent) than in urban areas (60 per cent), and higher among very poor and poor households than less poor households (Table 3.7.1). The most common event was 'decrease in food availability', followed by 'failure or theft of crops' (noting, however, that the latter event can cause the first event). A considerable proportion of families have also reported that a natural disaster, job loss, severe illness or injury, and birth/addition of new household member were among the worst events.

TABLE 3.7.1 NUMBER OF EVENTS HOUSEHOLDS FACE BY LOCATION AND POVERTY STATUS

NUMBER OF EVENTS	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
None (%)	30	37.7	25.8	22.6	38.8	50.8
1 to 5 (%)	67.6	60.1	71.7	74.5	59.5	48
6 or more (%)	2.4	2.3	2.5	2.9	1.6	1.2
Number of observations	**1,999**	**701**	**1,298**	**1,268**	**487**	**244**

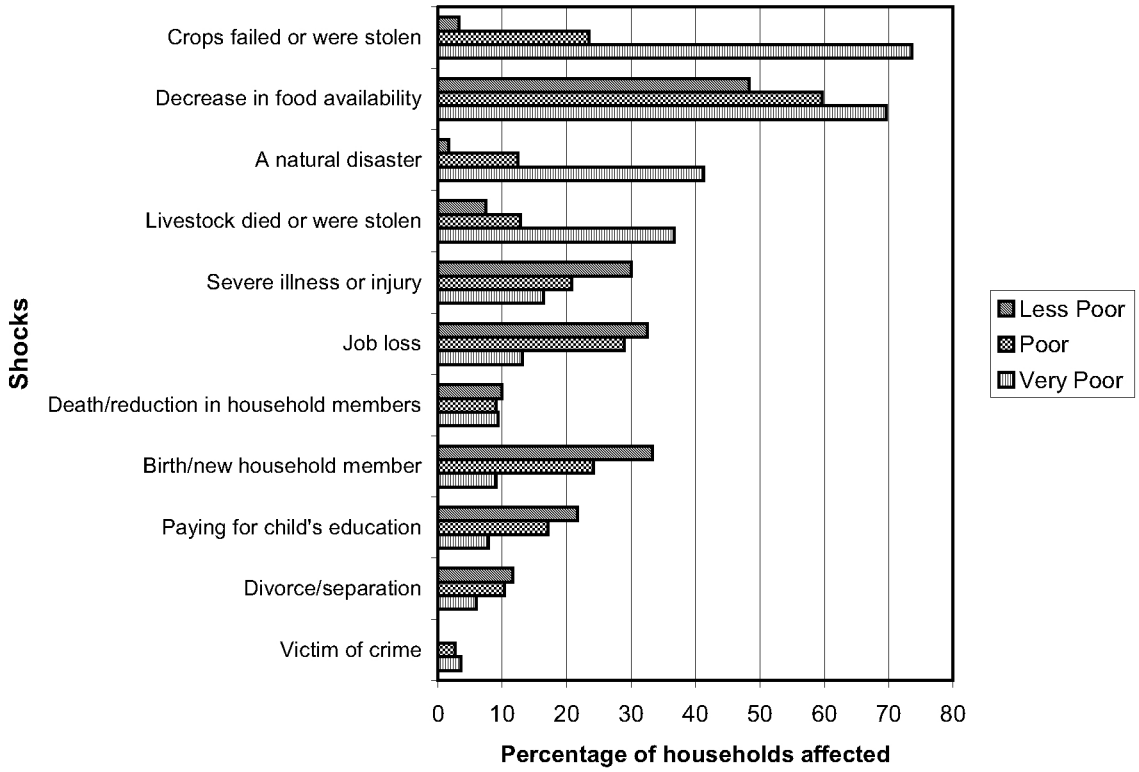
Shocks related to agricultural failures (crop failure, natural disaster, death of livestock) are naturally more prevalent in rural areas (Figure 3.1). However, people in both rural and urban areas seem to face similar problems regarding food availability. Job loss, birth or new household members, paying for children's education, illness and injury were more common in urban areas. The addition of new household members is a common problem in urban areas, perhaps because people migrate from rural areas to urban areas and live with their relatives.

FIGURE 3.1. FREQUENCY DISTRIBUTION OF ECONOMIC SHOCKS BY LOCATION (1-YR-OLDS)



The importance of negative events reported is different when broken down by poverty status (Tables 3.7.2 and 3.7.3). The problems of theft or death of livestock, crop failure, natural disaster and decrease in food availability are the highest among households in the very poor category. On the other hand, the problems of decrease in food availability, job loss, serious illness and injury, and birth/new household members are the highest for those in the less poor category (Figure 3.2). This naturally correlates with the primary dependence of rural people on agriculture. The results also indicate that the frequency of negative events (such as divorce/separation, birth/new household member, paying for child's education, severe illness or injury, and job loss) increases with wealth. On the other hand, the frequency of the following negative events decreases with wealth: natural disaster, decrease in food availability, death or theft of livestock, victim of crime, and crops failure or theft. However, the pattern for death/reduction in household members was almost the same across all poverty categories. These results suggest that as people move out of absolute poverty, their basic needs are more likely to be met and that other concerns then become important.

FIGURE 3.2. FREQUENCY DISTRIBUTION OF ECONOMIC SHOCKS BY POVERTY (1-YR-OLDS)



The most frequent answer to the question on what the households did when confronted with negative events was 'doing nothing'. However, some of the families responded to such negative events by selling assets, eating less and/or the use of credit. The rest of the possible responses to negative events were not commonly used as coping mechanisms (Table 3.7.3 and 3.7.4). The response 'doing nothing' is often an indication of perceived helplessness and may suggest an almost complete lack of resources.

TABLE 3.7.2 TYPE OF EVENTS BY LOCATION AND POVERTY STATUS

TYPE OF EVENT	TOTAL N	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
A natural disaster	445	3.0	44.9	41.3	12.4	1.7
Decrease in food availability	919	65.2	65.8	69.6	59.7	48.3
Death/reduction in household members	131	8.2	9.9	9.4	9.1	10.0
Job loss	254	35.7	10.2	13.1	28.9	32.5
Severe illness or injury	259	22.2	16.8	16.4	20.8	30.0
Victim of crime	43	3.0	3.1	3.6	2.7	
Divorce/separation	103	11.2	5.6	5.9	10.4	11.7
Birth/new household member	201	29.1	7.7	9.1	24.2	33.3
Paying for child's education	155	19.0	7.5	7.9	17.1	21.7
Moved/migrated/fled	57	7.8	2.4	2.2	8.4	8.3
Other	27	3.9	1.0	1.3	2.0	6.7
Livestock died or were stolen	407	14.0	35.9	36.7	12.8	7.5
Crops failed or were stolen	797	23.6	72.1	73.6	23.5	3.3

TABLE 3.7.3 RESPONSES TO WORST EVENTS (ROW PERCENTAGE) MULTIPLE-RESPONSE QUESTION

Worst event	Total count	Nothing	Sell things/ sell assets	Use savings	Use credit	Eat less	Buy less	Work more/ start work	Take children out of school	Send children to work	Fled/ moved away from problem	Migrated to work/ find work	Helped by relative or friends	Helped by Gov. or NGO	Other
Natural disaster	419	36	12	2	11	15	5	7	0	0	1	2	5	3	1
Decrease in food availability	387	33	9	5	11	13	5	12	1	1	0	3	2	5	1
Livestock died or were stolen	183	42	10	7	11	9	4	9	1	0	0	1	3	1	3
Crops failed or were stolen	1,021	32	13	6	9	11	6	9	0	0	0	3	1	8	1
Death/reduction in household members	103	51	6	6	6	7	7	8	0	0	1	2	6	1	0
Job loss	231	25	9	2	10	16	14	6	3	1	0	6	5	1	2
Severe illness or injury	213	38	10	2	14	11	2	5	1	2	0	1	8	1	4
Victim of crime	21	14	24	0	29	5	10	5	0	5	0	0	5	5	0
Divorce/separation	55	35	7	4	2	11	2	11	0	2	7	5	9	0	5
Birth/new household member	77	23	4	6	13	21	13	9	4	1	0	0	4	0	1
Paying for child's education	21	57	0	5	0	10	5	10	10	0	0	0	0	5	0
Moved/migrated/fled	19	21	16	0	5	5	5	5	0	5	0	16	11	0	11
Other	24	17	13	0	4	17	8	13	0	4	0	4	4	0	17
Total	2,774	34	11	5	10	12	6	9	1	1	0	3	3	5	2

TABLE 3.7.4 RESPONSES TO WORST EVENTS (COUNT OF RESPONSES)

Worst Event	Total count	Nothing	Sell things/sell assets	Use savings	Use credit	Eat less	Buy less	Work more/ start work	Take children out of school	Send children to work	Fled/ moved away from problem	Migrated to work/find work	Helped by relative or friends	Helped by Gov. or NGO	Other
Natural disaster	419	152	49	7	46	61	22	31	0	1	4	7	21	12	6
Decrease in food availability	387	127	34	20	42	50	20	46	5	2	1	10	8	19	3
Livestock died or were stolen	183	76	19	13	20	17	8	16	1	0	0	2	5	1	5
Crops failed or were stolen	1,021	328	137	63	90	114	58	92	4	2	1	28	12	85	7
Death/reduction in household members	103	53	6	6	6	7	7	8	0	0	1	2	6	1	0
Job loss	231	57	20	5	24	37	33	14	8	3	0	13	11	2	4
Severe illness or injury	213	80	22	5	30	23	4	11	2	4	0	3	17	3	9
Victim of crime	21	3	5	0	6	1	2	1	0	1	0	0	1	1	0
Divorce/separation	55	19	4	2	1	6	1	6	0	1	4	3	5	0	3
Birth/new household member	77	18	3	5	10	16	10	7	3	1	0	0	3	0	1
Paying for child's education	21	12	0	1	0	2	1	2	2	0	0	0	0	1	0
Moved/migrated/fled	19	4	3	0	1	1	1	1	0	1	0	3	2	0	2
Other	24	4	3	0	1	4	2	3	0	1	0	1	1	0	4
Total	2,774	933	305	127	277	339	169	238	25	17	11	72	92	125	44

3.8 Social capital

Among other forms of capital (human, financial, natural and physical), social capital can be a very important asset, especially for poor people, if it can be called upon during crises. However, if social capital is positively correlated with other forms of capital, those who are poorer in terms of human, financial, and physical capital may be denied help from community and relatives. We used the methodology described in section 2.4 to discuss social capital.

The overall social capital of households is given in Table 3.8.1. The majority of households have medium absolute structural social capital (58.3 per cent), medium social support (49.6 per cent), and high cognitive social capital (88 per cent). Fifty-six per cent of the caregivers had zero citizenship, indicating they neither join together to address common issues nor do they talk with the local authority on problems in the community.

Social capital did not differ significantly between rural and urban areas, although the proportion of caregivers who have medium and high absolute structural social capital, high social support, high cognitive social capital and some citizenship index was slightly higher for rural than for urban areas.

It seems there is some difference across poverty status in the structure of social capital (Table 3.8.1). The proportion of households who have medium and high absolute structural social capital, medium and high social support, and high cognitive social capital is higher among the very poor than the less poor households. Moreover, the proportion of caregivers who join together to address common issues or talk with the local authority on problems in the community is higher among the very poor than for the less poor. These relationships are statistically significant for all types of social capital except for citizenship type of social capital[14]. These results suggest that poorer households, who have little or no financial and physical capital, have higher levels of social connectedness in order to reduce their vulnerability. This might be because poorer households are more aware of their dependence on others and the cost of alternative use of their time is lower and hence find it cheaper to establish social ties. In summary, one would imagine that social capital is positively related to physical capital (poverty status defined by asset ownership), but the result is quite contrary: social relations (social capital) and physical capital are negatively related.

14 These relationships are statistically significant at one per cent level for absolute structural social capital and social support capital, and at five per cent for cognitive social capital. The relationship between citizenship social capital and poverty status is not statistically significant.

TABLE 3.8.1 SOCIAL RELATIONS BY LOCATION AND POVERTY STATUS

TYPE OF SOCIAL CAPITAL	TOTAL N	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Absolute structural social capital						
No ASSC (%)	27.3	34.7	23.3	23.3	32.5	37.7
Medium ASSC (%)	58.3	54.3	60.5	62	51.4	52.9
High ASSC (%)	14.4	11	16.2	14.7	16	9.4
Number of observations	**1,996**	**700**	**1,296**	**1,266**	**486**	**244**
Social support received last year						
No SS (%)	30.9	37	27.5	25.6	39.8	40.2
Medium SS (%)	49.6	50.3	49.2	51.5	44.7	49.2
High SS (%)	19.6	12.7	23.3	22.9	15.5	10.7
Number of observations	**1,993**	**701**	**1,292**	**1,264**	**485**	**244**
Cognitive social capital						
No CSC (%)	0.8	1.1	0.5	0.5	0.6	2.5
Medium CSC (%)	11	13.3	9.8	9.5	14	12.7
High CSC (%)	88.2	85.6	89.7	90	85.4	84.8
Number of observations	**1,999**	**700**	**1,299**	**1,268**	**487**	**244**
Citizenship						
No CIT (%)	55.5	57.7	54.3	54.7	54.4	61.9
Some CIT (%)	44.5	42.3	45.7	45.3	45.6	38.1
Number of observations	**1,999**	**700**	**1,299**	**1,268**	**487**	**244**

3.9 Psychosocial well-being of caregiver

The state of the caregiver's mental health and other aspects of well-being are likely to have important implications on the child's physical and mental development. While this issue requires a close examination using appropriate methods of analysis, some of the preliminary responses to questions about the psychosocial well-being of the caregiver are summarized in Table 3.9.1.

Overall, almost 33 per cent of the 1,999 caregivers reported having had some level of depression during the previous 30 days. The percentage of cases was almost identical for urban and rural areas, and across wealth categories.

TABLE 3.9.1 CAREGIVER'S MENTAL HEALTH BY LOCATION AND POVERTY STATUS

CAREGIVER DEPRESSION	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Non-case (%)	67	67	67	68	62	72
Case (%)	33	33	33	32	38	28
Number of observations	**990**	**700**	**1,299**	**1,268**	**487**	**244**

3.10 Nutritional status

We used the methodology described in Section 2.4 to analyse the nutritional status of the index children in our sample. Table 3.10.1 shows the mean values of the height for age, weight for age, and weight for height z-scores. For the whole sample they are: –1.48, 1.62 and –0.76, respectively. A study by the Ethiopian Health and Nutrition Research Institute (EHNRI) (2002), gives averages of –2.02, –0.39 and –1.70, respectively. Our sample shows better average nutritional status in terms of height for age and weight for height z-scores, while the EHNRI sample shows better weight for age attainments[15].

TABLE 3.10.1 MEAN AND PERCENTAGES OF NUTRITIONAL STATUS BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Height for Age z-score (stunting)						
Mean	-1.48	-1.27	-1.65	-1.68	-1.27	-0.98
Z-score <-2 (%)	38	30	43	45	29	21
Number of observations	**1,801**	**678**	**1,123**	**1,116**	**453**	**232**
Weight for Age z-score (underweight)						
Mean	-1.62	-1.31	-1.80	-1.88	-1.31	-0.92
Z-score <-2 (%)	41	31	47	50	31	16
Number of observations	**1,801**	**678**	**1,123**	**1,116**	**453**	**232**
Weight for Height z-score (wasting)						
Mean	-0.76	-0.57	-0.87	-0.93	-0.57	-0.31
Z-score <-2 (%)	14	10	16	17	11	6
Number of observations	**1,801**	**678**	**1,123**	**1,116**	**453**	**232**

15 Note that the EHNRI uses only 60 observations and used WHO's standards of 1983.

All the averages of the nutritional status in our sample are negative – indicating plausible skewness in the data set. This seems to be even more pronounced in the case of rural areas compared to urban areas, indicating the fact that nutrition indicators are worse in rural areas. Children in households with higher wealth indicator have a better mean of nutritional status.

Stunting, a measure of chronic under-nutrition, is obtained by dividing the height of children by their age and standardising the variables using international reference points; children scoring low z-scores (less than –2) are then classified as chronically malnourished. According to this measure, 38 per cent of the sampled index children are chronically malnourished. This is lower than the 57 per cent reported in the national survey of 1999/2000 (MOFED, 2002b) or the EHNRI (2002) result of 51 per cent.

Children born in rural areas tend to be more chronically malnourished (43 per cent) compared to their urban compatriots (30 per cent). Moreover, a larger proportion of the children born into very poor households tend to be more malnourished than those born into poor or less poor households. Thus, the proportions of the chronically malnourished in the very poor, poor and less poor categories are 45, 29 and 21 per cent, respectively.

Another measure of nutritional attainment of children is wasting or the weight for height measure. Here weight is divided by height and standardized using international standards. This measure indicates that 14 per cent of the sampled children are wasted. This figure is higher than the 10 per cent national average reported in the 1999/2000 national survey (MOFED, 2002b) as well as the 8 per cent reported in the EHNRI (2002) report. The trends identified for stunting are also identified in this indicator. Thus, rural children and children born in poor households tend to be more wasted than urban children and children born into less poor households.

Yet another measure of nutritional status is the weight for age or the measure of underweight. This is also another indicator of chronic malnutrition. Among our sampled index children, we found that 41 per cent of them have z-scores more than two standard deviations below the mean. This result is similar to the 42 per cent reported by EHNRI (2002). The results also indicate that more children born in rural areas (47 per cent) suffer from chronic malnutrition, based on this indicator, compared to those born in urban areas (31 per cent). Moreover, children born into the very poor households are more likely to be malnourished than those born into the poor and less poor categories.

As expected, the main descriptive indicators of malnutrition show that a large proportion of very poor children in Ethiopia are malnourished and that rural children suffer more than their urban compatriots. Relating measures of malnutrition to poverty status, we find that the proportion of the malnourished diminishes as wealth increases. These results conform to our expectations and provide face validity for the wealth index.

4 Results – Eight-year-old survey

4.1 Introduction

The results presented in this section focus on the eight-year-old child and not the household. In particular, the topics covered are the children's nutritional status, physical morbidity, child's schooling and child's feelings about school, literacy and numeracy, child development (using Raven's test), child's work and feelings about work, child's perceptions of well-being and child's social capital.

4.2 Child's nutritional status

The arithmetic means for z-scores of the three measures of malnutrition (stunting, wasting and underweight) are presented in Table 4.2.1. The results show that all the means are less than zero, indicating relatively skewed distributions of these measures (Table 4.2.1).

TABLE 4.2.1 CHILD-NUTRITION INDICATORS BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Height for Age z-score (Stunting)						
Mean	-1.45	-1.21	-1.61	-1.68	-1.10	-1.23
Z-score<-2 (%)	32.7	24.4	38.1	40.2	21.6	22.7
Number of observations	**857**	**340**	**517**	**505**	**255**	**97**
Weight for Age z-score (Underweight)						
Mean	-1.60	-1.38	-1.75	-1.77	-1.35	-1.30
Z-score<-2 (%)	32.7	24.1	38.3	38.8	24.3	22.7
Number of observations	**857**	**340**	**517**	**505**	**255**	**97**
Weight for Height z-score (Wasting)						
Mean	-0.97	-0.86	-1.07	-1.04	-0.95	-0.67
Z-score<-2 (%)	14.4	9.4	17.6	15.0	14.5	10.3
Number of observations	**857**	**340**	**517**	**505**	**255**	**97**

Table 4.2.1 also shows the percentage of malnourished children using these measures in our sample. There is an overall high incidence of stunting in the sample (32.7 per cent). There is, however, a wide variation in terms of location whereby only about a quarter of the children located in urban areas are stunted, whereas the figure for rural areas is 38.1 per cent. There is also a clear indication that the percentage of stunted children born into very poor households is very high (40.2 per cent) compared to those in the other categories. However, the distinction between those born into poor and less poor households is not great.

The nutritional status measured in terms of weight for height (wasting) is also very high. Thus, 14.4 per cent of the sampled eight-year-old children are wasted. The incidence is higher in rural areas (around 17.6 per cent) relative to urban areas (around 9.4 per cent). We also observe that the percentage of wasted children is higher (15 per cent) for children born into very poor households compared to those born into poor (14.5 per cent) or less poor (10.3 per cent) households.

A similar high incidence of low nutritional status is recorded using the weight for age (underweight) z-scores as well. The overall percentage of underweight children is 32.7 per cent, and rural children exhibit a higher level of malnutrition (38.3 per cent) compared to urban children (24.1 per cent). Moreover, the incidence of child malnutrition is lower for children in less poor households (22.7 per cent) compared to those in very poor households (38.8 per cent)

4.3 Child's health

Caregivers' perceptions about the health of their children indicate that the largest proportion of the sampled children is the same as their peers (48 per cent). When we analyse the data based on the location of the households, however, we observe that a larger percentage (51 per cent) of rural caregivers perceive their children to be as healthy as their peers. We also see that a larger percentage (54 per cent) of caregivers in less poor families perceive their children to be more healthy than their peers compared to those in very poor households (33 per cent).

Ten per cent of the sampled eight-year-old children have had long-term illness. However, there does not seem to be any difference in terms of location or poverty status. A relatively high percentage (20 per cent) of caregivers reported that their child was so ill they thought she/he might die. There is a difference between the percentages of children reported to have been very sick in urban areas (17 per cent) and rural areas (20 per cent). There is also a clear distinction in the incidence of severe illness among very poor children (21 per cent) and the less poor (11 per cent).

TABLE 4.3.1 PHYSICAL MORBIDITY BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Health compared to others						
Same (%)	48	44	51	52	46	36
Better (%)	37	41	35	33	41	54
Worse (%)	15	15	14	16	14	10
Number of observations	**1,001**	**351**	**650**	**620**	**281**	**100**
Children with reported long-term health problem	(%)	10	9	10	11	810
Number of observations	**1,001**	**351**	**650**	**620**	**281**	**100**
Child has been so ill that the caregiver thought she/he might die (%)	19	17	20	21	17	11
Number of observations	**998**	**349**	**649**	**618**	**281**	**99**
Treatment sought for illness that could have killed (%)	75	75	75	70	88	85
Number of valid observations	191	60	131	130	48	13
Child suffered severe toothache (%)	10	14	8	9	11	12
Number of observations	**998**	**350**	**648**	**619**	**279**	**100**
Child was ill in the 2 weeks before the interview (%)	19	19	19	21	14	22
Number of observations	**1,001**	**351**	**650**	**620**	**281**	**100**

Among those reporting their child so ill that they thought she/he might die, 75 per cent sought medical treatment. There is no variation between urban or rural households in this regard. There is also a mixed result in terms of poverty status. Thus, while only 70 per cent of very poor children were taken for treatment, the figure for the poor and less poor is 88 and 85 per cent, respectively.

Ten per cent of the total sampled children have suffered severe toothache. In this respect, however, it seems that children located in rural areas suffered less (8 per cent) compared to those located in urban areas (14 per cent). It is also interesting to note a lower percentage of poor children suffering toothache (9 per cent) compared to the less poor (12 per cent).

Twenty per cent of the sampled eight-year-old children were reported to have been ill in the two weeks preceding the interview. There is no distinction in this regard between children in urban and rural areas. The difference among the poverty status categories is mixed.

4.4 Literacy and numeracy

The results on simple literacy and numeracy tests of the eight-year-old children are summarized in Table 4.4.1. Different languages are used as medium of education in primary school in different states. The reading and writing tests were conducted based on these different languages. In some cases (for example, in SNNP), the medium of education for primary school varies from one zone to another. It was, therefore, important to develop the numeracy and literacy tests using local languages.

TABLE 4.4.1 LITERACY AND NUMERACY OF EIGHT-YEAR-OLD CHILDREN BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Reading level						
Can't read anything (%)	54	31	67	71	32	10
Reads letters (%)	20	17	21	16	24	29
Reads words (%)	5	7	4	3	9	8
Reads sentences (%)	21	45	8	10	35	54
Number of observations	**990**	**349**	**641**	**610**	**279**	**101**
Writing level						
No (%)	57	36	68	73	35	17
Yes without difficulty or errors (%)	23	39	15	13	38	44
Yes with difficulty or errors (%)	20	25	17	14	27	39
Number of observations	**987**	**346**	**641**	**609**	**276**	**102**
Numeracy						
Correct (%)	43	43	44	36	51	56
Incorrect (%)	57	57	56	64	49	44
Number of observations	**747**	**316**	**431**	**399**	**252**	**96**

Overall, 54 per cent of children cannot read or write anything, and only 20 per cent read letters. Not surprisingly, there are more children (67 per cent) unable to read in rural areas compared to urban areas (31 per cent). Similarly, 57 per cent of the total children are unable to write. The percentages for rural and urban areas are 68 per cent and 36 per cent, respectively. On the other hand, 43 per cent of the children answered the numeracy test correctly, which is also almost identical in urban and rural areas.

When compared by poverty status, there appears to be a strong relationship between poverty status of households and literacy and numeracy of children.

4.5 Child's schooling and feelings about school

Child schooling and the child's feeling about school were important elements of the eight-year-old child questionnaire. Results for child schooling are given in Table 4.5.1. According to the caregivers' report, 67 per cent of the children had attended school prior to, or during the time of, the survey year. Not surprisingly, school attendance is higher in urban areas (86 per cent) compared to rural (56 per cent). Similarly, 95 per cent of children from less poor households attended schools compared with only 53 per cent for very poor households.

On the other hand, of those children who attended school, 98 per cent were already in school at the time of survey. When disaggregated by location, 99 per cent of urban children attended school compared to 97 per cent in rural areas, implying that urban children are slightly better off than rural children. Again, of those children who are in school, children from less poor families have a better chance of attending school – 100 per cent according to these results. While expanding basic primary education is one of the top priorities of the federal and regional governments of the country, these results suggest that there is a lot to be done in this regard.

TABLE 4.5.1 CHILD'S SCHOOLING BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Child attended school last year (%)	67	86	56	53	87	95
Number of observations	**1,000**	**351**	**649**	**619**	**281**	**100**
Child is currently in school (%)*	98	99	97	97	98	100
Number of observations	**672**	**303**	**369**	**328**	**249**	**95**
Reason for not being in school						
Too expensive (%)	22	32	20	20	40.5	20
Too far away (%)	24	4	27	27	3	20
Child refuses or banned (%)	7	6	7	5	22	-
Poor quality of school (%)	1	-	1	-	3	-
Child disabled (%)	2	6	1	2	-	-
Needed to help family (%)	30	28	30	32	16	-
Other (%)	15	24	14	14	16	60
Number of observations	**340**	**50**	**290**	**298**	**37**	**5**
What does child do for fun?						
Plays with friends (%)	85	92	82	81	92	88
Watches TV (%)	1	1	-	-	-	5
Reads/Writes/Draws (%)	2	3	2	2	3	4
Helps parents (%)	10	2	14	14	4	-
Visits relatives (%)	1	1	1	1	-	-
Nothing (%)	2	1	2	2	1	1
Other (%)	1	1	1	1	-	2
Number of observations	**989**	**345**	**644**	**612**	**279**	**100**

**This is the percentage out of those who attended school last year.*

Caregivers were also asked the reasons why their children did not go to school. Thirty per cent of caregivers replied that the child was needed to help the family in various work activities. The other two main reasons included the school being too far away (24 per cent), and it being too expensive to send the child to school (22 per cent). Whilst the former is mainly a rural issue, the latter mainly arises in urban households.

Table 4.5.2 shows children's feelings about school. When children were asked what they do not like about their school, 59 per cent of them replied 'teachers or pupils beating'. The results are similar across locations and poverty status. Such outcomes indicate the serious level of beatings and bullying faced by children. This is an issue requiring further analysis and consideration in order to improve the school environment. The other two things children do not like about school are noise (24 per cent) and dirty toilets (16 per cent).

On the positive side, children were asked what were the main things they liked about school. Fifty-eight per cent (and the figure is constant across location and poverty status) said they like learning most, followed by teachers and pupils (40 per cent).

TABLE 4.5.2 CHILD'S FEELINGS ABOUT SCHOOL BY LOCATION AND POVERTY STATUS

CHILD'S FEELINGS ABOUT SCHOOL	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
What is the main thing you do not like about school?						
Teachers or pupils beating (%)	59	52	65	61	54	67
The noise (%)	24	28	20	24	26	25
Being bored (%)	1	1	1	1	1	-
Dirty toilets (%)	16	18	13	14	18	15
Nothing (%)	1	1	1	-	1	4
Number of observations	**358**	**163**	**195**	**157**	**146**	**55**
What is the main thing you like about school?						
Teachers and friends (%)	40	39	41	39	41	40
Learning (%)	58	58	58	59	57	57
Nothing (%)	2	3	2	2	2	3
Number of observations	**452**	**201**	**251**	**207**	**180**	**65**

In general, the low level of school attendance, coupled with the low level of literacy and numeracy tests, revealed by the preliminary results of the survey sends a strong message on the need to improve access to, and quality of, education for the poor.

4.6 Child development—Raven's test

The Raven's test was administered in five urban sentinel sites (three of which are in Addis Ababa) to assess child development. The outcomes of the test are summarized in Table 4.6.1.

TABLE 4.6.1 CHILD DEVELOPMENT (RAVEN'S TEST) BY POVERTY STATUS

RAVEN'S TEST RESULTS	TOTAL SAMPLE	POVERTY STATUS		
		VERY POOR	POOR	LESS POOR
Set A				
Low (0-4) (%)	7	11	6	8
Average (5-8) (%)	67	63	72	56
High (9-12) (%)	27	26	22	36
Number of observations	**251**	**19**	**157**	**75**
Set B				
Low (0-4) (%)	100	100	99	100
Average (5-8) (%)	-	-	1	-
Number of observations	**251**	**19**	**157**	**75**
Set AB				
Low (0-4) (%)	99	100	99	99
Average (5-8) (%)	1	-	1	1
Number of observations	**251**	**19**	**157**	**75**

Raven's test allows measurement of children's cognitive development from low levels to higher ones on a step-by-step basis. For 'Set A', the lowest level, 67 per cent of children obtained average scores and 27 per cent obtained high scores. Children from less poor families appear to have scored better than others. However, in the next levels of testing (Set B and Set AB), all children obtained low scores.

4.7 Child's work and feelings about work

Table 4.7.1 presents results related to work done by eight-year-old children. The results show that about 9 per cent of the children have worked for money or goods, with a larger percentage of rural children working (11 per cent) than urban children (4 per cent). The percentage is also higher for very poor households (12 per cent) than for poor and less poor (3 per cent each).

For almost three-quarters of the respondents, the main reason the child was working is to supplement household income, while for about 12 per cent the main reason was that the children like doing it. In percentage terms, most households – both urban and rural – said the most important reason for working was to supplement household income. However, bonded labour was the second most frequent response for urban households (about 8 per cent), while for rural households it was that the children like it (about 14 per cent). About 5 per cent of the children who work are reported to have been seriously hurt whilst working, with a larger percentage of cases reported in urban than rural areas (Table 4.7.1).

TABLE 4.7.1 CHILD WORK BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Has child ever worked for money or goods?						
Yes (%)	8.5	3.7	11.08	11.77	2.86	3
Number of observations	**1,001**	**351**	**650**	**620**	**281**	**100**
Main reason child is working						
Supplement HH income (%)	74.12	92.31	70.83	72.6	77.78	100
Generate own income (%)	2.35	-	2.78	2.74	-	-
Gain experience (%)	1.18	-	1.39	-	11.11	-
They like to (%)	11.76	-	13.89	13.7	-	-
Keep them out of trouble (%)	2.35	-	2.78	2.74	-	-
Bonded labour (%)	3.53	7.69	2.78	2.74	11.11	-
Other (%)	4.71	-	5.56	5.48	-	-
Number of observations	**85**	**13**	**72**	**73**	**9**	**3**
Has child been seriously hurt while working?						
Yes (%)	5	8	4	4	11	-
Number of observations	**85**	**13**	**72**	**73**	**9**	**3**

Table 4.7.2 presents the feelings of the child about work. More than half of 94 children responded that they like working. The children were also asked what they do not like about working, and about 41 per cent of the 39 children who responded said that it is too tiring, while about 30 per cent said they had no time for school, and 22 per cent said they had a poor working environment. About 28 per cent of 80 children said they had missed school due to being at work.

TABLE 4.7.2 CHILD'S FEELINGS ABOUT WORK

		TOTAL SAMPLE
Do you like working?	No (%)	45.74
Number of observations		**94**
What do not you like about working?		
	No time for school (%)	29.73
	Poor working environment (%)	21.62
	Long hours (%)	8.11
	Relationship with employer (%)	5.41
	Too tiring (%)	40.54
	Number of observations	39
Have you ever missed school because you were working?		
	Yes (%)	27.5
Number of observations		**80**

4.8 Child's perception of well-being

The child's perception of well-being is one of the outcome indicators, which is a child centric outcome indicator obtained from the subjective views of children. This section covers those indicators, including environmental quality (water, air, rubbish); the degree to which people 'look down' upon children or treat them badly; perceived safety of their community and sufficient food to eat. There is also a question about aspirations: 'what do you want to be when you grow up'. Children's responses to the questions are summarized in Tables 4.8.1 and 4.8.2.

TABLE 4.8.1 CHILD'S PERCEPTIONS OF WELL-BEING ON WATER, AIR, SAFETY, AND RUBBISH ON THE STREETS BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
Is the water people drink around here good, bad or average?						
Good (%)	82	89	79	77	90	92
Bad (%)	10	3	13	14	4	2
Average (%)	7	8	7	8	6	6
Not known (%)	1	0	1	1	0	0
Number of observations	**989**	**350**	**639**	**609**	**278**	**102**
Is the air people breath around here good, bad or average?						
Good (%)	67	68	67	67	68	66
Bad (%)	19	17	20	20	16	22
Average (%)	10	13	8	8	14	11
Not known (%)	4	2	5	5	2	2
Number of observations	**993**	**351**	**642**	**611**	**280**	**102**
Is the amount of rubbish on the streets good, bad or average?						
Good (%)	33	21	39	37	26	25
Bad (%)	29	37	25	27	34	32
Average (%)	38	42	36	37	40	43
Number of observations	991	347	644	609	280	102
Is the area you live in safe for children?						
Yes (%)	76	72	78	79	75	65
No (%)	24	28	22	22	25	35
Number of observations	**962**	**343**	**619**	**586**	**276**	**100**

Most of the children in the sample felt the water people drink (82 per cent) and the air they breathe (67 per cent) to be good, and the area they live in to be safe for children (76 per cent). However, only 33 per cent felt good about the rubbish on their street. Of those who feel bad about the rubbish, the proportion is higher for urban children than for rural children, indicating that dirty streets are more of an urban problem. The child's perception regarding the quality of water is better in urban areas, and among poor and less poor households, than in rural areas and among very poor households. There is no clear difference between rural and urban areas and among different poverty categories regarding the quality of air people breathe.

TABLE 4.8.2 CHILD'S AMBITION, LIKES AND DISLIKES, AND PERCEPTION OF CHILDREN ON THE SUFFICIENCY OF FOOD TO EAT BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
What do you want to be when you grow up?						
President (%)	2	1	3	2	3	1
Doctor (%)	26	36	21	19	36	41
Nurse (%)	4	4	4	3	5	6
Police (%)	4	3	5	4	4	3
Teacher (%)	41	25	50	51	30	9
Other (%)	1	1	2	2	1	
Number of observations	**996**	**348**	**648**	**618**	**279**	**99**
What makes you happy?						
Being bought clothes (%)	52	39	58	59	41	39
Being bought sweets (%)	7	8	7	8	8	5
Having a party (%)	1	2	1	2	1	1
Playing with friends (%)	16	13	18	16	16	16
Nothing (%)	1	1	1	1	1	
Other (%)	10	17	7	7	16	18
Number of observations	**986**	**344**	**642**	**614**	**276**	**96**
What makes you unhappy?						
Being beaten (%)	42	41	43	44	40	42
Parents fighting (%)	11	7	14	14	8	2
Dirty place (%)	14	19	11	11	20	17
Nothing (%)	7	5	8	7	7	8
Other (%)	11	21	6	7	16	25
Number of observations	**954**	**338**	**616**	**592**	**265**	**97**
What do you like about the area you live in?						
My friends (%)	28	33	26	25	33	34
My family (%)	46	37	50	49	42	35
Nothing (%)	3	4	3	3	4	6
Other (%)	3	5	2	2	4	8
Number of observations	**981**	**347**	**634**	**607**	**275**	**99**
What do you not like about the area you live in?						
Being beaten (%)	42	32	48	47	36	28
It's ugly (%)	7	7	6	7	6	7
It's dangerous (%)	3	1	4	4	1	
Nothing (%)	14	11	16	13	16	14
Other (%)	5	9	3	3	6	11
Number of observations	**949**	**341**	**608**	**584**	**270**	**95**
Do you think people in this area treat you well or badly?						
Well (%)	90	88	91	90	91	88
Badly (%)	10	12	9	10	9	12
Number of observations	**940**	**335**	**605**	**575**	**267**	**98**
Do you get enough food to eat?						
Yes (%)	78	81	76	74	82	91
No (%)	22	19	24	26	18	9
Number of observations	**989**	**349**	**640**	**610**	**280**	**99**

Most of the children in the sample want to become a teacher (41 per cent) or a doctor (26.1 per cent), with urban children having a stronger ambition to be a doctor than rural children. Children from wealthier families have a stronger desire to be a doctor than a teacher, while children from poorer households more strongly want to be a teacher than a doctor. Buying clothes is the most happy-making activity of the majority of children, followed by playing with friends. Rural children feel happier than urban children when they are being bought clothes and playing with friends, which suggests that rural children are not well-clothed, and not allowed to play with friends or are too far away from other any children. The desire to be bought clothes declines as the family becomes less poor, while the desire of children to play with friends is the same across poverty status category. Forty-five per cent of the children dislike the area they live in because they are being beaten. However, 90 per cent of the children feel they are well treated by the people in their area: in this regard, the pattern of responses is the same across rural and urban households, and among the very poor, poor and less poor households.

4.9 Child's social capital

Young Lives Project provides an opportunity to explore the difference between children's social capital and caregivers' social capital and the role that each of them plays in the child's well-being. Connectedness in this report is measured by asking about 'frequency of play' and support is to be measured by asking about 'availability of someone to help the child'. The results are given in Table 4.9.1. Seventy-five per cent of the children play with other children daily, 15 per cent play weekly and 8 per cent play less often. Only 1 per cent of the children do not play with friends, which is an exception.

Moreover, for 90 per cent of the children there is always someone who will help them when they have a problem. However, there is no clear difference in the child's social capital between rural and urban children, and among the different poverty categories. For the majority of the children, it is the mother who helps them but for others it will be a brother/sister, with nearly double the amount of children in rural areas receiving help from a sibling. This might be due to the fact that mothers in rural areas and in poorer families may be involved in farm or other work to support the family. Thus, they may seek help from their elder children. Also, in rural areas and in poorer families, brothers and sisters may have the time to help their mothers due to not going to school.

TABLE 4.9.1 CHILD'S SOCIAL CAPITAL BY LOCATION AND POVERTY STATUS

	TOTAL SAMPLE	LOCATION		POVERTY STATUS		
		URBAN	RURAL	VERY POOR	POOR	LESS POOR
How often do you play with your friends?						
Daily (%)	75	80	73	76	75	73
Weekly (%)	15	14	16	15	15	18
Less often (%)	8	5	10	8	9	9
Never (%)	1	1	1	1	1	1
Number of observations	**996**	**351**	**645**	**613**	**281**	**102**
If you had a problem, is there someone who would help you?						
Yes (%)	90	92	90	89	92	96
No (%)	10	8	11	11	8	4
Number of observations	**977**	**347**	**630**	**604**	**271**	**102**
Who is this person helping you?						
Mother (%)	51	57	47	46	61	52
Grandparent (%)	5	6	5	5	4	5
Brother/sister (%)	9	6	11	11	8	3
Aunt/uncle (%)	2	5	1	1	2	8
Friend (%)	4	2	5	5	2	0
Other (%)	26	20.6	28.5	28	18	30
Number of observations	**896**	**321**	**575**	**545**	**256**	**95**

5. Provisional conclusions and policy implications

This report has tried to review what is known about child poverty in Ethiopia and the relevant aspects of the policy environment. An attempt has also been made to present descriptive results using part of the data collected. The discussion of the descriptive results has focused on urban/rural differences and differences across three poverty categories. While more rigorous analyses and disaggregation will follow, the following provisional conclusions and implications are derived from this study.

Better education of caregivers and household heads is necessary. Biological mothers care for 97 per cent of the index children, and 89 per cent of caregivers have not completed primary school. Moreover, 87 per cent of household heads have not completed primary school. This suggests the need for better education of caregivers and household heads, as this would be helpful, among other things, for the children.

Improved services are critical – particularly for rural and very poor households. A limited number of households have access to electricity, safe drinking water and toilet facilities. Water piped into the dwelling is almost exclusively found in urban areas, where 29 per cent of study households had access to this. Only 3 per cent of urban households and about 1 per cent of rural households have access to waterborne toilet facilities. These problems are more serious for rural and very poor households, which suggests the need to focus on these groups in attempts to expand these services.

Need for improved access to health services for the poorer households and those in rural areas. Only 40 per cent of rural biological mothers undertake antenatal visits. Almost all rural mothers (96 per cent) give birth at home without the assistance of a medically trained person, and 21 per cent of the children had not received vaccinations against both BCG and measles. The death of a child under five years of age was reported in 25 per cent of the households. The problems are worse for rural and poorer households. These suggest the need to expand primary health services – such as assistance at delivery by a medically trained person and vaccination, particularly to the very poor and those in the rural areas.

Dependence on others for care of the index child is more common for rural and very poor households. In rural areas and very poor households, the proportion of non-household members caring for the child, and the proportion who allow children younger than five years of age to take care of the index child, are both higher compared to urban areas and less poor households. This suggests that wealthier households do not make as much use of outside caregivers for their children, possibly because they have sufficient resources to be able to allocate a household member to this task.

Child health problems are important. Ten per cent of the index children have long-term health problems and 36 per cent of children experienced illness in the 24 hours before the interview. The percentages are higher for rural and very poor households – who also have more limited access to medical help. On the other hand, injuries to children appear to be more common among poor urban households.

Rural and very poor households diversify more but they also tend to be more indebted. The three most frequent activities for household members were agriculture, hunting, forestry and fishing (60 per cent), community, social and personal services (27 per cent), and wholesale and retail trade (20 per cent). A larger percentage of households in rural areas (47 per cent) were involved in more than one sector, compared with urban areas (32 per cent). These percentages are higher for the very poor than for the less poor. About a third of the households reported having serious debts, of whom 33 per cent thought they would be able to repay on time. While rural households diversify more than urban households, they are also more indebted. Poorer households also appear to be more indebted.

Shocks seem to depend on location and poverty status. Most families faced up to five events or shocks, with the proportion experiencing shocks being higher in rural areas (72 per cent) than in urban areas (60 per cent), and higher among very poor and poor households than less poor households. Decrease in food availability and failure or theft of crops are the most common problems. The problems of theft or death of livestock, crop failure, natural disaster and decrease in food availability are highest among very poor households. The frequency of negative events – such as divorce and separation, birth of new household member, paying for child's education, severe illness or injury, and job loss – increases with wealth. The results suggest that as people move out of absolute poverty, their basic needs are more likely to be met and other concerns then become important. The most frequent response to dealing with negative events was doing nothing, which is often an indication of perceived helplessness and may suggest an almost complete lack of resources. The results suggest the need to consider location and poverty status when attempting to tackle these problems.

Poorer households seem to have more social capital. The majority of households have medium absolute structural social capital, medium social support, and high cognitive social capital. More than half of the caregivers had zero citizenship, indicating that they neither join together to address common issues nor do they talk with the local authorities on problems in the community. The proportion of households with medium and high absolute structural social capital, and medium and high social support and high cognitive social capital, is higher for those in the low wealth than those in the high wealth category. These results suggest that poorer households – who have little or no financial and physical capital – have higher levels of social connectedness in order to reduce their vulnerability. This might be because poorer households are more aware of their dependence on others and the cost of alternative use of their time is lower and hence find it cheaper to establish social ties. Thus, while one would imagine that social capital is positively related to physical capital, the results suggest the opposite: social relations (social capital) and physical capital are negatively related.

Psychosocial well-being of caregivers is an important issue. Overall, almost 33 per cent of the caregivers reported to having had some level of depression during the previous 30 days. The percentage of cases was almost identical for urban and rural areas and across wealth categories.

Poor nutritional status of index children more serious in rural and very poor households. As expected, the main descriptive indicators of chronic malnourishment, wasting and stunting, show a large proportion of children in Ethiopia to be malnourished, with those in rural areas and born into very poor households suffering more than their urban and less poor compatriots. The nature of the problem is similar for the eight-year-old children. These problems should be addressed.

Long-term health problems are significant in eight-year-old children. A number of eight-year-old children suffer from long-term health problems but the differences across location and poverty status do not appear to be large.

Low level of education of eight-year-olds is more serious for rural children and those born into very poor households. Overall, 54 per cent of children cannot read or write anything. Only 20 per cent can read letters and 57 per cent are unable to write. Forty-three per cent of the children answered the numeracy test correctly, the figures almost identical in urban and rural areas. Sixty-seven per cent of the total number of children had attended school prior to, or during the time of, the survey year. For 30 per cent of the caregivers, the reason why the child did not go to school was that she/he was needed to help family in various work activities. The other two main reasons included the school being too far away (mainly in rural areas) and it being too expensive to send the child to school (mainly in urban areas). About 59 per cent of the children do not like their school because teachers or pupils beat them. These results suggest the seriousness of the level of beatings and bullying children face. The low level of school attendance, coupled with the low level of literacy and numeracy tests revealed by the preliminary results of the survey, sends a strong message on the need to improve access to and quality of education for the poor.

When asked questions about their perception of well-being, most of the children felt that the water people drink (82 per cent) and the air people breathe (67 per cent) are good, and the area they live in is safe for children (76 per cent). A considerable proportion of children had bad feelings about the amount of rubbish they see on their surrounding streets. The results of children's perceptions about issues such as water- quality are contrary to the data on sources of water for the households. This suggests the need for education of children about the quality of goods and services they consume.

Need to address issues in child development. For the first level of the Raven's test of child development, 67 per cent of children obtained average scores and 27 per cent obtained high scores. Children from less poor families appear to have scored better than others. However, in the higher levels of testing, all children obtained low scores. It is important to note that the Raven's test requires, among other things, experienced and well-trained enumerators to undertake the fieldwork properly and, hence, such results should be treated with caution.

Need to address child work as an important problem. The results show that about 9 per cent of the children have worked for money or goods. For almost three-quarters of the respondents the main reason for the child working is to supplement household income, though for about 12 per cent the main reason was that the children like it. About 5 percent of the children that are working are reported to have been seriously hurt while working, with more work related injuries being reported in urban than in rural areas. More than half of 94 children responded that they like working. About 41per cent of the 39 children who disliked working said that it is too tiring while about 30 per cent said they had no time for school. About 28 per cent of 80 children said they have missed school because of being at work.

Children's social capital is important. Seventy-five per cent of the children play with other children daily. For 90 per cent of the children there is always someone who can help them when they have a problem, usually their mother, though in rural areas nearly double the number of children will be helped by a sibling. This might be due to the fact that mothers in rural areas and in poorer families

may have to work to support the family and, thus, seek help from their elder children. Also, in rural areas and in poorer families, brothers and sisters may have the time to help their mothers due to not going to school.

Overall, the results suggest that the different types of problems discussed are more common in rural than urban areas and in very poor than poor and less poor households. However, these results are based on a limited descriptive analysis of the data and a more rigorous analysis is needed.

Appendix

Advisory Panel

The following is the list of members of the Advisory Panel of the Young Lives Project Ethiopia with the respective names of institutions they represent.

Dr Abera Geyid, Director, Ethiopian Health and Nutrition Research Institute

Ato Jemal Mohammed, Programme Director, Ministry of Capacity Building

Ato Getachew Adem, Head, Macroeconomic Policy and Planning Department,

Ministry of Finance and Economic Development

Dr Teferra Wonde, Public Health Expert, World Health Organisation

Dr June Pierre-Louis, Nutrition Adviser, United Nations Children's Fund

Ato Sintayehu Gebre-Giorgis, Poverty Reduction Programme Officer, Christian Relief and Development Association

Dr Alemayehu Seyoum, Ethiopian Economic Association

Ato Fikre Baisa, Central Statistical Authority

Ato Tesfaye Abreha, Social worker, Ministry of Labour and Social Affairs

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Young Lives is an international longitudinal study of childhood poverty, taking place in Ethiopia, India, Peru and Vietnam, and funded by DfID. The project aims to improve our understanding of the causes and consequences of childhood poverty in the developing world by following the lives of a group of 8000 children and their families over a 15 year period. Through the involvement of academic, government and NGO partners in the aforementioned countries, South Africa and the UK, the Young Lives project will highlight ways in which policy can be improved to more effectively tackle child poverty.

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