Young Lives Qualitative Research: Round 1 – Ethiopia

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Young Lives
An International Study of Childhood Poverty

Contents

Executive Summary

This report presents initial analysis of the first round of qualitative data collected between September and November 2007 as part of the Young Lives study in Ethiopia. Data collection was carried out in five of the twenty Young Lives study communities, with both cohorts of children – the younger cohort (then aged between 6 and 7 years) and the older cohort (ages 12 to 13) – as well as their caregivers, teachers, health workers, and community representatives.

The sub-sample included 60 children, 12 from each of the sites with equal numbers of boys and girls from each cohort. Key variables for sub-sampling included gender, cohort, ethnicity, religion, parental presence and school attendance. These criteria were used to select a core group of 12 'case study' children in each of the communities, in addition to another eight children per community who could be 'stand by' cases and who were included in group-based research activities.

Three overriding questions guided the qualitative research which should be sensitive to both differences between children (for example, age, gender, socio-economic status, ethnic, linguistic, or religious identity), and inter-generational differences (for example, in the perspectives of children and their caregivers).

1. What are the key transitions in children's lives, how are they experienced (particularly in relation to activities, relationships, identities, and well-being) and what influences these experiences?

2. How is children's well-being understood and evaluated by children, caregivers and other stakeholders? What shapes these different understandings, and what causes them to change? What do children, caregivers and other stakeholders identify as sources of and threats to well-being, and what protective processes can enable children to minimise these threats?

3. How do policies, programmes and services shape children's transitions and well-being? What are the different stakeholder perspectives on these processes? What is the interplay between public, private and not-for-profit sectors and communities within these processes?

The qualitative research entailed a mix of methods to generate data on the themes of transitions, well-being and services including individual interviews with children, caregivers and teachers, and group interviews with children (both cohorts) as well as with adults in the community. Creative methods such as drawing and self-report diaries were used as a basis for discussions with children on key research themes. Semi-structured observations of homes, schools and community settings provided the context for analysing and understanding the data.

Childhood transitions

Key transitions for the older cohort children were education, work and early marriage. In one of the research communities, female genital cutting was also considered an important rite of passage. An analysis of school transitions shows that the case study children, especially those living in rural areas, were in grades much lower than expected for their age. The main reasons for this were engagement in paid work, illness or their family's poverty, rather than 'grade retention' as the first four grades had automatic promotion. Almost all rural children reported that they had engaged in paid work and that this had affected their education: two boys had never attended school because they were needed for family work. Analysis of the

one-week self-reported diaries indicated that older rural children spent more time on work than on schooling and playing combined. In some communities older rural girls reported having no leisure time.

Key transitions for the younger cohort children were education, work and, in one of the research communities, female genital cutting. Younger rural children did not have the opportunity to attend pre-school because there were none in their communities. Some younger boys in the rural communities went to a religious school instead of pre-school. Poor urban children also had little access to pre-school as these were private and charged fees. Rural parents complained that their children had not had access to formal primary school, even though they had reached the statutory school age of seven. Rural schools were reported to be of poor quality in terms of furniture, books, libraries, sanitation and teaching.

Children's well-being

There was little difference in children's and adults' understanding of well-being and ill-being. Children and adults felt that children's well-being depended on (1) having parents and access to resources, (2) using these resources for education, basic needs, health and personal care, (3) having good relationships with family and friends, (4) achieving a good balance between time spent playing, learning and working, and (5) behaving well and having a good physical appearance. Education and having parents were ranked top of the well-being indicators, whereas having no parents and poverty were signs of living a bad life. Children's concepts of well-being were influenced by their circumstances. For example, rural children considered having agricultural resources as an indicator of well-being, while urban children focused on educational quality.

Children and caregivers identified a variety of risks that children confront in their daily lives and that threaten their well-being including the death of parents, illness and dropping out of school. A number of risks specific to girls were mentioned including engaging in early sexual relationships which lead to health problems, rape, abduction, pregnancy, having a child outside marriage and so on. Respondents characterised poverty as a major obstacle to children's development, schooling, health and future lives. For example, children from poor families are at greater risk of dropping out of school, being exposed to heavy work and ill-health.

Protective measures to minimise the threats to children's well-being identified during the research included support for the poor from non-governmental organisations (NGOs), donors and the government, parents taking care of their children, and children themselves being disciplined.

Services

Free medical care was available in the research communities, but health centres had insufficient staff, laboratories and drugs to provide adequate health care. As a result, even poor families had to travel long distances to get treatment which meant either incurring further costs or remaining untreated.

1. Introduction

About Young Lives

Young Lives is a long-term international research project investigating the changing nature of childhood poverty in four developing countries – Ethiopia, Peru, India (in the state of Andhra Pradesh) and Vietnam – over 15 years. This is the time frame set by the UN to assess progress towards the Millennium Development Goals (MDGs). Through interviews and group work with children, their parents, teachers, community representatives and others, we are collecting a wealth of information not only about their material and social circumstances, but also perspectives on their lives and aspirations for the future, set against the environmental and social realities of their communities.

We are following two groups of children in each country: 2000 children who were born in 2001-2 and 1000 children who were born in 1994-5. These groups provide insights into every phase of childhood. The younger children are being tracked from infancy to their mid-teens and the older children to adulthood, when some will become parents themselves. When this is matched with information gathered about their parents, we will be able to reveal much about the intergenerational transfer of poverty, how families on the margins move in and out of poverty, and the policies that can make a real difference to their lives.

The longitudinal nature of the survey and our multi-dimensional conceptualisation of poverty are key features of Young Lives research (Young Lives 2008). Much existing knowledge about childhood poverty is based on cross-sectional data that reflect a specific point in children's lives, or relate to only one dimension of children's welfare. Children's own views on poverty and well-being are seldom explored. Research is rarely tied in a systematic way to investigation of broader societal trends or policy changes.

The potential of the project lies in its focus on tracking children's progress throughout childhood – over 15 years. We collect quantitative and qualitative data at the individual, household and community level. Quantitative data is gathered through comprehensive surveys that include interviews with the children once they are old enough to participate directly, with their parents and caregivers, and with key community members (such as teachers, village elders or elected council representatives). Data are collected in each round on households' economic circumstances, livelihoods, assets and social capital. The questionnaires also collect evidence related to coping strategies such as migration, parental education and other experiences, child outcomes and the extent to which children and their parents and carers use services (e.g. health care, pre-school care or education programmes). This data is combined with data collected from a smaller sample of younger and older children (204 children across the four study countries), their caregivers, and their teachers, using child-focused qualitative methods (Crivello, Camfield and Woodhead 2009). In this way we can create a detailed picture of children's experiences and well-being linked to information about their households and communities and set within the national context. This provides us with data suitable for in-depth analysis of children's poverty and the effectiveness of government policies that concern their lives and well-being.

Young Lives is a collaboration between key government and research institutions in each of the study countries with the University of Oxford, the Open University, and the Institute of Education (London) in the UK, alongside the international NGO, Save the Children-UK. The partners in Ethiopia are the Ethiopian Development Research Institute (EDRI), which is responsible for data collection, data management and analysis, and Save the Children UK,

where our policy team is based. The first round of qualitative research in 2007 was led by Yisak Tafere, with a second round in Autumn 2008.

About this report

Qualitative research is a major feature of Young Lives, drawing on a mix of complementary methods to understand the diverse experiences and aspirations of children from different geographical, socio-economic and cultural locations. This report presents an initial analysis of some of the qualitative data collected in five of the twenty Young Lives study sites in Ethiopia between September and November 2007 ('Qual-1') and serves as an overview for others interested in using our data.

Data collection was carried out with both cohorts of Young Lives children; the younger cohort (aged 6 to 7) and older cohort children (then aged 12 to 13), as well as their caregivers, teachers, health workers and community representatives. The sub-sample included 60 children, 12 from each of the five study sites with equal numbers of boys and girls from each cohort (i.e. 15 boys and 15 girls from the older cohort, and 15 boys and 15 girls from the younger cohort.

The qualitative research component is premised on the recognition of children as social actors who provide an essential source of information about how poverty impacts on their lives and well-being. Children's own understanding and perspectives serve as a major source of qualitative data, along with key adults in their lives. The aim has been to produce a detailed, grounded description of children's lives and of the dynamic processes that underlie life trajectories, in ways that will complement quantitative data analysis and inform policy.

Three overriding questions guided the qualitative research which should be sensitive to both differences between children (for example, age, gender, socio-economic status, ethnic, linguistic, or religious identity), and inter-generational differences (for example, in the perspectives of children and their caregivers).

1. What are the key transitions in children's lives, how are they experienced (particularly in relation to activities, relationships, identities, and well-being) and what influences these experiences?

2. How is children's well-being understood and evaluated by children, caregivers and other stakeholders? What shapes these different understandings, and what causes them to change? What do children, caregivers and other stakeholders identify as sources of and threats to well-being, and what protective processes can enable children to minimise these threats?

3. How do policies, programmes and services shape children's transitions and well-being? What are the different stakeholder perspectives on these processes? What is the interplay between public, private and not-for-profit sectors and communities within these processes?

Young Lives uses an innovative methodology, with multi- and interdisciplinary research and a mix of qualitative and quantitative methods. While this report focuses on the first round of qualitative data, it is important to note that its interpretation will be strengthened and complemented by analysis of both the quantitative data and the second round of qualitative data (Qual-2 collected in late 2008). The quantitative data is collected through a survey of all 3,000 children in each Young Lives study country, along with a household survey and information about their community. The first round of survey data was collected in 2002, a second round in 2006, third round being collected in late 2009.

Methodology

The qualitative research team conducted data gathering activity at five sites in Ethiopia: one from each of the five Young Lives regions. The rural communities were: Tach-Meret in the Amhara region, Leki in Oromia, and Semhal in Tigray. The urban communities were: Atkilt-tera in Addis Ababa and Leku in Awassa City in Southern Nationalities, Nations and Peoples Region (SNNP).[1]

The sites were selected to include relatively poor communities (based on responses to the Young Lives survey and the poverty index) and to ensure coverage of rural and urban livelihoods, connectedness and remoteness, and ethnic homogeneity and heterogeneity (see also Young Lives 2008). The assumption being that children living within different settings experience life differently and that there is a need to understand these differences through in-depth qualitative research. While the rural communities selected were relatively homogenous in terms of religion, ethnicity and livelihoods, the urban areas accommodated people from diverse backgrounds.

Key variables for sub-sampling included gender, cohort, ethnicity, religion, parental presence and school attendance. These criteria were used to select a core group of 12 'case study' children in each of the communities, in addition to another eight children per community who could be 'stand by' cases and who were included in group-based research activities.

The qualitative research entailed a mix of methods to generate data on the themes of transitions, well-being and services including individual interviews with children, caregivers and teachers, and group interviews with children (both cohorts) as well as with adults in the community. Creative methods such as drawing and self-report diaries were used as a basis for discussions with children on key research themes. Semi-structured observations of homes, schools and community settings provided the context for analysing and understanding the data.

Legal and institutional context for Young Lives children in Ethiopia

Ethiopia ratified the United Nations Convention on the Rights of the Child (CRC) in December 1991. By doing so, the government showed its commitment to providing universal primary education without discrimination of any kind irrespective of the child's gender, race, disability or any other marker of difference. Article 36 of the Constitution of Federal Democratic Republic of Ethiopia recognises that children should not to be subject to activities that compromise their education. This is consistent with Article 28 of the CRC obliging states to encourage regular attendance at school and the reduction of dropout rates.

In relation to this, the Ethiopia Labour Law proclamation No. 377/2003 prohibits the employment of people aged under fourteen (a modification of the internationally accepted work age of 15, or 18 for hazardous work). Ethiopia is also a signatory to International Labour Organisation (ILO) convention 182 on the elimination of the worst forms of child labour.

Young women's sexual and reproductive rights are protected under Ethiopian law. Based on the provision of the CRC, the Constitution stipulates the elimination of harmful practices such as female genital cutting. Ethiopian law specifies 18 as the minimum age for marriage and emphasises that marriage should be entered into with the free and full consent of both parties. These laws have been in force since 2000, when the Revised Family Law was adopted.

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1 The Young Lives children and their families share a great deal of personal information with us. For this reason and to protect their confidentiality, all children and their communities have been given pseudonyms to protect their anonymity.

The Ethiopian primary school system has two cycles. The first cycle covers grades 1 to 4, while the second cycle covers grade 5 to 8. First cycle schools are usually provided at the local level, but second cycles schools can be located far away from children's homes, for example, in towns.

The most reliable data available on young people's transitions is collected by the Ethiopian Central Statistics Agency (CSA). The Demographic and Health Survey (DHS) carried out in 2005 provides some insights on young people's education and marriage practices in the country. The 2005 survey showed that the net enrolment rate in primary education in Ethiopia was 42.3 per cent. There was only a very slight difference between the rate for boys (42.2 per cent) and girls (42.4 per cent).

CSA data shows that about 13 per cent of women aged between 15 and 19 years old reported that they were married by the age of 15 (CSA 2006: 82). More than 65 percent of women aged between 25 and 49 years reported having had sexual intercourse before the age of 18, and 32 per cent before the age of 15. The median age at first sexual intercourse for women aged 25 to 49 years was 16.1 years; identical to the median age at first marriage. This suggests that Ethiopian women from this generation generally began sexual intercourse at the time of their first marriage. However, the median age at first sexual intercourse has risen over the past two decades: from 15.7 years for women age 45 to 49, to 18.2 years for women aged 20 to 24. Among women now aged 15 to 19, only 11 per cent have had sexual intercourse.

Report structure

The following three sections present some preliminary analysis of the data on the three research themes: transitions, well-being and services. Section 2 examines the key transitions in children's lives and how they are experienced. It begins by looking at school transitions, work and social transitions for the older cohort then looks at transitions for the younger cohort. Section 3 examines how children, their caregivers and other significant people in their lives understand and evaluate children's well-being. It also looks at the perceived threats to children's well-being and how children and their caregivers minimise these threats. Section 4 examines the services, policies and programmes that impact on children's lives, focusing on healthcare and education. Section 5 outlines some of the research and policy implications emerging from the analysis.

2. Childhood transitions

This section presents initial findings from the first round of qualitative data collection on the questions: What are the key transitions in children's lives, how are they experienced (particularly in relation to activities, relationships, identities and well-being) and what influences these experiences? It begins by discussing older children's understandings and experiences of key transitions and then looks at those of younger children. Finally, it examines *self-reported* information from diaries kept by the older cohort children on transitions in their lives.

2.1   Key transitions: the older cohort

The four key transitions for the older cohort were schooling, work, female genital cutting and early marriage for girls. Information on schooling and work was generated from discussions with adults and children. Due to the sensitive nature of the subject matter, children were not asked about female genital cutting and early marriage; the data presented was generated mainly through discussions with adults.

Schooling

The older cohort children were expected to attend local schools and should have completed at least the first cycle of primary school. However, the qualitative research suggests that children had varying access to primary school. Some children had never gone to school and many had started late, particularly in rural areas, and attended school irregularly, which had affected their 'age for grade'.

According to Young Lives survey data from 2006 on the older children (aged 11 to 12 at the time) in the five qualitative sites, 30 per cent were below grade 4, which is the minimum grade they would be expected to have achieved by age 11 if they started school aged 7 (the usual age in Ethiopia). At this stage, there was little difference between boys and girls. There were, however, significant variations in educational attainment according to location. For example, while 48 per cent of rural children had not achieved the correct age for grade, this only applied to 12 per cent of urban children. There were a number of reasons for this including irregular school attendance due to work pressures in rural areas and distance to second cycle primary schools.

At the time of the qualitative fieldwork in 2007, the children were aged 12 to 13. By this age, they would have been expected to have reached grade 5 or 6. However, less than half of them had achieved the expected grade with significant variations according to location and gender. As Table 1 shows, children from the urban communities, especially girls, were more likely to have reached the expected grade.

Table 1. *Grade level of older cohort children (aged 12-13)*

Grade	Rural girls	Rural boys	Urban girls	Urban boys
Had never attended	0	2	0	0
1	0	1	0	0
2	2	1	0	0
3	1	2	1	0
4	1	3	1	1
5	1	1	1	2
6	2	0	1	1
7	0	1	1	1
8	0	0	2	0

The only two children who were in grade 8, the highest grade reported, were urban girls. Conversely, the two children who had never attended school were rural boys. One of the rural boys complained that his parents preferred him to help with herding rather than go to school:

> "My parents prevented me from joining school and forced me to herd cattle; they give priority to their cattle than to my education."

There were a number of reasons for the big rural-urban disparity in educational attainment, namely: rural children starting school late, irregular attendance because of seasonal work and the distance from home to second cycle primary schools.

Work

Older cohort children 'know themselves' as one research participant described it, meaning that by 12 or 13 years old a child is seen as able to take some responsibility for their lives. Children of this age are expected to combine schooling with work. All children contributed to family activities, varying according to gender and location. Older cohort girls went shopping, prepared food and coffee, cleaned the house, fetched water, collected fire wood, used the

grinding mill and carried out other household activities. Boys worked on farms, herded cattle and fetched water and firewood. In urban communities, girls, and sometimes boys, contributed to household activities such as preparing food, cleaning the house, shopping and so on.

Data from all five research communities revealed that children not only participated in household activities but were also involved in income generation. The types of work that the children were involved with depended on the form of livelihoods were they lived. For example, in Leki children as young as 10 worked on vegetable farms and boys caught fish for sale. Boys preferred to fish because it generated more income than working on vegetable farms. In Tach-Meret, boys collected and sold stones in the nearby town and girls picked runner beans. In Semhal children herded cattle for cash (5 birr per cow, per month). There is some evidence from this community that children replaced their parents in work on the Productive Safety Net Programme, which provided food or cash for work on 'public works' projects for poor families.

In the urban communities, children sold plastic bags, shone shoes, drove horse carts and carried things to earn money during the day and sold *kollo* (roasted beans), candy and peanuts in the evening. Children sometimes worked to support the family business; for example, by preparing food at home for their mothers to sell on the street.

Most children in the research communities worked to support the family businesses, contribute to the household income and to provide for their own expenses such as schooling. For many children, work was a necessity. Teachers from Tach-meret said they had seen some children coming to school crying because they did not get enough food to eat. They came to school very tired and hungry, often after they had finished hard work at home. Some did not wear proper clothes and felt very cold. They had not eaten lunch before coming to school in the afternoon.

Many children worked to contribute to the household income. A father from Leki explained why his daughter had to work:

> "She is involved in our daily work and supports us in many ways. The income she obtains from is used for purchasing the household consumption. She works for up to 6 hours per day. She gets 8 birr per day but it is half day it is up to 5 birr per day. The work she does involves weeding and digging in the irrigation field and collection of vegetables like onions and tomatoes during the harvest time. It is impossible to live without work. If she cannot work like this, she will not get medical service when she is sick. She also learns how to work."

Children who had to work like this girl found it very difficult to combine work and schooling. Both adults and children in the research communities had mixed attitudes towards child work. Adults felt that it was necessary for their children to work: it helped them learn how to work and, in some cases, provided the money needed for children to continue with school. In the rural communities, children worked for cash to buy school materials so that they could go to school for half the day. In Tach-meret, parents criticised the government initiative to ensure full-day schooling because they wanted their children to work half the day and go to school half the day.

In some cases, children were engaged in work activities that caused them health problems and interrupted their schooling; for example, 'heavy work' for the family or working as day labourers. Children from the rural communities who worked for cash reported multiple health problems as a result of heavy work. In Leki, children worked on vegetable farms in the sun, in Tach-meret children carried heavy stones to sell, and in Semhal children undertook digging work on public works projects. Many of these children reported continuous headaches, sustained injuries, and other health problems.

Children's schooling is often negatively affected by work. As a result of work, many children in the research communities missed class, got poor grades and failed in class and, eventually, dropped out of school. In Tach-meret, teachers reported that children who worked half days got too tired to follow their lessons. This was especially true for children who attended afternoon classes after spending the morning doing heavy work. The indirect effect was that working children often missed school because of work-related illnesses. In Leki, children said that their parents rarely took them to the health centre when they were sick, but instead let them rest at home. As a result, they could not produce the formal sick note that schools required and were sometimes not allowed to return to school.

Female genital cutting

Female genital cutting (FGC, female circumcision or female genital mutilation) is prohibited in Ethiopia, but is still practised in some communities and there are still those who support it. Although it was more difficult to get information on FGC than on schooling and work, participants in one of the research sites confirmed that it was performed on girls around the age of the older cohort in their community.

The research participants explained that FGC was traditionally performed on girls when they were ready to marry, usually at around 15 years old. It used to be performed with the full consent of the girl's parents, accompanied by ceremonies. But the recent law banning FGC had radically changed the way it was carried out; both in terms of the age at which FGC was performed and the cultural practices surrounding it. Parents explained that while they had 'accepted' the law banning FGC, many girls defended the practice. Some girls choose to undergo FGC because they believed that boys will refuse to marry a girl who has not. A research participant explained:

> "In the past circumcision of girls was conducted during the time of marriage [15 years old]. It was conducted with the full consent of the parents. But recently the government has forced the people to stop circumcision of girls; on the contrary girls refused to accept these policies of the government and continued to be circumcised even without consulting their parents. Today girls can be circumcised even at the age of 6 or 7 and sometimes above the age of 15. The main reason behind this is that male children refused to marry girls who are not circumcised, and as a result some of the uncircumcised married girls were highly stigmatised by both the unmarried girls and boys. These things created conflict between the parents and other community members and the younger children on the one hand. On the other hand, it goes against the policy of the government."

Adults in the community were concerned about changes to the way FGC was being practised. They claimed that children were organising FGC themselves, without informing their parents, and going to traditional healers. To avoid being caught, girls were undergoing FGC at night, and usually in the summer when the schools are closed so that they could rest at home afterwards without being missed. Although it was difficult to believe that the parents knew nothing about their children's actions, the research participants expressed concern about the multiple risks associated with FGC, namely being against the law, undermining cultural practices, and risking the lives of children who visited healers unaccompanied who can then not get parents' care after going through the genital cutting.

Female genital cutting continues in these communities for many complex reasons. Research participants referred to the long history of traditional belief that girls who had not undergone FGC were 'unsettled', clumsy (break household utensils), and often failed to find a husband. Although the participants were aware of some of the risks involved, the view still prevailed

that earlier generations of women had undergone FGC when young without problems. And for girls, the main reason for continuing with the practice was to ensure they would be accepted for marriage.

Early marriage

The legal minimum age for marriage in Ethiopia is 18 years old. But in practice, it is expected that many girls will marry before then. The reasons for this differ depending on the specific cultural context and the views of the parents concerned. In some communities, parents see the years between puberty and 18 as important for fixing marriages for their daughters. They want to see their daughters *berhan* (enlightened) through marriage, and they feel relieved when they have helped secure an independent life for them.

Parents are more likely to arrange early marriage for their daughters when they feel that their future options may be limited; for example, when there are doubts over their potential educational achievements or the type of marriage they would be able to secure when older. Early marriages can also be seen as beneficial by parents as they remove the risks of early sexual relationships outside marriage and abduction. Early sexual relationships are associated with health risks and pregnancy outside marriage, which brings shame to the family as well as the girl.

Arranged, early marriages can also be an economic transaction. Poor households and older parents sometimes choose to arrange early marriages for their daughters in order to gain resources and protection from in-laws. In one of the research communities, g*ebera* (bride wealth) is paid to the girl's parents. A group from this community explained:

> "Sometimes, early marriages are practised in the community; this is mainly through the full involvement of both sets of the parents and when this would involve *gebera* (money and cattle paid to the family of the bride). In this case, the family of the bridegroom will pay *gebera* up to 2000birr [about 100 pounds] and many livestock to the family of the bride. This kind of marriage can be considered as exchanging the female children for money."

Because under-age marriage is against the law in Ethiopia, families reported using a variety of strategies to disguise arranged, early marriages. For example, families would announce an 'engagement' which was, in effect, a marriage: the girl would live with her husband in his family's house, and attend school from there. The wedding ceremonies were arranged to coincide with saints' days, which are celebrated with feasts, and usually during the summer when schools are closed. Another strategy is the so-called 'voluntary abduction' when the couples agree to marry even though the girl is under-age. In case their early marriage is revealed anyway, it is usually settled through the involvement of elders from both sides of the boy and the girl's families.

The qualitative research showed that children in the study communities were aware of the factors that shaped or obstructed their well-being. In group exercises, children identified heavy work, early marriage and circumcision as indicators of ill-being. Yet children tended to comply with traditional practices such as early marriage. Why was this? First, children had been socialised from an early age to believe that being obedient to parents and older people was an indicator of being a 'good child'. Socialisation took place at home, and through religious institutions and schools: children learned to follow their parents' will in areas such as work and arranged marriages. An elder from Leki described how:

> "Children are advised to develop good behaviour and to learn different kinds of activities from their families. Parents and community members have the responsibility to teach children how to perform activities both at home and in the farm. Churches and

mosques have the duty to teach the children to be disciplined and to respect their cultural values. Religious institutions teach boys to be religious person/leader. Children learn these norms from parents and teachers as well as in religious institutions [mosque and church]."

A caregiver from Atkilt-tera explained:

"If a child wants to grow up in a good manner and to get a good status, he/she must respect his/her teachers, his older and younger brothers and sisters with no discrimination. If he/she does this, he/she will be successful in life, for obedience and respect signify much and God adores such qualities."

The consequences of this socialisation appeared to differ according to gender. Research participants suggested that girls were more obedient than boys. As a result, girls were more negatively affected than boys when conflicts arose between obeying their parents and following other paths: for example, work versus schooling, or marriage versus schooling.

As well as wanting to obey their parents, children also complied with adults' expectations because they needed material support from their families. In the research communities, as in the rest of Ethiopia, family is an important source of resources for children. In rural areas, parents share their land and livestock with their children. In urban communities, parents pay for their children's education, healthcare and other needs. Parents used this as a point of leverage to persuade their children to follow their wishes: for example, rural caregivers encouraging early marriage for daughters by gifting livestock or a part of their land.

Some changes and challenges

Discussions with community members revealed changes to perceptions on what constitutes successful transitions for children. These changes have mainly come about as a result of the government's commitment to adopting international laws on children's rights. There are now laws covering child work, primary education, access to healthcare, female genital cutting and early marriage. However, it has not always been possible to enforce these laws. While there has been a significant shift in terms of perceptions on FGC and early marriage, this has not been the case with child work. This may be because early marriage and FGC are being monitored by local groups such as women's associations and transgressions are clearly punishable. This is less the case with parents who engage their children in work.

Despite some observable changes in attitude, traditional norms still dominate. Some local authorities and women's groups (in Semhal and Leki) felt that change was too slow. Community members in Semhal, for example, argued that 'these government's laws come very recently, long after our culture was created by our fore parents' and see little reasons why they should change the inherited culture for 'laws ever change together with governments.' A healthcare worker in Tach-meret explained:

"When you talk to people they tell you they have brought attitudinal change, but in practice there is no significant change yet. If men accept some changes, still women at home incline to cultural values. You tell them about the harmfulness of some traditional practices and they look to agree and even tell you back what you tell them. But in practice they do not respect it."

Some parents were reluctant to follow government policies that they felt exposed their children to risks. For example, participants in the rural communities were concerned that waiting for daughters to reach age 18 before they married exposed them to risks of early sexual activity, early pregnancy, having children outside marriage, being less marriageable when they are older, and poor family relationships. A village elder from Leki explained why

some parents opted for early marriage in order to avoid the risks associated with self-arranged marriage:

> "In the past the norm was to not to marry children before the age of 15 was not a problem but now this is changed. After they started to learn both in formal and religious institutions, girls' behaviour is highly changed. They start to say that they want to protect their right and they want to establish marriage based on their interest. This leads to establishing marriage with any person without recognising the behaviour and economic condition of the person. He may tell her that he will take her to town and helps her in education. Then she will conceive a child and after she becomes pregnant the person force her from his house saying that he has no capacity to up bring the child. Then, she starts to return back to the house of her parents but since she married without the consent and according to the norms of the community, parents do not accept her. As a whole the change in the norms on marriage, family relation, etc greatly affects girl's education and future life."

2.2   Key transitions: the younger cohort

The three key transitions the younger cohort experience at this age are starting school, work and female genital cutting.

Schooling

The younger cohort children were of an age where they might be expected to attend pre-school or have started primary school. However, according to Young Lives survey data from 2006 o (when the children were aged 5 to 6), more than 95 per cent of the younger cohort children in the five qualitative research sites had not started school or pre-school. At the time of the qualitative fieldwork in 2007, when the children were aged 6 to 7, only four (two rural and two urban) of the case study children were in primary school (three of whom were girls).

The research revealed a significant difference in access to pre-school education according to location: in the urban communities, all the children attended pre-school (with just two attending an informal, church, pre-school), while in the rural communities none of the children attended pre-school. The main reason for this was the lack of facilities in the rural communities. Caregivers and children in the rural communities complained about the lack of access to both pre- and primary schools. They explained that they could not go to school because no pre-schools were availably and the primary schools claimed they were too young to start. Parents were concerned that their children's time was 'wasted' as they were too young to work, could not play because of the lack of suitable play areas, and could not attend school because there were no pre-schools in their communities.

Work

Younger cohort children had started contributing to some family activities. In the rural communities, children herded cattle, carried small things, fetched water and firewood, took messages to and from neighbours and cared for their younger siblings. In the urban communities, children helped with simple activities such as carrying messages, shopping, washing up, making coffee and washing their socks. However, they spent more of their time playing with friends or going to school than working.

Female genital cutting

Information generated in one of the research communities suggests that one ethnic group practised female genital cutting and male circumcision when children were between the ages of 1 and 8 years old. A number of strategies are used to disguise FGC. For example, boys' circumcisions were organised to coincide with big holidays (such as *Meskel*) and community members were invited. While boys were openly circumcised, FGC was performed on girls inside the home where visitors could not see them undergoing the cutting as this risks parents being accused of violating the law prohibiting FGC. Community members related a local saying: *Bekilo lemenqolashet, Ahiyan ankebalelot* (in order to castrate a mule you first roll the donkey on the ground), meaning that in order to perform FGC on girls, a ceremony for boys had to be organised.

2.3   Self-report data on time use: older cohort

Information generated through self-report diaries showed how the older cohort children divided their time between three key activities: schooling, work and play. Older cohort boys and girls were asked to account for how they spent each part of their day between getting up in the morning and going to bed at night; for example, between breakfast and lunch, and between dinner and bed time. In each of these time periods, the children reported what they were doing, where they were, who they were with and whether they liked or disliked the activities and the reasons why.

The diaries revealed that the older cohort children spent an average of 55 per cent of their time on work. This included both household activities and income generating work. Schooling, which included attending classes and studying outside class, took up 23 per cent of their time. They spent the remaining 22 per cent of their time playing.

There were significant variations in time use depending on location and gender. As table 2 shows, rural children spent 70 per cent of their time on work, while urban children spent 22 per cent. In contrast, urban children spent much more of their time on schooling than rural children: 63 per cent for urban children but only 21 per cent for rural children. The main reasons for these differences were that in rural areas there was more paid work available, large family size and the distance from home to school. This data on time use helps to explain the low 'age for grade' achieved in rural areas detailed in section 2.1 of this paper.

Table 2.   *Time use of older cohort children (%)*

	Schooling	Work	play
Atkilt-tera (urban)	63	22	15
Tach-meret (rural)	21	70	9

The variations in time use according to gender were also significant. There was little gender difference with regard to schooling. However, girls spent more time working while boys spent more time playing. For example, in Leki girls spent much of their time on work and girls from Tach-meret had little time for play. Their time use was heavily influenced by the circumstances in their community: in Leki vegetable farms provided work for girls and in Tach-meret girls reported that there was not enough space for them to play.

3. Children's well-being

This section presents a preliminary analysis of understandings of child well-being and ill-being. It seeks to answer the questions: How is children's well-being understood and evaluated by children, caregivers, and other stake holders? What shapes these different understanding and what causes them to change? What do children, caregivers and other stakeholders identify as sources of and threats to well-being, and what protective processes can enable children to minimise these threats? It begins by looking at children's understandings, and then examines the perceptions of caregivers and other adults in the community.

3.1 Children's perspectives on well-being and ill-being

The older cohort

Information on older children's understandings and experiences of well-being were gathered through group-based activities and individual interviews. The two methods produced very similar results because in the group-based activities, where well-being and ill-being indicators were ranked, children were also given the opportunity to present their individual views.

The data generated highlighted physical, social, emotional, material and education-related indicators of well-being. There were some differences in children's understandings of well-being based on gender and location. Urban girls valued access to education, good housing and clothing, and open family relationships. Urban boys' understanding of well-being was also described in terms of access to education and good housing, but boys also valued good food and recreation (visiting entrainment places).

Rural children valued agricultural resources and physical appearance as indicators of child well-being. Having a clean house, with different rooms, made of corrugated iron, and having cattle and donkeys were considered important characteristics of doing well in life. Their understanding of well-being was defined by the material context in their communities. For example, houses made of corrugated iron are well protected from heavy rains and a donkey is useful for carrying heavy things long distances where there is no other means of transport. Rural girls greatly valued physical appearance as an indicator of a child doing well. Being clean, having good clothes, having nice hair, being pretty and having good posture were considered important. Boys from Semhal placed importance on family relationships and being obedient to parents.

Older children's understandings of ill-being relate to the lack of well-being indicators, or their negative aspects. Their perceptions were again influenced by the material context in their communities. Urban children felt that gambling and not going to school (voluntarily) were indicators of ill-being, while rural children felt that living in hut and shortage of farm land and livestock were important indicators. The rural children believed that living in a hut increases the risk of exposure to malaria, colds and other diseases. Lack of livestock or land threatens livelihoods. Children also felt that lack of access to education, lack of clothing and food, living in a dirty environment, and poverty were indicators of ill-being. Physical and social factors such as being foolish, not dressing well, being thin and being physically weak were considered indicators of a child who is not doing well. Boys from Atkilt-tera, most of whom had lost either one of both of their parents, considered the death of parents as the top indicator of a bad life.

The younger cohort

The younger cohort also participated in group-based activities and individual interviews and identified their understandings of well-being and ill-being. Their participation was more limited than that of the older children, especially in the rural communities. The younger children placed importance on their parents' resources, relationships, personal behaviour, access to school and playing as indicators of well-being. They identified being the child of rich parents as the most important indicator of well-being. They defined this in terms of having parents who had a car and a house, who could afford to send their children to school with school materials and uniforms, and provide their basic needs such as clothing and food and also some play materials (toys and games were mentioned in the urban communities).

Social and emotional indicators were also important. The younger children felt that family love and affection were necessary for well-being. Being well behaved and having parents who allowed their children to attend community feasts and play with friends were considered indicators of well-being. Children felt very strongly that having parents was an essential element of child well-being. This may also be related to the material aspects of well-being as losing parents means losing all the indicators of well-being the younger children identified.

Information on younger children's understandings of ill-being highlighted factors associated with bad behaviour and poor family relationships. Younger children also felt that lack of access to healthcare and education, shortage of food and living in a polluted community were indicators of a bad life for children. The younger children identified risks including being beaten and insulted by teachers, and reported being afraid of wild animals, horror films (in the urban communities) and bad dreams.

3.2   Adults' perspectives on children's well-being and ill-being

Older cohort

Adults in all the research communities identified a range of indicators of child well-being applicable to boys and girls of any age including: (1) material security, specifically being able to satisfy basic needs such as food and clothing; (2) good and harmonious family relationships, characterised by love, affection and care; (3) access to advice and moral guidance; (4) access to education and appropriate work that does not interfere with schooling; (5) a good physical environment to live in, which is clean with plentiful natural resources; (6) personal characteristics such as confidence, sociability and cleanliness that enable children to relate well to others.

There were some differences in how adults from different communities perceived a good life for children. For example, in Semhal early marriage for girls was characterised as becoming *berhan* (enlightened) and *abeba* (fruitful) and seen as a blessing only rich girls could enjoy. In Leki early marriage was seen as a risk to girls' health and education, and in Atkilt-tera early pregnancy outside marriage and illegal abortion were more pressing concerns.

There were also some interesting gender differences in adults' understandings of child well-being. Male participants in all the research communities mentioned play – having toys, spaces and time for recreation – whereas female participants did not. Conversely, women highlighted the importance of having both parents and access to healthcare (men mentioned health only in the sense of a resource to achieve goals).

Common understandings of ill-being included: (1) the absence of the dimensions of well-being listed above (e.g. basic needs such as food and parental care); (2) ill-health or disability, which incurred large medical expenses; (3) feeling inferior to or resentful of others;

(4) inability to learn due to poor quality tuition, lack of time, physical weakness through overwork or lack of food; (5) large, disharmonious families; (6) poor parenting leading to mutual disrespect between parents and children and a lack of role models; (7) living and working on the street leading to exposure to drugs, crime, violence, prostitution, etc. (mainly for the community in Addis Ababa) and (8) corresponding risks of overwork, beating, sexual abuse, early marriage and exposure to HIV/AIDS.

Younger cohort

There was little variation in how adults and children perceived a good life for younger children. Caregivers felt strongly that education was an important indicator of a good life. They believed that parents should invest in and support their children's education so that they have the chance of a better life. Caregivers identified having parents who could provide their children with education, basic needs, healthcare, clothing and toys as essential for a good life for children. Urban parents, however, went further and sought better quality education. They also identified recreational facilities and personal hygiene as important indicators of well-being. In the rural communities, not having to work was considered an indicator of a good life for children. Good relationships and harmonious families who show love and do not beat their children were also identified as indicators of child well-being.

Adults identified the death or poverty of one or both parents as the top indicator of a bad life for children. Caregivers tended to highlight what was missing or negatively affecting the lives of children in their respective communities. In the urban communities, environmental pollution and big families were identified. In the rural communities, shortage of land, food, livestock, and a heavy work load were some of the examples given. Caregivers also placed importance on physical and social indicators of ill-being such as being too thin, weak, as well as lack of confidence and being shy. Parents saw both the causes and effects of poverty as indictors of ill-being.

Ill-being and risks: protective measures

Many of the children in the research communities have difficult lives and face substantial risks in the future. While poverty is the root cause of their problems, the qualitative research showed that there were complex and interrelated factors that were contributing to children's ill-being. Discussions with caregivers and other adults in the research communities highlighted a range of issues related to reducing or preventing child ill-being and anticipating future risks.

In the two urban communities, caregivers identified family as a key institution in children's lives. Family plays a pivotal role in fulfilling children's basic needs and in promoting peaceful relationships both within families and between family members and others in the community. Families, religious institutions and teachers are responsible for giving children advice and guidance on issues that influence their well-being such as health, education and behaviour. For example, family members advise girls against engaging in early sexual relationships. Raising children's awareness on potential risks can help protect them from being exploited in work or in sexual relationships, and steer them away from damaging behaviours such as drug misuse and crime. A community representative from Atkilt-tera explained: 'we have to work on child right and to protect children from exploitation as we did succeed in preventing HIV/AIDS'. Caregivers and other adults guide children to listen to advice, and to respect their elders and community norms.

Caregivers and other adults in the urban communities suggested that government, donors, non-governmental organisations (NGOs) and community based organisations should work together to tackle children's problems related to health and education. In Ethiopia, *iddir*

(burial societies or funeral associations) play an important role raising awareness on providing appropriate care for marginalised and disadvantaged children and how to improve care. Caregivers felt that the *kebele* (neighbourhood-level government) should take responsibility for mobilising the community to create safe places for children to play and to clear away the rubbish that adversely affected children's health. They also felt that an institution was needed at the *kebele* level which could raise awareness of the problems associated with drug misuse and addiction among children and young people. NGOs were also identified as playing a critical role in reducing threats to children's well-being. In both the urban communities, NGOs work actively on the provision of food, money and educational materials to orphan and destitute children. The participants in the group discussions were very keen for the NGOs to focus on the protection of child rights, social protection and raising awareness on harmful traditional practices like female genital cutting and family planning.

In the three rural communities, caregivers and other adults in the community were mainly concerned about children's behaviour, and about their health and education. Caregivers identified good family relations and freedom within the family as important for improving children's discipline and making them obey their parents and respect local norms. In other words, parents were seen as important role models for children in terms of family relationships and behaviour. In Tach-meret, it was suggested that the government should ban cinemas that expose children to 'bad' influences. The community representatives, in particular, felt that girls should be protected from female genital cutting and that the cultural norm of 'girls to the kitchen' should be avoided.

In relation to schooling, community members felt that strong collaboration was needed between schools, religious institutions and parents' committees to reduce the complex problems around children's education. They highlighted measures including improving school facilities, reducing child labour, having more school clubs, motivating teachers and, above all, reducing household poverty as necessary. They also suggested that the government should establish pre-schools and expand and/or construct primary schools close to where children live so that girls especially have less far to travel to school. Some caregivers felt that incentives were needed to encourage parents to send their children to school. For example, caregivers explained that a shift system in schools would enable children to combine going to school with contributing to family activities. In relation to children's health, caregivers and other adults in the rural communities suggested that more health centres were needed close to where people live and that these should have adequate equipment and medicine.

4. Access to services

This section presents initial findings from the first round of qualitative data collection on the questions: How do policies, programmes and services shape children's transitions and well-being? What are the different stakeholder perspectives on these processes? What is the interplay between public, private and not-for-profit sectors and communities within these processes? Successful transitions for children are determined by the quality of and access to services which vary greatly from community to community. In general, services in urban areas are better than those in rural areas. This section examines healthcare and education services and, briefly, some of the other services that affect children's transitions and well-being.

4.1   Healthcare

In all the research communities, people have access to government health centres. However, none of these communities have higher-grade health centres or hospitals so the quality of service available to them is often inadequate. Access to healthcare services was better in the two urban study communities: one had four private clinics, one NGO clinic, a private hospital and a government health centre (located outside the community) and the other had a government health centre and two clinics (one private and one NGO). In the rural communities, access to healthcare services was much poorer: two had a health post and one had a so-called 'health-nucleus' which offered a lower grade of service than a health post. Even health posts provide only a very basic level of service, dispensing pain killers, malaria tablets and contraceptives and sometimes providing information on disease prevention. They do not offer many essential services such as laboratories, X-rays and the dispensing of necessary drugs. Health workers in health posts were described as not being properly trained, unfriendly and, in some cases, not available when they were supposed to be. People in rural areas had to travel long distances to the nearest towns to visit health centres, hospitals and private clinics. In one of the rural study communities people walked for more than two hours to get to the nearest hospital.

In both the rural and urban communities, private clinics were available put they charged more than poor families could afford. The cost of drugs was also too high. Poor families have been entitled to free drugs since the introduction of 'free' medication care support papers from the local authorities to prove their poverty status. However, free medication support papers were only accepted in the government health centres which provided low levels of care. Patients could be referred to hospitals from the health centres to get a higher standard of care, but this entailed travelling to the nearest town which incurred transport and accommodation costs. As a result, 'free' treatment for poor people was rarely free.

In all the research communities, traditional healing was still used. Traditional healing includes home-based treatments (some parents begin treating sick children at home with food and herbal treatments) as well as bone setters and treatment with holy water. The reason for their continued use is largely cultural – many people believe that traditional healers are 'better' – but lack of access to, and the high cost of, formal healthcare services also plays a part. Most of the research participants were aware of the risks involved in using traditional healing and that it was not always effective in terms of curing disease. Caregivers explained that children sometimes failed to tell their parents when they were ill because they did not want to worry parents who they realised were poor. For example, a child in one of the rural communities described how she had never been to a formal heath centre despite suffering from kidney infections.

Caregivers reported that there were no dedicated child health services in their communities; instead, children have to use the poor quality services available to adults. In all the study communities, caregivers felt that the government should prioritise quality, affordable, or free, healthcare services for children. In the urban sites, caregivers wanted to see a hospital or a health centre in their communities. In the rural areas, caregivers wanted a well equipped health-post or a health centre with proper medicines and well-trained staff. As the use of traditional healing carries high risks for children, families need to be made aware of how to access formal health services.

4.2   Education

School emerged from the research as one of the most important institutions in children's lives. The research also showed that there were significant differences in access to education in rural and urban areas. One of the urban sites had private pre-schools or kindergartens, a traditional church school and two primary schools. There were also secondary schools and private primary schools in neighbouring communities. The other urban site had three private kindergartens, a primary school and a secondary school. None of the rural sites had a pre-school, although there were traditional church schools that took children at pre-school age. The rural sites did have primary schools, but there were located at some distance away. All children living in rural areas had to travel to attend secondary school.

The availability of education did not however guarantee access. For example, caregivers in the urban communities explained that the private pre-schools were too expensive for poor families. Those who could not afford to send their children to private kindergartens enrolled them in the cheaper and lower quality traditional church schools. In these church schools, the preparation for primary school was not as good as in the private pre-schools as the children only learned numbers and local alphabets. In general, richer families sent their children to private kindergarten and primary schools, and poorer families sent their children to church schools and then government primary schools. In some of the urban communities, help was available to poor families from NGOs in terms of paying for food and school materials.

Government primary schools were accessible to all families, albeit at a distance in some of the rural areas. However, caregivers and other adults in the research communities were critical of the quality in government schools in terms of lack of facilities, poor standards of cleanliness and bad teaching. They gave examples of dirty toilets, dirty school grounds, and dirty, overcrowded classrooms with as many as 80 children in one classroom, insufficient text books and unmotivated teachers. In one of the urban communities, teachers reported that in one of the government primary schools, 70 to 80 children were assigned to a single classroom and one book was usually shared among 5 to 6 pupils. Caregivers were also very critical of the teaching in first cycle primary schools (grades 1 to 4), where teachers taught all subjects to the same class over subsequent grades. This denied children the opportunity to gain exposure to different teachers with varying skills, experiences and teaching styles. Caregivers were concerned that when children were assigned a weak and undisciplined teacher, they were exposed to a bad role model. Both teachers and caregivers doubted that any teacher could have sufficient knowledge in all subjects. Moreover, having to teach the same grades over subsequent years undermines teacher motivation. Caregivers felt that the quality of education was higher in private schools which had better, cleaner facilities and equipment such as classrooms, toilets, playgrounds and libraries and had more highly motivated teachers.

In the rural communities, children who attended the government primary schools faced similar problems in terms of poor quality. In some rural schools children had to sit on benches on the floor and use their knees as tables because of the lack of proper chairs and tables. Overcrowding was a major problem in some schools: a teacher in one school said that there were about 120 children per classroom. In the rural areas, caregivers did not have the choice of sending their children to private pre- or primary schools because there were none. In some cases, pre-school age children went to church/Koran schools. In other cases, the community arranged informal teaching such as high school graduates teaching children basic numbers and alphabets during the summer vacation. Caregivers in two of the rural areas also described problems when trying to register their children for primary school at the appropriate

age. The schools claimed that children should be 7 years old to register and used the traditional measurement of asking a child to 'touch his/her ear by putting his opposite hand over the head.' Caregivers felt that this inaccurate way of determining a child's age was denying their children access to schooling.

Another concern for caregivers in the rural communities was the distances between home and school. Caregivers explained that younger children were often too tired to walk to school. In one of the communities, caregivers described how children of 8 years old found the two hour walk to school too much and would spend their time playing during the journey. These children returned home without having been to school. Even those younger children who had schools closer to home would have to travel further to school once they graduated to the second cycle primary school – and even further to attend secondary school. In the rural communities, children often have to work which can lead to frequent absences and drop- out. Due to the risk of sexual abuse on their journey to (distant) schools, some parents fear that their girls might drop out at certain stages.

In the urban communities, caregivers and other community representatives suggested that the government, NGOs, private organisations and the community needed to cooperate in order to increase the number of kindergartens and primary schools, and to prioritise the quality of education. In the rural communities, the establishment of kindergartens was seen as critical to increase children's knowledge and prepare them for primary education. In one of the rural communities, caregivers and other community representatives suggested alternative approaches to education such as summer schools to help prepare younger children for first grade. In both the rural and urban communities, caregivers suggested that teachers in primary schools should be assigned to teach different subjects.

In the rural communities, new schools need to be built, existing schools need upgrading and all schools need better facilities and teaching materials. Teachers also need to make more effort to equip students with the knowledge and skills they need, and parents need to oversee their children's learning. These improvements would increase educational quality and help to reduce dropout rates and enhance girls' education. Primary school teachers felt that strengthening school clubs could help to raise awareness of girls' education and promote child rights in schools. A teacher in one of the rural sites suggested consultations with various stakeholders (including parents and school administrators) to reduce dropout rates and improve the quality of education. The same teacher also said that children need to be well motivated and focus on their education.

4.3   Other services

All the rural communities had access to safety net programmes. In one of the rural sites, an irrigation scheme had been set up. In the urban communities, NGOs provided support to poor people.

In all the research communities there was support for better recreational and play facilities for children. In one of the urban communities, there was a strong feeling that the government, NGOs and community based organisations should cooperate to reduce harmful traditional practices and to protect the rights of children. Community representatives felt that government and other organisations needed to work together to create a package of measures to promote the well-being of children and young people.

5. Conclusions and implications for further research and policy

In this section we discuss some of the themes emerging from the qualitative data collected in four of the Young Lives sites in Ethiopia which merit further exploration and consideration. While the policy interventions proposed below will depend on the capacity of government, they should be considered in the longer term for their potential to contribute to breaking the cycle of poverty in Ethiopia.

First, access to and quality of schooling emerged as a serious concern for both caregivers and children. There were no government pre-schools in either the rural or urban communities. Hence, poor urban families could not afford to pay fees in private kindergartens and rural children had no access to pre-schools. Both groups instead used local religious institutions (for boys) and in one community secondary school leavers were organised to provide children with basic preparatory education. This suggests that the government should consider establishing public pre-schools. Until that is possible, locally organised alternatives that prepare children for primary school should be used. Religious institutions and educated young people who live locally are two of the alternatives to formal pre-school that could be better organised through the provision of resources and a curriculum.

Second, in the rural areas second cycle primary schools are located a long way from the communities, and secondary schools are located in towns. Journeys between home and school can expose poor children, especially girls, to assault or sexual abuse. It is therefore essential to have local primary schools up to grade 8 close to each community and legal protection against sexual abuse, early marriage or abductions for girls who travel to towns.

Third, in addition to the problem of access, the quality of schooling is an even greater problem.

Dirty schools, overcrowded classrooms and teachers having to walk long distances to reach the school all have a negative impact on children's education. Caregivers were also concerned about teachers having to teach all subjects to the same class over subsequent grades. As well as ensuring increased enrolment, the government therefore needs to focus on improvements to the quality of schooling.

Fourth, healthcare was almost non-existent in the rural communities and the health centres did not provide adequate services. Many children and caregivers reported ill-health which, for children, had a negative impact on their schooling. As the local health centres did not offer the drugs and other services people needed, people had to travel long distances to access health services which poor families could not afford to do. Healthcare facilities offering appropriate levels of service to local people are needed and child-focused healthcare should be introduced with dedicated treatment rooms for children, and specialised staff and medications.

Fifth, discussions with children and data from their self-report diaries revealed that engaging in household activities and paid work had a significant negative effect on their health and education. In some of the research communities, government safety-net programmes and local investments had increased the prevalence of child labour. There should be mechanisms to enforce the existing legal provisions to address child labour that affects schooling and

support should be provided to poorer children so that they can attend school properly, including free school meals and materials.

Sixth, the physical and mental health risks to girls associated with early marriage, abduction and female genital cutting remain a concern for both caregivers and children. These practices continue despite laws banning them which the local authorities try to enforce. Their continuation may be due to the power of local traditions (see Tafere and Camfield 2009 for an alternative perspective). Parents expressed concern over some of the new laws; for example, some believed that postponing a girl's marriage until 18 years old increased the risk of pre-marital sex, early pregnancy or sexually transmitted diseases that would remain untreated as girls fear going to health care because they caught the disease having sex before marriage. On the issue of female genital cutting, parents seemed to have accepted the law banning the practice but they still see it being practised. Hence, understanding cultural norms and convincing local elders would be useful to enforce the laws aimed at protecting girls.

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Annex 1. Tables

Table A1. *Ranking of top three well-being and ill-being indicators (older cohort children)*

Site	Well-being	Ill-being
Atkilt-tera – girls	1. Access to education 2. Educational materials and adequate food 3. Having good house and clothes	1. No access to education 2. Not having educational materials 3. Having inadequate food
Atkilt-tera – boys	1. Good education 2. Having a balanced diet 3. Going to entertaining places	1. Losing parents, lack of education 2. Being badly behaved 3. Lack of proper education
Leki – girls	1. House with corrugated iron (protects from malaria) 2. Having cattle 3. Having a donkey for loading things (reduces burden)	1. Shortage of food 2. Living in hut (exposure to cold, disease and malaria) 3. Shortage of clothes / wearing old clothes
Leki – boys	1. Having land and livestock 2. Having a corrugated iron house and food crops 3. Producing vegetables such as tomatoes, onions and peppers	1. Shortage of land for farming and housing 2. Shortage of livestock (leading to insufficient income for medication) 3. Not having a house or enough clothes for the family
Tach-meret – girls	1. Having new and clean clothes 2. Having a clean house 3. Having a big house with a kitchen and good garden	1. Having a damaged house 2. Having dirty, old clothes 3. Being thin and having a weak physical appearance
Tach-meret – boys	1. Being fat 2. Having a balanced diet, working and going to school simultaneously 3. Wearing good clothes	1. Being thin, not having a balanced diet, not going to school, shortage of clothes 2. Having a bad feeling (*yekafew*), bad weather, lack of family assets 3. Living in a thatched house
Semhal – girls	1. Looking pretty, having good posture, having enough food to eat 2. Having well-dressed hair 3. Having nice, neat and new clothes	1. Not having enough food, being thin 2. Having badly treated, dirty, dry hair 3. Worn-out clothes
Semhal - boys	1. Having good food and good clothing, being healthy and obedient, having good peaceful family relations, having parents 2. Attending formal school 3. Cattle-herding	1. No access to education, no family, being ill, having a poor family, being disobedient, being in conflict with peers, being a thief, being unclean 2. Not having good clothes 3. Being foolish
Leku – girls	1. Acquiring knowledge/education about health issues such as sanitation 2. Open discussion within family 3. Access to basic necessities	1. No access to schooling 2. Lack of love for family and country 3. Poverty/lack of financial resources or lack of fulfilment of basic necessities
Leku – boys	1. Having a house, food and good clothes 2. 3. Having clothes to protect against malaria and common cold, having a house, having food (no life without food) 4. Access to education in order to have a better life in the future, having clothes	1. Gambling (leading to bad behaviour), no access to schooling and not thinking about future 2. Lack of money to meet basic needs (possibly leading to criminal activity 3. Not having a house, inability to get food

Overall, education indicators were most important for well-being (and ill-being). The table also shows the importance of health for well-being as indicators on, for example, inadequate food, housing and clothing are related to increased exposure of children to health problems.

Table A2. *Younger cohort children's understanding of well-being and ill-being (summary of individual interviews)*

Community	Well-being	Ill-being
Atkilt-tera	- Having a family - Having a good house and a car - Playing with toys and games and doing some light work like washing dishes and cleaning the house - Starting school - Being well behaved and not insulting or hitting other children	- Being beaten and insulted by teachers and other students at school; - Living in dirty areas - Being rude to mother; - Fear of horror movies and bad dreams
Leku	- Having parents - Having a good house, private house and other assets - Family love and care - School (starting school, having a uniform, friends) - Being well behaved	- Lack of love from the caregiver - Fear of wild animals - Having badly behaved friends - Being beaten and insulted by teachers and other students at school - Living in a dirty area
Tach-meret	- Fulfilment of basic needs especially food and clothes - Participating in family/community ceremonies - Getting love and affection from parents - Not being beaten by family members or others	- Lack of love from parents - Being beaten by family members and older children in the community - Illness and the problem of access to treatment - Fear of wild animals
Leki	- Parents who provide children with basic needs and protection - Having good clothes - Playing with friends	- Lack of clothes and livestock - Illness and inability to get treatment - Lack of access to schooling - Conflicts within the family - Being beaten by parents or other children in the community
Semhal	- Having parents - Getting good food and clothing - Attending school - Playing with friends	- Illness and inability to get treatment - Lack of access to schooling - Conflicts within the family - Being beaten by parents or other children in the community

Table A3. *Overview of understandings of well-being reported by children and adults in the research communities (older cohort children)*

Themes	Children's definitions	Adults' definitions
Physical health and security	• Having a clean environment at home, school and in the community • Good house (e.g. corrugated iron roof, separate kitchen), adequate food, personal hygiene, access to healthcare, physically strong and plump • Not sexually harassed or assaulted (especially girls), avoiding early marriage and heavy work	• Having a good, clean environment with a pleasant climate and plentiful natural resources • Balanced diet, pure water, physically strong and plump, good personal hygiene, clean house with sleeping area, sanitation, sufficient sleep, access to healthcare when sick • Not beaten or over-worked, avoiding early marriage and being prepared for menstruation, family planning
Good relationships and behaviour	• Having parents, receiving love, advice and support from family • Agreeing with and helping parents, not quarrelling with them	• Having parents, receiving care, guidance, support, and protection from families, respecting parents and accepting advice • Accepted, valued and respected by parents and the community, peaceful relationships in the family, having well-behaved friends and good relationships in the community. • Opportunities for girls to marry early and have children (Semhal) • Having a peaceful mind, being broad-minded and calm in their perspective • Appearing/feeling equal with other children, feeling 'proud' and being 'superior' (boys, Semhal)
Education, knowledge	• Access to a good quality education (e.g. private schools in urban areas), educational materials, time to study.	• Access to a good education (e.g. extra tuition in urban areas), educational materials, time to study, religious tuition and opportunities for religious participation where available
Personal development	• Access to television and telephone to 'educate and bring new ideas', being respected and consulted by parents, encouraged in their education, good behaviour, personal characteristics such as curiosity, confidence and sociability	• Encouraged to think freely, having educated parents who can oversee children's study and give advice, able to distinguish good and bad, being taught to live in a good way • Having work appropriate to age and gender that can be combined with education and recreation
Play	• Having appropriate places to play, 'going to entertaining places', time to play outside work, study and chores	• Local places and toys for play, money for boys' recreation

Table A4. *Overview of understandings of well-being reported by children and adults in the research communities (younger cohort children)*

Themes	Children's definitions	Adults' definitions
Physical health and security	• Having livestock, good housing and food • Having access to health care when ill • Not being beaten by older family members or teachers	• Having a clean environment • Getting good food, personal care and clothing • Not being overburdened in work • Getting support from government for the well-being of children (e.g. social protection safety net)
Good relationships and behaviour	• Having parents, receiving love, advice and support from family • Being well behaved	• Having parents, getting proper care, guidance, support, and protection from families, • Being well behaved, respectful, polite and having good relationship with family members • Getting equal parents' attention with other siblings
Education, knowledge	• Schooling (starting and attending school and having uniforms)	• Having access to school with necessary facilities and good teachers
Personal development	• Participation in community festivities and ceremonies with friends	• Proper physical growth with fast and actively thinking mind • Having access to TV
Play	• Having good environment and materials for play	• Having good play areas, playing materials and good friends

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