GENDER & ADOLESCENCE: GLOBAL EVIDENCE

MIDLINE REPORT SERIES

Ethiopian young people's sexual and reproductive health and rights

Evidence from GAGE Round 3

Elizabeth Presler-Marshall, Nicola Jones, Sarah Baird, Workneh Yadete, Joan Hamory, Saini Das and Fitsum Workneh

September 2024

Acknowledgements

The authors wish to thank Dr Kassahun Tilahun for data management support; and to appreciate the inputs of Dr Guday Emirie, Fitsum Workneh, Robha Murha, Yitagesu Gebeyehu, Mazengia Birra, Meti Kebede, and Dr Kiya Gezahegne in data collection and analysis. We are also grateful for the inputs of the survey team to the quantitative data collection from Laterite Ethiopia. We would like to thank Kathryn O'Neill for her editorial support, Ottavia Pasta for designing the infographics, Jojoh Faal Sy for layout and Christine Khuri for publication coordination. We also wish to thank colleagues from Pathfinder and Care Ethiopia for their partnership around the evaluation of the Act with Her adolescent empowerment programme. We are also grateful to the government sector ministries, particularly the Ministry of Women and Social Affairs, and non-government partners who have been utilising our evidence for policy and programming. Above all we would like to thank the adolescents, caregivers, service providers and experts who participated in the research and who shared their valuable insights.

Suggested citation:

Presler-Marshall, E., Jones, N., Baird, S., Yadete, W., Hamory, J., Das, S. and Workneh, F. (2024) *Ethiopian young people's sexual and reproductive health and rights: evidence from GAGE Round 3.* Report. London: Gender and Adolescence: Global Evidence.

Table of Contents

Figures

Boxes

Tables

Introduction

Ethiopia is Africa's second most populous country, with an estimated population of nearly 130 million as of 2024 (United Nations Population Fund (UNFPA), 2024). With young people (aged 10 to 24) accounting for one-third of that population, and a total fertility rate of nearly 4 children per woman, Ethiopia is poised to double its population in just 28 years (ibid.). Cognisant that future economic development depends on investing in young people's well-being, including their sexual and reproductive health and rights (SRHR), the Ethiopian government's National Adolescent and Youth Health Strategy prioritises two goals: raising the age of first marriage and first sex (which, in Ethiopia, remain tightly interlinked despite child marriage having been illegal for decades); and reducing adolescent pregnancy, pregnancy-related mortality, and HIV prevalence (Ministry of Health, 2021). Progress on some metrics notwithstanding, the Ministry of Health (ibid.) acknowledges that young people's sexual and reproductive health needs remain under-served, and Ethiopia is considered off-track to deliver on Sustainable Development Goal (SDG) 3, which is to ensure healthy lives and promote well-being for all at all ages (Sachs et al., 2023).

This report builds on previous research and synthesises findings from the Gender and Adolescence: Global Evidence (GAGE) programme's third round of data collection (conducted in 2021 and 2022) to explore patterns in Ethiopian young people's sexual and reproductive health (Ogunbiyi et al., 2023; Pincock et al., 2023a;b; Jones et al., 2022; Presler-Marshall et al., 2020; Jones et al., 2019a;b). Paying careful attention to similarities and differences between groups of adolescents (aged 13–17) and young adults (aged 18–21), based on gender, geographical location, and intersecting disadvantages (including disability and child marriage), we explore multiple indicators of sexual and reproductive health. These include access to timely puberty education, environments supportive of good menstrual health, delayed sexual debut, awareness and uptake of contraception, awareness and uptake of pregnancy-related services (including abortion), and experiences of intimate partner violence. The report concludes with implications for policy and programming.

A young nurse © Nathalie Bertrams/GAGE 2024

Context

Although there was a 'mini' Demographic and Health Survey (DHS) published in 2021 (drawing on data collected just prior to the Covid-19 pandemic), the most recent comprehensive evidence on Ethiopian young people's sexual and reproductive health comes from the 2016 DHS (Central Statistical Agency of Ethiopia (CSA) and ICF, 2017). That survey, which does not collect data on puberty or menstrual management, found that of young women aged 20–24, 13% had experienced sexual debut by age 15, 43% by age 18, and 62% by age 20. Analogous figures for young men the same age were 1%, 12% and 30% respectively. For young women, these figures closely match marriage rates, indicating that most girls and young women experience sexual debut within marriage. Of never-married adolescents aged 15–19, 4% of girls and 7% of boys had had sexual intercourse. Of never-married young adults aged 20–24, 15% of young women and 29% of young men had had sex.

Although 98% of girls aged 15–19 and 99% of young women aged 20–24 reported having heard of a modern method of contraception, only a minority of young wives were currently using one (CSA and ICF, 2017). The DHS reports that 32% of married adolescent girls aged 15–19 and 39% of married young women aged 20–24 were using a modern contraceptive method. Contraceptive uptake among unmarried girls and young women was estimated to be slightly higher, because – unlike their married peers – they are under no pressure to demonstrate their fertility (Ministry of Health, 2021). Across cohorts, most young contraceptive users were using injectables, and reported that contraceptive decision-making was either theirs alone or was shared with their husband (CSA and ICF, 2017). Unsurprisingly, early motherhood is common. Of young women aged 20–24, 3% were mothers by age 15, 21% were mothers by age 18, and 38% were mothers by age 20.

The DHS found that a minority of young people (aged 20–24) had comprehensive knowledge about HIV – only 24% of young women, and 39% of young men (ibid.). That said, 68% of young women and 79% of young men reported knowing where to get an HIV test, and 38% and 31% respectively reported having ever been tested.

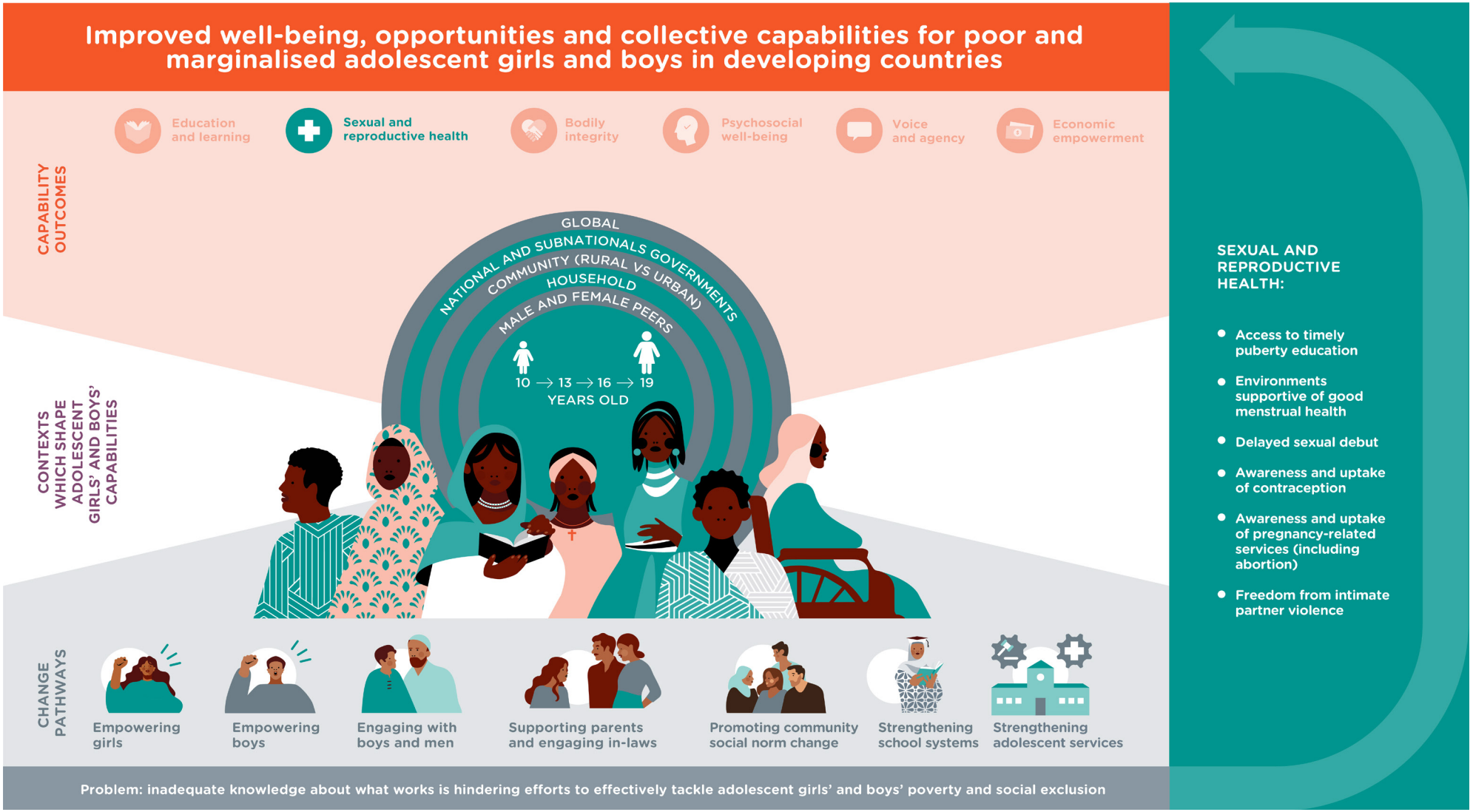
The DHS also found high rates of intimate partner violence. Of married girls aged 15-19 and married young women aged 20-24, most (63% and 58% respectively) had reported that their husband displayed controlling behaviour (ibid.). One-third of both reported having experienced physical, emotional or sexual violence at the hands of their husband. This violence is widely perceived as justified. Of adolescents aged 15–19, 60% of girls and 33% of boys believe that wife-beating can be justified for at least one reason. Analogous figures for young adults aged 20–24 were 60% and 29% respectively.

Conceptual framing

Informed by the emerging evidence base on adolescent well-being and development, GAGE's conceptual framework takes a holistic approach that pays careful attention to the interconnectedness of what we call the '3 Cs' – capabilities, change strategies and contexts – in order to understand what works to support adolescents' development and empowerment, both now and in the future (see Figure 1). This framing draws on the three components of Pawson and Tilley's (1997) approach to evaluation, which highlights the importance of outcomes, causal mechanisms and contexts, though we tailor it to the specific challenges of understanding what works in improving adolescents' capabilities.

The first building block of our conceptual framework is capability outcomes. Championed originally by Amartya Sen (1985; 2004) and nuanced by Martha Nussbaum (2011) and Naila Kabeer (2003) to better capture complex gender dynamics at intra-household and societal levels, the capabilities approach has evolved as a broad normative framework exploring the kinds of assets (economic, human, political, emotional and social) that expand the capacity of individuals to achieve valued ways of 'doing and being'. At its core is a sense of competence and purposive agency: it goes beyond a focus on a fixed bundle of external assets, instead emphasising investment in an individual's skills, knowledge and voice. Importantly, the approach can encompass relevant investments in children and young people with diverse trajectories, including the most marginalised and 'hardest to reach' such as those with disabilities or those who were married as children. Although the GAGE framework covers six core capabilities, this report focuses on sexual and reproductive health, specifically: access to timely puberty education; environments supportive of good menstrual health; delayed sexual debut; awareness and uptake of contraception; awareness and uptake of pregnancy-related services (including abortion); and intimate partner violence.

Figure 1: GAGE conceptual framework



The second building block of our conceptual framework is context dependency. Our '3 Cs' framework situates young people socio-ecologically. It recognises that not only do girls and boys at different stages in the life course have different needs and constraints, but also that these are highly dependent on their context at the family/household, community, state and global levels.

The third and final building block of our conceptual framework – change strategies – acknowledges that young people's contextual realities will not only shape the pathways through which they develop their capabilities but also determine the change strategies open to them to improve their outcomes. Our socio-ecological approach emphasises that to nurture transformative change in girls' and boys' capabilities and broader well-being, potential change strategies must simultaneously invest in integrated intervention approaches at different levels, weaving together policies and programming that support young people, their families and their communities while also working to effect change at the systems level. The report concludes with our reflections on what type of package of interventions could better support Ethiopian young people's sexual and reproductive health.

Sample and methods

This report draws on mixed-methods data collected in Ethiopia between early 2021 and late 2022. It adds to what we have learned from data collected at Baseline (2017–2018) and during Round 2 (2019–2020).

At Baseline, the quantitative sample included 6,924 adolescents from households across two cohorts (younger adolescents aged 10–12 years, and older adolescents aged 15–17 years), with purposeful oversampling of adolescents with disabilities and those who were married as children. Data was collected from three marginalised rural areas – Amhara's South Gondar, Oromia's East Hararghe, and Afar's Zone 5 – as well as urban Dire Dawa, Debre Tabor, and Batu city administrations. For this initial round, only younger cohort adolescents were sampled in rural areas, and in Batu only older adolescents were sampled.

For Round 2, an additional 1,655[1] young people (aged 10–20 at the time of recruitment) were added to the sample. Most were added because they were rural (to balance the older cohort in urban areas) or because they had married as children (due to this status being of special interest to GAGE). Others were added because they were out of school, had a disability, or were internally displaced. Altogether, this brings the total sample size for Round 2 to 8,579 young people. Data was collected from the same locations, three rural and three urban.

For Round 3, budget limitations meant that GAGE researchers only surveyed people living in rural South Gondar, rural East Hararghe and the city of Debre Tabor (see Figure 2). The total eligible sample was 8,543. This included 6,194 young people who were part of the Round 2 sample from these three locations, 807 older adolescents (new to the study) in Debre Tabor, aged 14–18 at time of recruitment, and 1,533 very young adolescents (also new to the study) aged 11–13 at time of recruitment. The final Round 3 survey sample involved 7,509 young people.

To facilitate the analysis of change over time, this report focuses on the 4,810 adolescents who were surveyed in both Round 2 and Round 3. Of these, 202 had reported a functional disability,[2] even if they have an assistive device available (such as glasses, hearing aids or a mobility device) (see Table 1). The sample included more females (2,802) than males (2,008). Of the females, and because GAGE oversampled those who had experienced child marriage, 734 had been married prior to age 18. At the time they were surveyed, the younger cohort had a mean age of 14.3 years; we refer to these individuals as adolescents. The older cohort had a mean age of 18.9 years. To distinguish these young people from those in the younger cohort, we refer to them as young adults, despite the fact that a small minority of them are legal minors under the age of 18.

An important point to note, for interpreting our findings, is that the younger cohort (3,857 adolescents) is much larger than the older cohort (953 young adults). The younger cohort is also more likely to be rural than the older cohort (approximately 90% versus 65%). Because of these differences, means by age cohort that do not take account of location cannot be directly compared; thus our findings

1 This total includes: (a) 1,124 older rural adolescents (aged 17–19 at recruitment) from East Hararghe, South Gondar, and Afar. Of these, 680 were female (490 of whom were married) and 444 were male (117 of whom were married); (b) 387 married adolescents, including those living in the same three rural areas (aged 10–16 at recruitment) and in GAGE's urban locations (aged 14–20 at recruitment); (c) 157 adolescents with disabilities (aged 10–20 at recruitment) – but only 64 new individuals who were not part of (a) and (b) already detailed; and (d) 140 adolescents with characteristics of special interest (e.g. those who were internally displaced or out of school) – but only 80 new individuals who were not part of (a), (b) or (c) already detailed.

2 Determined by using the Washington Group on Disability Statistics Short Set on Functioning (WG-SS): https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/

Figure 2: GAGE Round 3 research locations

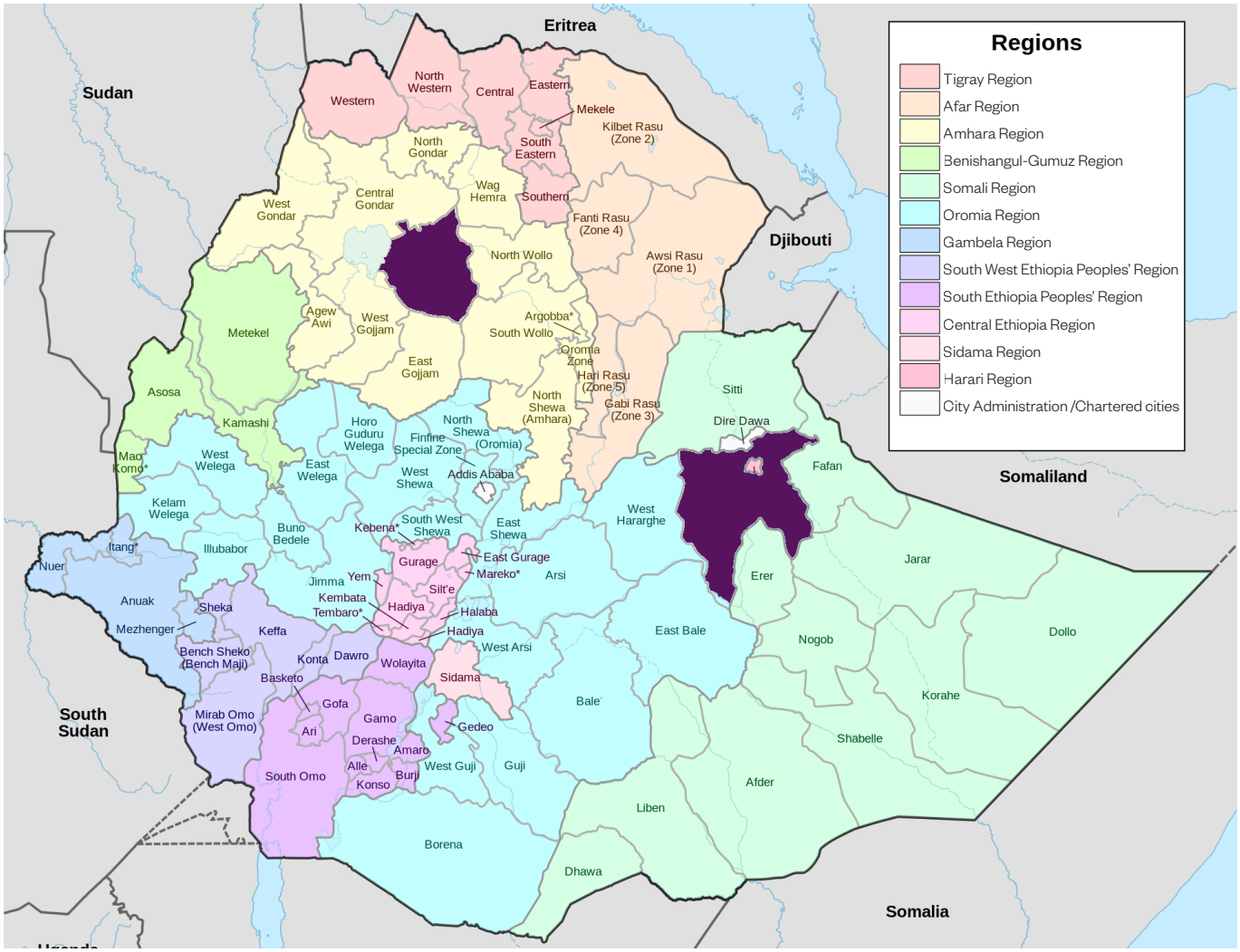


Table 1: Quantitative panel sample

	Locations			Sub-sample of those with disability	Sub-sample of girls married <18	Total
	Rural		Urban			
	South Gondar	East Hararghe	Debre Tabor			
Females	1260	1164	378	107	734	2802
Males	852	816	340	95	na	2008
Younger cohort	1777	1704	376	157	377	3857
Older cohort	335	276	342	45	357	953
Total	**2112**	**1980**	**718**	**202**	**734**	**4810**

are presented by cohort. For some indicators, we present changes over time between Round 2 and Round 3.

The qualitative sample for this report was primarily purposively drawn from the larger quantitative sample. It also, however, includes additional research participants who were purposively selected to explore the effects of the recent conflict in South Gondar – given that this represented a major shock to young people, their households, and their communities. Because of the security situation and the timeline of the 2021 national election, the Round 3 qualitative data was not collected in a single window. It instead represents an amalgamation of six rounds of data collected in Debre Tabor and rural South Gondar and East Hararghe during the same time period in which surveys were fielded. In total, the qualitative sample includes 203 interviews[3] with 336 young people, as well as 37 interviews with 219 caregivers and 141 interviews with 198 key informants (see Table 2).

3 Both individual and group interviews were conducted with young people and adults.

Table 2: Qualitative sample

Respondent Type	Sex	Location			Total
		Rural		Urban	
		South Gondar	East Hararghe	Debre Tabor	
Adolescents	Girls	56 (90)	11 (27)	9	76 (126)
	Boys	50 (81)	12 (29)	6	68 (116)
Total		106 (171)	23 (56)	15	144 (242)
Young adults	Females	13 (22)	8 (16)	8	29 (46)
	Males	13 (25)	6 (12)	11	30 (48)
Total		26 (47)	14 (28)	19	59 (94)
Sub-sample of those with disability		5 (11)	-	3	8 (14)
Sub-sample of girls married <18		5 (8)	2	2	9 (12)
Sub-sample of IDPs		4 (16)	-		4 (16)
Parents/Caregivers	Mothers	10 (58)	6 (35)	3 (18)	19 (111)
	Fathers	10 (56)	5 (34)	3 (18)	18 (108)
Total		20 (114)	11 (69)	6 (36)	37 (219)
Key informants		99 (125)	32 (63)	10	14 (198)
TOTAL		265 (492)	82 (218)	55 (85)	402 (795)

The table presents the number of interviews and then in brackets indicates the total number of participants as some interviews were with pairs or groups of people.

Prior to commencing research, GAGE secured approval from ethics committees at ODI and George Washington University, the Ethiopian Society of Sociologists, Social Workers and Anthropologists, and the research ethics boards from the relevant regional Bureaus of Health of Ethiopia. We also secured informed assent from adolescents aged 17 and under, and informed consent from their caregivers, and from adolescents aged 18 or over. There was also a robust protocol for referral to services, tailored to the different realities of the diverse research sites (Baird et al., 2020).

A 14-year-old girl and her 18-year-old husband on their honeymoon © Nathalie Bertrams/GAGE 2024

Findings

Our findings are organised according to our conceptual framework: puberty-related knowledge; menstrual management; sexual activity; awareness of contraception and disease prevention; uptake of contraception; pregnancy; and intimate partner violence. As explained earlier, survey findings are presented by cohort – first for adolescents and then for young adults.

Puberty-related knowledge

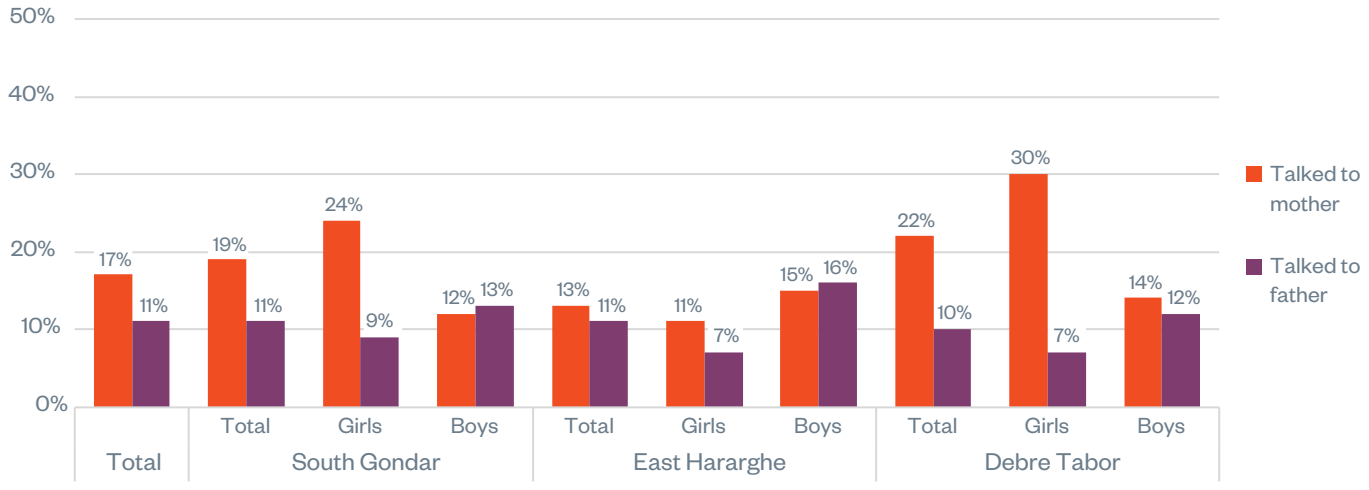
Survey findings for adolescents

The Round 3 survey asked adolescents whether they had ever talked to their mother and father about puberty.[4] A minority of adolescents answered yes. Across locations, 17% had ever spoken to their mother about the topic; 11% had ever spoken to their father (see Figure 3). Adolescents living in Debre Tabor (22%) and rural South Gondar (19%) were significantly more likely to have spoken to their mother about puberty than adolescents in East Hararghe (13%). In Debre Tabor (30% versus 14%) and South Gondar (24% versus 12%), girls were significantly more likely to have spoken to their mother about puberty than boys. Boys were concomitantly significantly more likely to have spoken to their father about puberty than girls in both South Gondar (13% versus 9%) and Debre Tabor (12% versus 7%). This was not the case in East Hararghe, where GAGE research has consistently found that girls are highly disadvantaged on myriad fronts compared to boys. In that location, boys were significantly more likely than girls to have spoken to both their mother (15% versus 11%) and father (16% versus 7%) about puberty.

The Round 3 survey found that most adolescents knew that menarche (first onset of menstruation) means that girls can get pregnant (80%) and that the menstrual cycle is approximately 28 days (74%) (see Figure 4). Location and gender differences were significant. Adolescents living in rural South Gondar (83% and 81% respectively for menarche and cycle length) and Debre Tabor (79% and 80% respectively), where school enrolment is relatively high, had better knowledge than their peers living in East Hararghe (77% and 66% respectively), where school enrolment – especially for girls – is far less common (see Presler-Marshall et al., 2024a). Not surprisingly, across all locations, girls were more aware of average cycle length than boys (94% versus 67% in Debre Tabor, for example). However, especially in East Hararghe (84% versus 72%) but also in rural South Gondar (85% versus 82%), boys were significantly more likely than girls to understand the relationship between menarche and fertility.

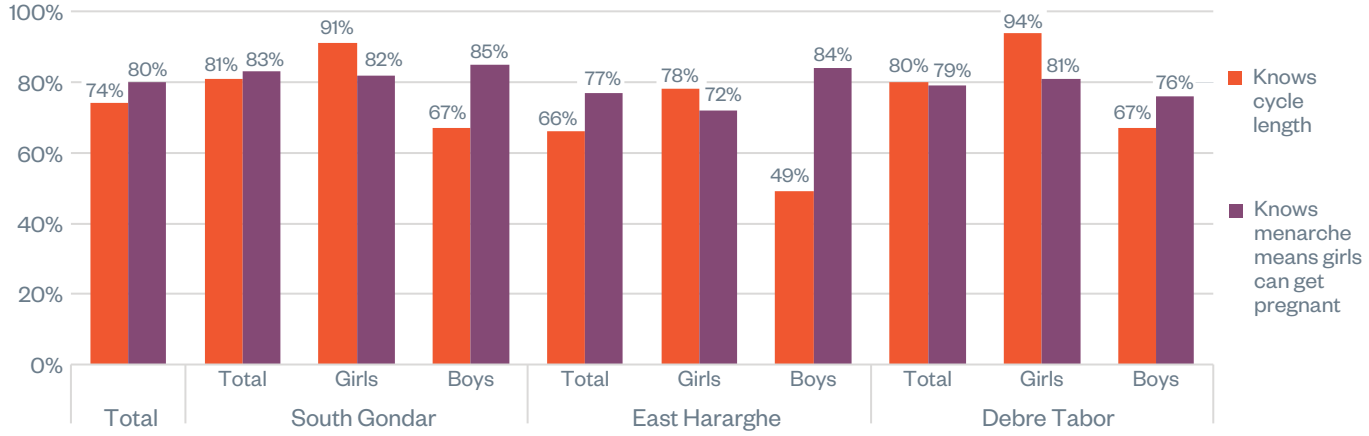
In the approximately 18 months between Rounds 2 and 3, adolescents' knowledge about menstruation improved significantly. Rural adolescents were 23 percentage points more likely to know how often menstruation occurs at Round 3 than they were at Round 2 (there was no change for adolescents in Debre Tabor). Interestingly, and possibly due to rural adolescents' exposure to the Act with Her programme (see Box 1), this finding is not merely due to girls having reached menarche; significant improvements in knowledge were seen among girls and boys alike. Across all three locations, adolescents were also 7 percentage

Figure 3: Ever spoken with mother or father about puberty, adolescents only



4 These questions were asked only among adolescents still living with a mother (father) or female (male guardian). Only 25 adolescents were no longer living with their mother/female guardian, and 201 were no longer living with their father/male guardian.

Figure 4: Adolescents' knowledge about menstruation



Box 1: Act with Her

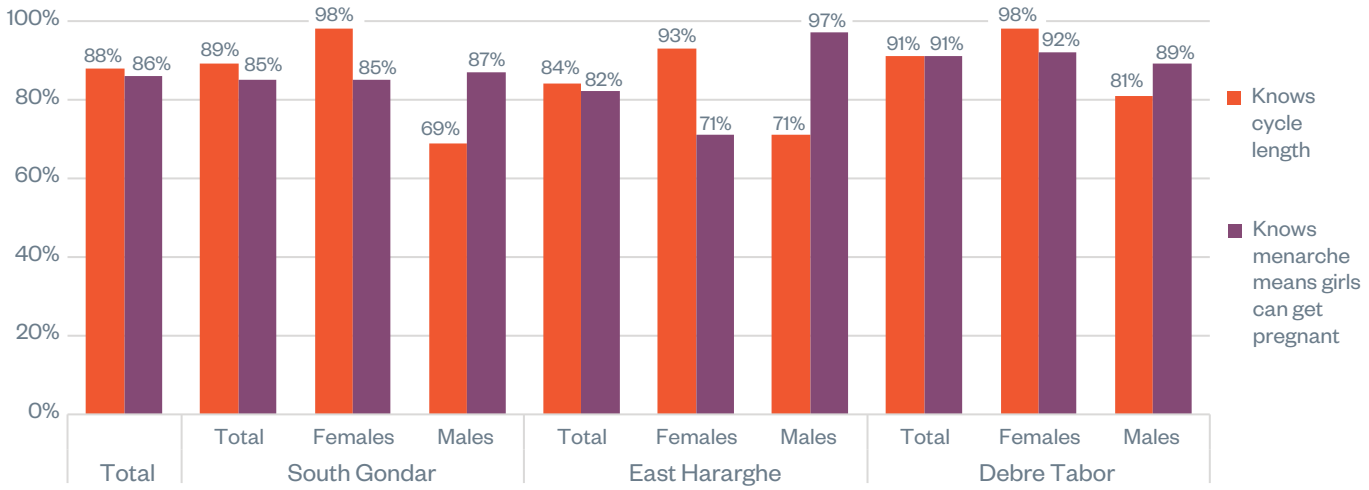
The Act with Her (AwH) programme, which has been implemented by two non-governmental organisations (NGOs), Pathfinder and CARE, aimed to improve the educational, health, psychosocial and economic outcomes of Ethiopian adolescent girls. The programme provided girls – and, in some communities, boys too – with near-peer mentors and an age-appropriate curriculum that focused on sexual and reproductive health, negotiation skills, and gender norm change. In some communities, the programme also worked with parents, service providers and community leaders to either strengthen (South Gondar) or establish (East Hararghe) school-based clubs to further disseminate sexual and reproductive health education and messages about gender norms. For more on the AwH programme, see Hamory et al. (2023).

points more likely to know that menarche means that girls can get pregnant at Round 3 than they were at Round 2. Boys in East Hararghe experienced the largest gains in knowledge: they were 18 percentage points more likely to have correct knowledge at Round 3 than at Round 2 (84% versus 67%).

Survey findings for young adults

Young adults were almost all aware that menarche means that girls can get pregnant (86%) and that the menstrual cycle averages 28 days (88%) (see Figure 5). Location differences were significant. As was the case with adolescents, young adults living in Debre Tabor (91% for both questions) and rural South Gondar (85% and 89% respectively for menarche and cycle length) were significantly more likely to have accurate knowledge than their peers living in East Hararghe (82% and 84% respectively). Gender differences were also significant. Unsurprisingly, in all locations, young women were more aware of cycle length than young men. However, while young

Figure 5: Young adults' knowledge about menstruation



men and young women living in Debre Tabor and rural South Gondar were similarly aware that menarche means that girls are able to become pregnant, in East Hararghe this was not the case. Again underscoring females' disadvantage, young men were significantly more likely than young women to understand this (97% versus 71%).

At Round 3, young adults in South Gondar were a significant 9 percentage points more likely to know that menstruation occurs approximately every 28 days than they were at Round 2. Young men experienced the most growth in knowledge: they were 17 percentage points more likely to answer correctly at Round 3 than they were at Round 2.

Qualitative findings

During qualitative interviews, and due to the taboos that surround cross-generational conversations that relate to sexuality, relatively few adolescents reported discussing puberty with their parents. Of those that did, all were girls and nearly all spoke only of discussions with their mother. In more urban Debre Tabor, mother–daughter discussions about puberty were usually timely (in that mothers prepared daughters for menarche), and often quite frank. A 13-year-old girl, when asked if she had begun having periods, replied:

> *I have not yet started menstruating. But I am getting signs … I have vaginal discharges … I asked my mom about it. I was confused and asked why I have white liquid coming out of my body rather than blood. I thought it was menstruation, just like what I was taught at school.*

In rural areas, girls were less likely to be prepared for menarche in advance, but sometimes did approach their mother when it occurred. A 14-year-old girl from East Hararghe recalled:

> *I tell my mother the first day I see menstruation. She said it is no problem, it is related with your age, anyone experiences it at a certain age, she told me that all females experience it.*

Menstruation has traditionally been stigmatised in Ethiopia, with the Afan Oromo word for menstruation actually being *turi (d*irt). Even girls in Debre Tabor sometimes reported that they cannot discuss their periods with their mother. A 14-year-old girl from that city explained, '*It is shameful*.'

Most young people who were well versed in pubertal changes reported that they had learned about puberty at school. Some reported learning in the classroom. A 17-year-old boy from Debre Tabor, when asked how he and his peers had learned about their changing bodies, stated, *'We got the information from the school. We learn about it starting from grade 5 in Biology course.'* A 15-year-old girl from East Hararghe, unusual in that she was still enrolled in school, reported *'we have learned in science class'.* Other young people, nearly all girls and young women, reported having learned about puberty in school-based girls' or gender clubs. A 12-year-old girl from rural South Gondar explained that she had not only learned about menstruation in her school's girls' club, but had been taught that the age of menarche is in part related to nutrition:

> *I am young, I am 13 years old. When our life is good life, I will experience menstruation soon. However, since the condition of living is not good for me, I may experience the first menstruation when I become older than 15.*

As has been noted in earlier GAGE publications (Baird et al., 2022), NGO efforts – and especially the Act with Her programme – have been key to improvements in adolescents' (though not young adults') knowledge about puberty. Girls in both rural South Gondar and East Hararghe reported learning about their developing bodies. An 11-year-old girl from East Hararghe, when asked what she had learned from Act with Her, replied:

> *We learn about body change, that there are changes in voice, growing of hair under armpits and over sex organs, widening pelvic bone. After we experience those changes, we experience menstruation.*

Critically, because boys in rural areas are often not taught at school about menstruation, Act with Her is also teaching boys about girls' developing bodies – and that menstruation is normal. A 12-year-old boy from East Hararghe reported that he had learned about the link between menstruation and pregnancy during Act with Her sessions: *'She may conceive if she has begun to see her menstruation … I learned in education by CARE organisation … We haven't learned on regular education.'* A 13-year-old boy from South Gondar added that he had learned that menstruation is nothing to be ashamed of:

> *Last year a grade 7 female student got her period at school … she was ashamed and she was forced to be absent from school for 3 days … But it was wrong and there is nothing to be ashamed.*

A 15-year-old girl from East Hararghe noted that boys' education has made girls' lives better:

Boys used to laugh at a girl that experienced menstrual leak … Teachers advise them [the boys] by saying, 'These girls are your sisters. Menstruation is natural. When they menstruate, you should have to help them instead of laughing at them'.

Menstrual health

Survey findings

Of the females in the Round 3 sample, nearly all young women (99%) and most adolescent girls (52%) had reached menarche. For adolescent girls, location differences were significant, with girls in Debre Tabor (65%) and East Hararghe (57%) more likely to have begun their periods than girls in South Gondar (44%). Unsurprisingly, the average age of menarche also varied by location. Of young women, those in South Gondar (15.1 years) began their periods significantly later than their peers in East Hararghe (14.1 years) and Debre Tabor (14.5 years) (see Figure 6). Differences in the average age of menarche are likely due to differences in nutrition (see Nguyen et al., 2020). The Baseline survey found that girls in South Gondar – when compared with peers in the other locations – were more likely to be chronically malnourished (Jones et al., 2019b).

Menstrual hygiene management (MHM) practices[5] varied significantly by location. Looking only at young women, because all are now menstruating, those in urban Debre Tabor (81%) were more likely to use modern disposable or purpose-made reusable pads than their peers in rural South Gondar (48%) and East Hararghe (43%) (see Figure 7). In Debre Tabor, young women were also more likely to practice hygienic disposal of period products (84%)[6] than their peers in South Gondar (57%) and East Hararghe (58%) (see Figure 8). For both indicators, patterning among adolescent girls, only half of whom had begun menstruating, was similar (and similarly significant).

The Round 3 survey found that rural young women – especially those from East Hararghe – are often embarrassed or afraid to ask their family members for support with manging their periods. Although only 21% of young women in Debre Tabor reported being embarrassed or afraid, analagous figures in South Gondar and East Hararghe were 49% and 79% respectively (see Figure 9). Of menstruating adolescent girls, those in East Hararghe were more also likely to be embarrassed or afraid than those in South Gondar (72% versus 51%)(there were too few menstruating girls in Debre Tabor to report).

A sizeable minority (16%) of young women reported at Round 3 that their daily activities are restricted by menstruation. This was significantly more common in Debre Tabor (23%), where young women are more likely

Figure 6: Age of menarche, young women only

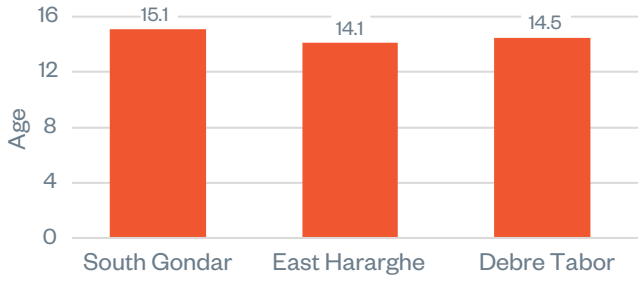


Figure 7: Improved practices regarding period products, young women only

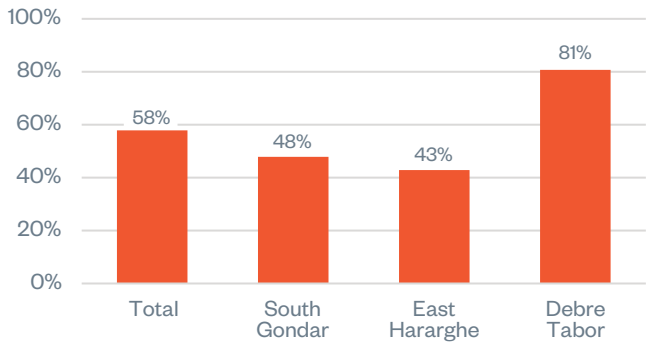
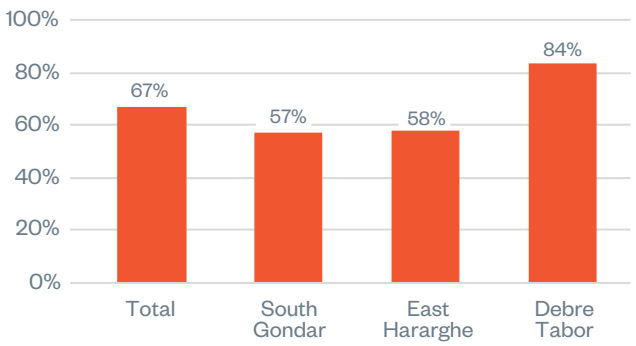


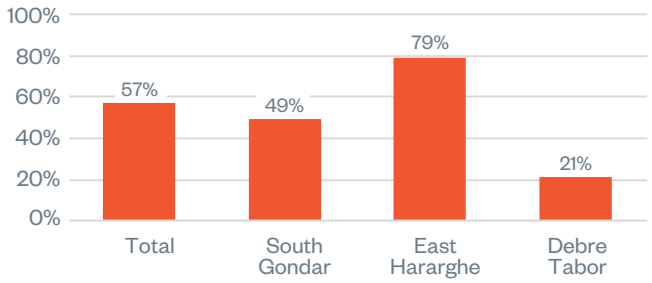
Figure 8: Hygienic disposal of period products, young women only



5 Menstrual hygiene management (MHM) is defined and tracked as the proportion of : 'Women and adolescent girls [who] are using a clean menstrual management material to absorb or collect menstrual blood, that can be changed in privacy as often as necessary for the duration of a menstrual period, using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management materials' (see United Nations Children's Fund (UNICEF), 2019).

6 This includes washing and re-using if using a reusable pad as well as disposing of used products by putting them in a rubbish heap or latrine or by burning them.

Figure 9: Embarrassed or afraid to ask family members for support with menstrual hygiene management, young women only



to be in school or working outside the home, than in South Gondar (15%) and East Hararghe (10%) (see Figure 10). For menstruating girls, 12% – with no location differences – reported that their activies are restricted by menstruation.

Of young women who reported menstruation-related restrictions on their daily activities, those in Debre Tabor (65%) were disproportionately likely to report that their periods interfere with their work (see Figure 11). Those in East Hararghe, which is primarily Muslim, were disproportionately likely to report that they cannot cook food (38%, see Figure 12) or go to a place of worship (25%, see Figure 13).

Qualitative findings

During qualitative interviews, most girls and young women reported using either purpose-made reusable pads or old cloth as period products. This was true even in Debre Tabor and was primarily related to the cost of disposable products. A 16-year-old girl from East Hararghe explained, '*It* [reusable pad] *is expensive. I want to buy it but I can't afford.*' While some girls and young women, typically those from Debre Tabor, reported that they had learned at home (from their mother or older sisters) how to manage their periods, most reported that they had learned at school, almost always in an extra-curricular girls' club that was receiving NGO support. A 16-year-old girl from Debre Tabor explained that this school-based education is especially important for girls from rural areas:

> *The students can be a member in the girls' club and they can get the whole information about menstruation there. There is also an organisation which teaches the students about menstruation, including educating about how to prepare and use a pad. This education is very important for those students who are from rural areas.*

Figure 10: Normal daily activities are restricted by menstruation, young women only

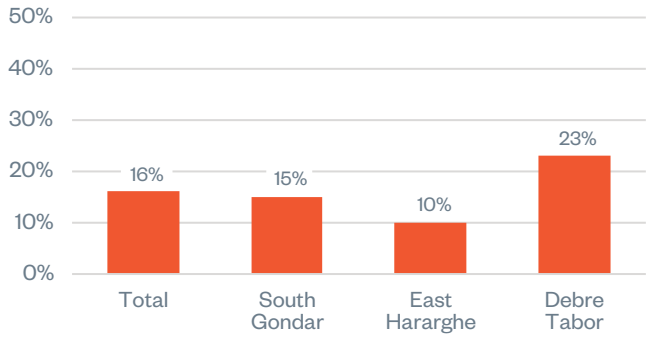


Figure 11: Cannot work while menstruating, of young women who reported restrictions

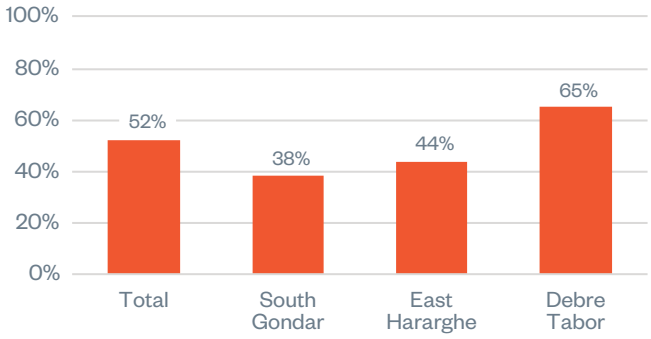


Figure 12: Cannot cook while menstruating, of young women who reported restrictions

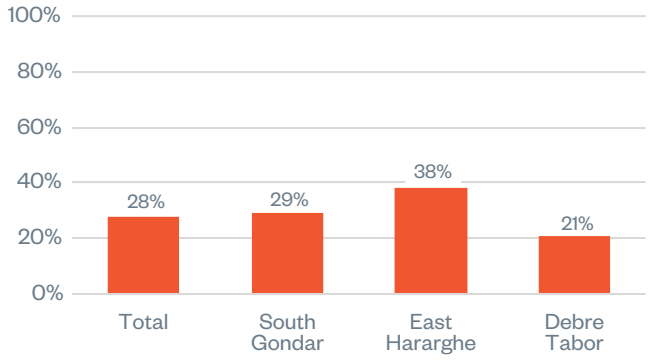
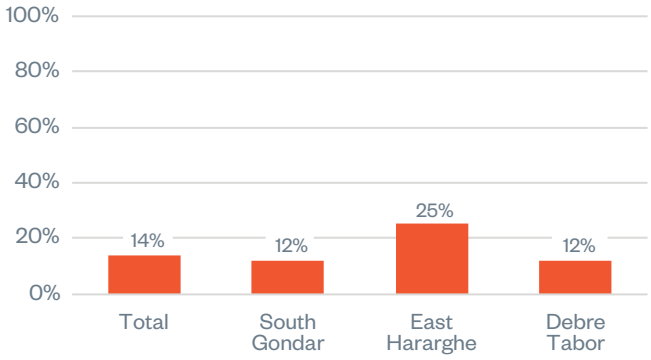


Figure 13: Cannot go to a place of worship, of young women who reported restrictions



An 11-year-old girl from East Hararghe agreed: '*No one tells you what to do or how to keep menstrual hygiene at home. We learn in school clubs about menstrual hygiene.*'

A minority of girls and young women reported using disposable period products. Most were from urban Debre Tabor and all relied on parental (usually maternal) support. A 16-year-old girl from Debre Tabor reported that her mother keeps a supply of period products on hand, so that she does not even have to ask: '*My mother buys the materials prior to the menstruation times and there is always a reserve.*' Indeed, while a 19-year-old young woman from Debre Tabor reported that she is comfortable enough with menstruation that she can '*ask my father for money for modes* [period pads]' and then purchase them herself, several girls noted that having a mother able and willing to do the purchasing is critical, due to girls' embarrassment. A 16-year-old girl from East Hararghe explained, '*I am ashamed about buying pads … Those who own shops are males, so I fear asking them.*' A 14-year-old girl from East Hararghe added that her mother buys not period products, but disposable diapers – which guarantee a leak-free day at school due to their larger size:

> *My mother is a businesswoman. She brings materials from* [a zonal town], *he brings diapers of different sizes, younger children use number 4 and I and my older sister use number 5 … We use diapers and pants over* [them], *it prevents leaks when we go to school.*

Students and teachers added that the menstrual hygiene management rooms that have recently opened in many schools, with support from CARE and Pathfinder, have transformed girls' ability to attend school while on their periods. A 15-year-old girl from South Gondar explained that she used to miss school the week her period was expected, to avoid embarrassment:

> *When you experience a menstrual leak at school, it is very scary … When you want to leave the school compound because of a menstrual leak, the security workers of the school do not allow you to leave the compound … You may be afraid to tell them about menstruation.*

A 12-year-old girl from East Hararghe noted that girls can now attend school without worry – even if school latrines do not have running water – because, '*There is a separate room, the room has also a washing place. The girls can wash and change their pad there. If you feel sick, there is a place to sleep.*' A teacher from South Gondar reported that between efforts to reduce menstruation-related stigma, lessons on how to make and use reusable pads, and the new MHM rooms, girls' attendance has improved significantly:

> *We have been proud of our MHM activities. These have been effective and students have now been able to use the MHM centres. Female students are no longer missing school because of menstruation.*

That said, several older girls and young women noted that girls' clubs and MHM facilities are available only in primary schools,[7] leaving secondary students to fend for themselves. A 16-year-old girl from Debre Tabor stated, '*The clubs are not functional in high school and those clubs are not fruitful.*'

Sexual activity

Survey findings

The Round 3 survey found that a minority (12%) of adolescents had experienced sexual debut (see Figure 14). Gender and location differences were significant. Across all locations – and unsurprising given girls' much greater risk of child marriage – girls were more likely than boys to be sexually active (19% versus 1%). Girls in East Hararghe (37%) were significantly more likely than their peers in rural South Gondar (9%) and urban Debre Tabor (3%) to have experienced sexual debut. Among adolescent boys, although sexual activity was rare, boys in East Hararghe (3%) were more likely to have had sexual intercourse than their peers in other locations (<=1%).

Half of young adults (50%) reported on the survey that they had experienced sexual debut (see Figure 15). As was the case with adolescents, females (62%) – who were disproportionately more likely to be married – were more likely to have had sex than males (29%). As was also the case with adolescents, young adults living in East Hararghe were more likely to have had sex than their peers living in other locations. In East Hararghe, 87% of young women and 63% of young men reported that they were sexually active.

Rates of sexual debut closely match rates of marriage. In East Hararghe, 25% of adolescent girls had already been

7 Primary school in Ethiopia includes through 6th grade and is meant for students up to age 12. However, it is common—especially in rural areas—for students to be years over age for grade.

Figure 14: Has experienced sexual debut, adolescents

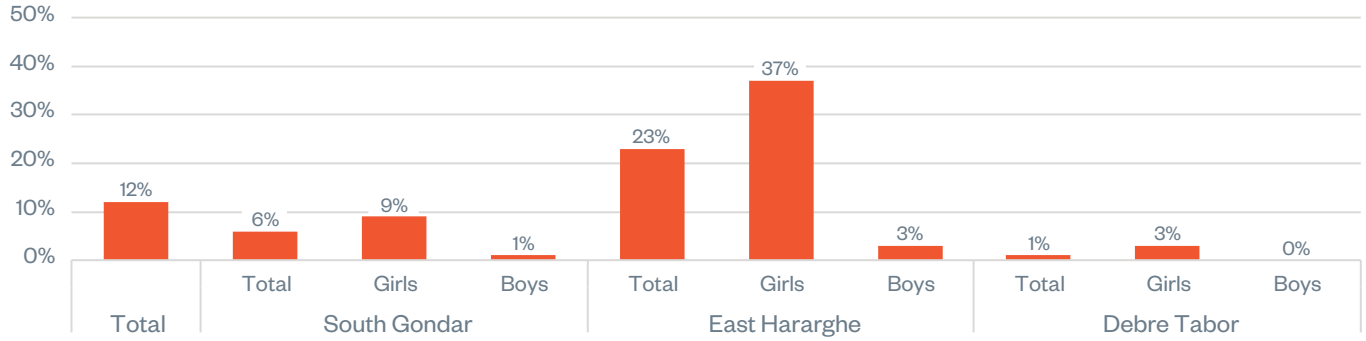
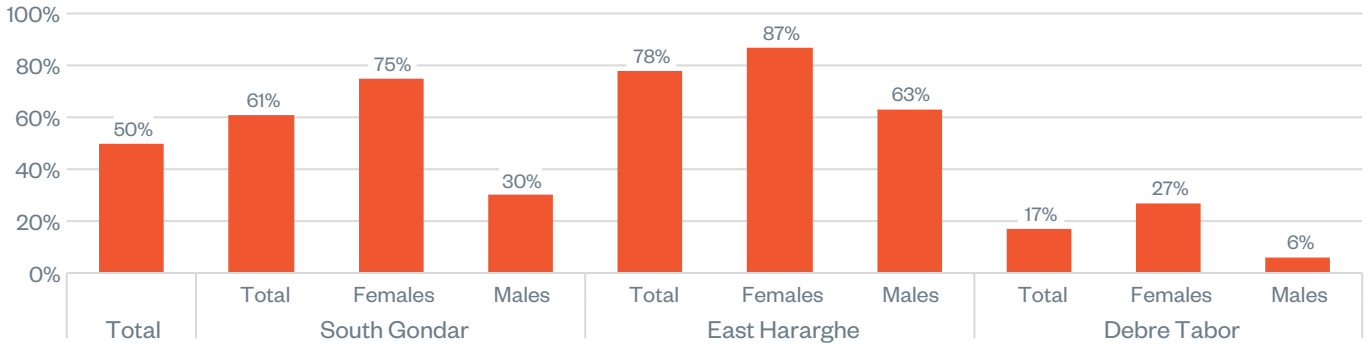


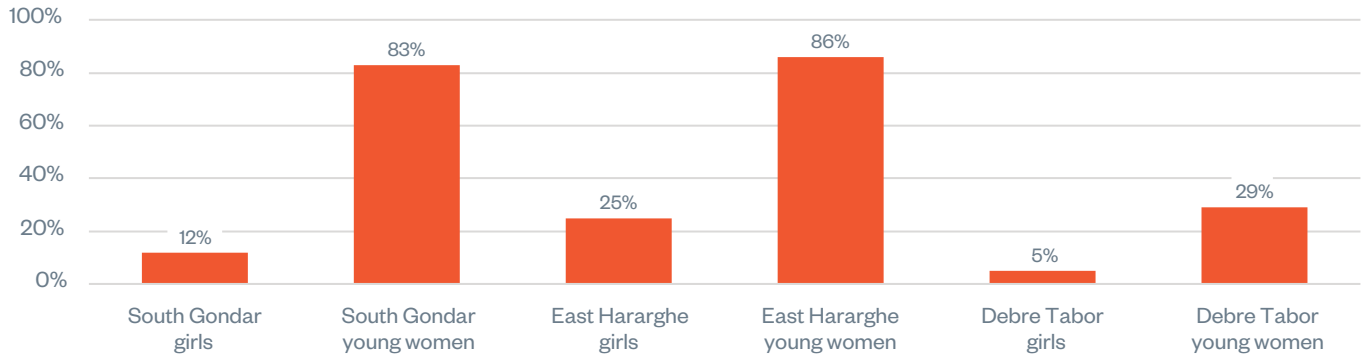
Figure 15: Has experienced sexual debut, young adults



married by Round 3 (see Figure 16).[8] With the caveat that our rural older cohort sample purposively oversampled married girls, in both East Hararghe (86%) and South Gondar (83%), most young women had been married. Early marriage was less common in Debre Tabor; only 29% of young women had been married. Although it is rare for adolescent boys to marry, many of the young men in our sample had been married. Early marriage was most common in East Hararghe; 70% of the young men in our sample in that location had been married (see Figure 17).

The Round 3 survey found that nearly all sexual activity takes place within marriage (see Figure 18). Of adolescent girls, 2% of those who are never-married have had sex, compared with 86% of those who are (or have been) married. With the caveat that very few (n=31) never-married girls have had sex, nearly all were from East Hararghe. With a similar caveat, there are only 48 ever-married girls who have not had sexual intercourse, and nearly all were from South Gondar. Of young women, 3% of those who are never-married have had sex, compared with 93% of those who are (or have been) married. Premarital

Figure 16: Has ever been married, females



8 Recall that some of the GAGE sample was purposefully recruited based on having been married. Therefore, marriage rates are likely higher than the population average. At Round 3, of the adolescent girls who were randomly recruited – that is, not sampled due to having been married – 15% in East Hararghe, 6% in rural South Gondar, and none in Debre Tabor had been married when surveyed. For adolescent boys who were randomly recruited, the corresponding rates of marriage were 2% in East Hararghe, 0% in South Gondar, and 0.5% in Debre Tabor. Because the older rural cohort was not sampled randomly, similar figures cannot be computed.

Figure 17: Has ever been married, males

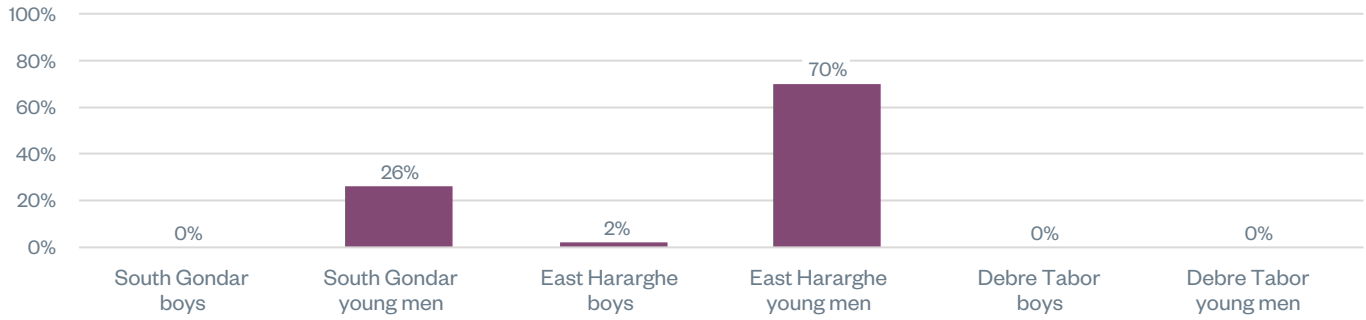
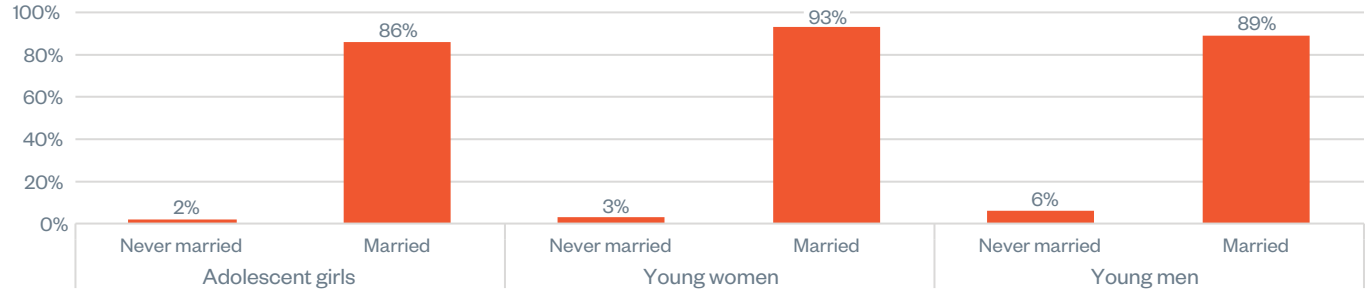


Figure 18: Has experienced sexual debut, by marital status



sexual activity was more common – but still rare – among males. Of young men, 6% of those who are never-married reported having had sex, compared with 89% of those who are (or have been) married.[9]

Qualitative findings

Qualitative evidence aligns with survey findings: for girls, sexual debut is related to marriage. A 16-year-old boy from East Hararghe explained, '*The girls get married early. They start sex early.*' Indeed, underscoring the importance of early sexual and reproductive health education, some girls in our sample in both East Hararghe and rural South Gondar experienced sexual debut years before menarche because they were married so young. A 15-year-old girl from South Gondar reported, *'Some girls married at just 9 or 10 … And most of the time they got pregnant at the age of 13.*'

Despite parents reporting that most girls become sexually active during mid-adolescence, regardless of whether they are married, girls and young women in all locations reported that voluntary premarital sexual activity is uncommon. A 16-year-old girl from South Gondar stated, *'There are some girls that have sex with the boyfriend, but most girls do not have premarital sex.' This is because, according to a 14-year-old girl from the same location, girls who have sex prior to marriage – even if they are raped – are 'cursed for being ruined'* (see also Presler-Marshall et al., 2024b). A religious leader in East Hararghe agreed:

> *There is a culture in our society which highly opposes a return of a girl to her family's house after she went with a boy. This is a great shame in our society … Her family will be happier if she died than seeing her come back home.*

That said, something that is clear from broader narratives – and which speaks to the need to scale-up youth-friendly sexual and reproductive health services that target unmarried adolescents – is that premarital sexual activity is likely more common than survey findings suggest. Although none of the unmarried girls and young women interviewed spoke about having a boyfriend, many mentioned friends who did. Similarly, although most boys and young men stated that they were not sexually active, quite a few reported that it is common among their peers to carry condoms, *'just in case'. A 15-year-old boy from rural South Gondar stated, 'Many youths have condoms in their pockets.'* A teacher noted that girls and young women are often pressured into early sex because they are poor:

> *The main cause that pushes girls to rush toward a relationship and to start sexual intercourse is economic problems – they have to fulfil what they need. For instance, as you know, most people here are poor, lead*

9 We cannot report on adolescent boys because too few reported ever being married or having had sex.

a hand-to-mouth type of life, so they can't afford to give their daughters clothes, shoes and other things.

Across locations, it is not uncommon for girls and young women to experience sexual debut as the result of violence. In South Gondar, this violence is generally perpetrated by strangers and is recognised as violence. Indeed, as noted in the GAGE companion midline report on bodily integrity, a full one-quarter of young women in rural South Gondar and urban Debre Tabor reported having experienced sexual violence by the time of Round 3 data collection (see Presler-Marshall et al., 2024c). A mother from Debre Tabor stated that *'any girl above the age of 10 can get raped'*. In East Hararghe, where the survey found that 'only' 8% of young women had experienced sexual violence, qualitative research found that this is because sexual violence is not recognised as sexual violence. This is partly because the perpetrators of sexual violence in East Hararghe are usually boys and young men that are known to girls (which means that parents, and girls themselves, blame girls for having been with those boys in the first place); and partly because girls 'give in' to sexual violence rather than endure the physical violence that would ensue if they resisted. A 16-year-old girl reported that: *'When it gets dark, boys want to have sex with girls, they beat the girl that refuses sex … They do not beat the girl that accepts…'.*

Knowledge of contraception and disease prevention

Survey findings for adolescents

The Round 3 survey found that a large majority of adolescents (79%) understand that getting pregnant in early adolescence can be dangerous for girls (see Figure 19). Both location and gender differences were significant. Adolescents in Debre Tabor (93%) were more likely to agree than their peers in East Hararghe (79%) and rural South Gondar (76%). In Debre Tabor and South Gondar, girls were significantly more likely than boys to agree that early pregnancy is dangerous. In East Hararghe, where adolescent girls were very likely to be married and concomitantly unlikely to be enrolled in school, the reverse was true and the gender gap was larger: 88% of boys but only 73% of girls agreed that early pregnancy can be dangerous. Adolescents' understanding of the risks of early pregnancy improved by 9 percentage points in the approximately 18 months between Round 2 and Round 3 data collection. Boys in East Hararghe experienced the largest gains in knowledge – 22 percentage points.

The Round 3 survey found that more than half of adolescents (61%) could name a form of modern contraception (see Figure 20). Location differences were again significant, with adolescents in Debre Tabor (86%)

Figure 19: Agrees that getting pregnant in early adolescence can be dangerous, adolescents

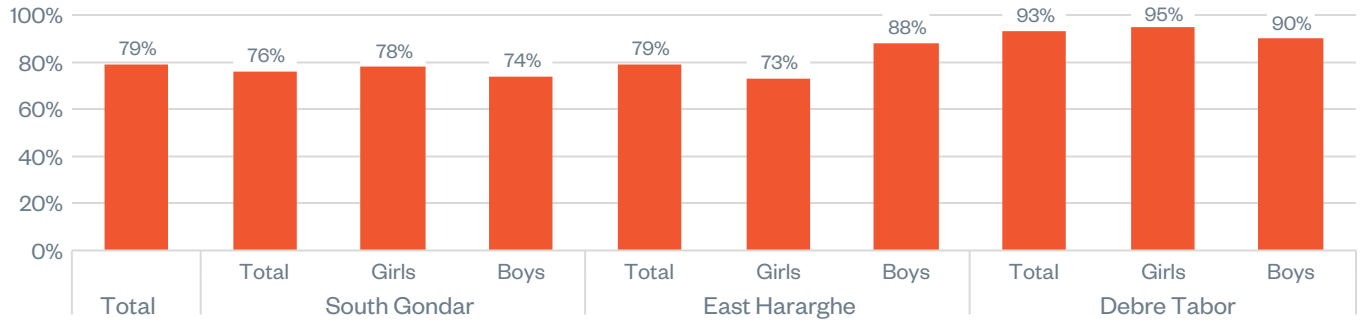
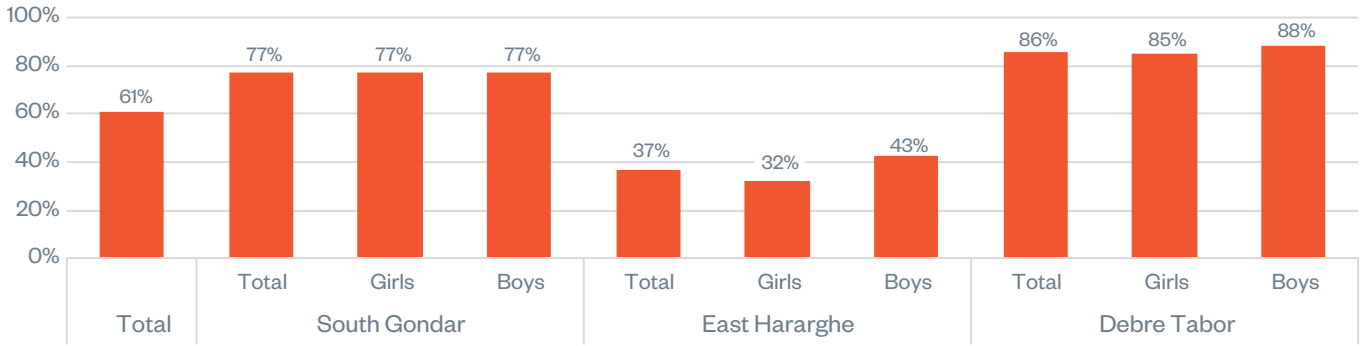


Figure 20: Can name a form of contraception, adolescents



and rural South Gondar (77%) far more likely to be able to name a method than their peers in East Hararghe (37%). Gender differences were significant only in East Hararghe, where boys (43%) were more likely than girls (32%) to be able to name a modern contraceptive method. In the approximately 18 months between Round 2 and Round 3, adolescents' ability to name a method climbed 14 percentage points. Although gains were large across the board, boys in East Hararghe showed the biggest improvements in knowledge (20 percentage points).

Aggregating across locations, ever-married girls (65%) were more likely to be able to name a form of modern contraception than their never-married peers (56%).

Survey findings for young adults

A large majority of young adults (84%) agreed that early pregnancy can be dangerous for girls (Figure 21). Although gender differences were not significant, location differences were. Young adults living in Debre Tabor (90%) and rural South Gondar (82%) were more likely to understand that early pregnancy can be dangerous than their peers in East Hararghe (77%).

The Round 3 survey found that most young adults (82%) could name a form of contraception (Figure 22). As was the case with adolescents, location differences were significant, with young adults in Debre Tabor (95%) and rural South Gondar (89%) more likely to be able to name a form of contraception than their peers in East Hararghe (58%). Gender differences were significant in Debre Tabor, where young women (97%) were more likely to be able to name a form than young men (92%), and in East Hararghe, where young men (68%) were much more likely to be able to name a form than young women (51%). Since Round 2, young adults' ability to name a form of modern contraception has improved by a significant 5 percentage points. Improvements were largely driven by young men, with those living in East Hararghe (18 percentage points) experiencing the largest knowledge gains.

Ever-married and never-married young women were equally able to name a method of modern contraception. Aggregating across locations, however, ever-married young men (75%) were less likely to be able to name a method than their never-married peers (86%).

Qualitative findings

During qualitative interviews, young people in all locations reported having learned at school that child marriage and adolescent pregnancy can be dangerous for girls. With the caveat that most girls in East Hararghe leave school in early adolescence before completing primary school, even girls in that location regularly reported having been exposed to school-based messaging. A 15-year-old girl from East

Figure 21: Agrees that getting pregnant in early adolescence can be dangerous, young adults

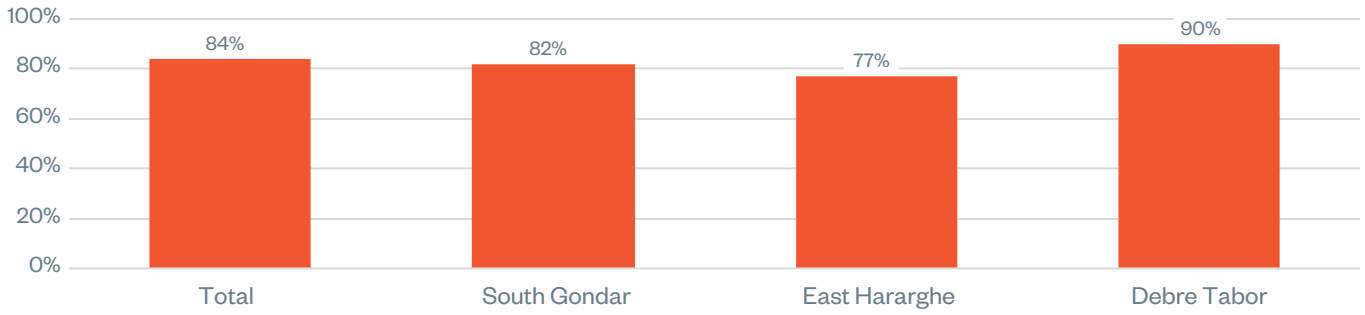
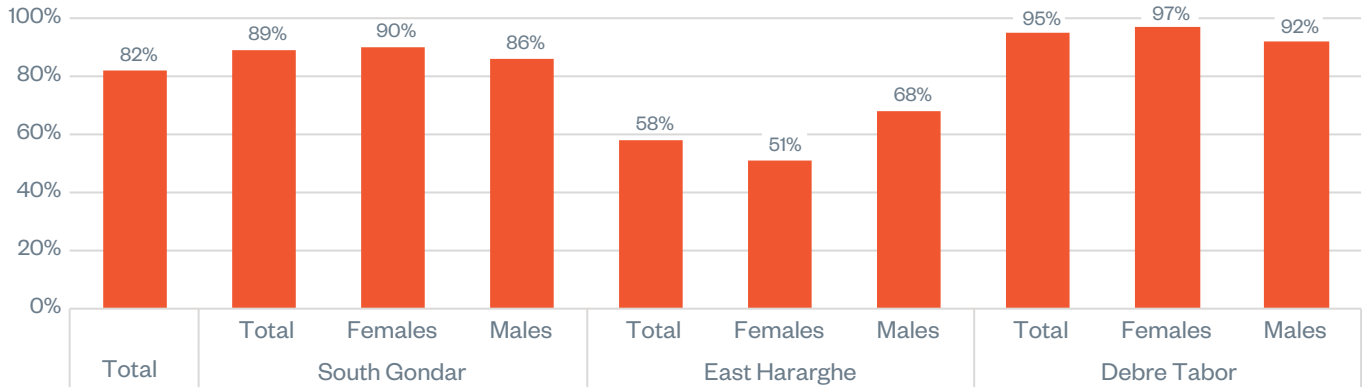


Figure 22: Can name a form of contraception, young adults



Hararghe explained, *'The teacher has collected girls and taught us about early marriage and the consequences of early marriage. If we get married early we might face difficulty during birth.'*

Only in urban Debre Tabor, however, did young people report having learned at school how to prevent pregnancy. A 14-year-old girl explained, *'We were taught about contraceptives in 8th grade. There are injections, pills, or the loop* [IUD]*.'* A mother added that it is important that adolescents learn about contraception in school, because parents do not discuss this topic at home: '*There is no open discussion within families. We do not have such tradition … if a girl asks her mother such question, that will raise suspicion that she has started a relationship.'* Even in Debre Tabor, however, young people reported that schools are not providing comprehensive – and practical – education about family planning. A 16-year-old girl explained that she relies on the media for information:

> *We had the education in biology and also in science at lower grades … We have the education but the education is not that much in detail. Mostly the teachers focus on condoms but not on the other contraceptive methods. The chapters in the books are also very short … Because of that, I tried to get the information from the media.*

Respondents in Debre Tabor also reported receiving school-based HIV education. A 16-year-old girl stated that:

> *Since we are grade 3 students, we have the education on HIV and AIDS almost in every subject. I think everyone knows about HIV and AIDS by now. We are told how it is still a problem for the country and also to protect ourselves from the disease.*

That said, several young people and parents added that HIV education has been deprioritised in recent years, due first to the pandemic and then to conflict-related violence. The father of an adolescent reported:

> *There is no awareness creation in schools, these days … The current situation of the country dominates the media and our discussion. Therefore, the education and health issues are not getting proper attention.*

Education and health key informants admitted that sexual and reproductive health education has fallen behind in recent years. A key informant with the Bureau of Health stated that:

> *A youth reproductive health club is established in each school. The club has connection with the youth reproduction department of the Bureau in practice and through reports. The students benefited from the services and were happy participating in the clubs … These days it is reduced.*

Uptake of contraception, and desired fertility

Survey findings for adolescents

Uptake of contraception among sexually active girls (n=330) varies by location. Girls in South Gondar (64%) were far more likely to have used a contraceptive method than their peers in East Hararghe (8%) (see Figure 23). Too few girls in Debre Tabor were sexually active to report. Looking only at sexually active married girls (n=283), uptake rates climb slightly, indicating that unmarried girls are more likely to have had unprotected sex than married girls. Regional differences were stark: in South Gondar, 67% of sexually active married girls reported that they had ever used contraception; the analogous figure in East Hararghe was 9%.

Rates of current uptake of any modern contraceptive method were similar to ever uptake. Sexually active girls in South Gondar (46%) were far more likely to be using a modern method than their peers in East Hararghe (6%) (see Figure 24). Marital status did not significantly affect rates of current use.

Figure 23: Ever used any method of contraception, sexually active adolescent girls only

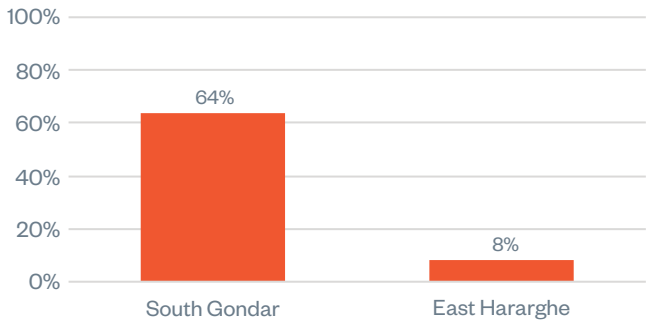
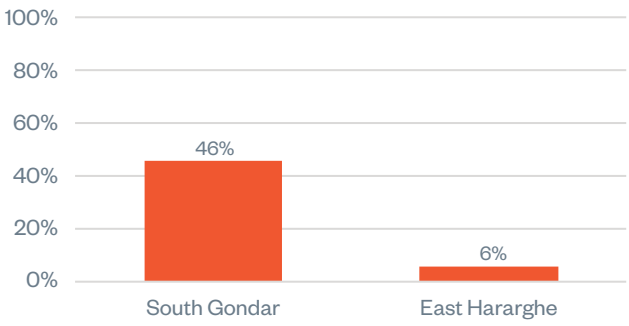


Figure 24: Currently using a modern method, sexually active adolescent girls only



Of sexually active girls currently using a modern method (n=51), nearly all (82%) were using short-acting hormonal methods (e.g. injections or pills), rather than long-acting hormonal methods (e.g. implants or intrauterine devices (IUDs). Condom use was rare among sexually active adolescents: in aggregate, only 3% reported that they had used a condom at the most recent sexual intercourse.

Uptake of contraception is shaped by adolescents' aspiration to have many children. In aggregate, adolescents reported wanting to have a mean of 4.9 children (see Figure 25). Adolescents in East Hararghe (6.3) wanted to have significantly more children than their peers in rural South Gondar (3.9) and Debre Tabor (3.1). In rural South Gondar, gender differences were significant (but not in East Hararghe or Debre Tabor). Boys wanted to have more children than girls: 4.2 versus 3.7.

Survey findings for young adults

Uptake of contraception among sexually active young adults (n=435) varies by sex and location. Young women (53%) were significantly more likely than young men (26%) to report that they (or their partner) had used a method. Young women in rural South Gondar (82%) and Debre Tabor (74%) were far more likely to report that they had ever used a method than their peers in East Hararghe (11%) (see Figure 26). Due to sample size constraints, it is only possible to report on young men's uptake in East Hararghe, where 14% of sexually active young men report having ever used a method in conjunction with their partner.

Current uptake of any modern method is similar, albeit lower than ever uptake. Sexually active young women in Debre Tabor (53%) and rural South Gondar (43%) were more likely to report current use than their peers in East Hararghe (8%) (see Figure 27). Only 2% of sexually active young men in East Hararghe reported that they or their partner were currently using a modern method. For young adults, as with adolescents, marital status does not significantly affect current use of a modern contraceptive method.

Of sexually active young women currently using a modern contraceptive method, nearly all (84%) were using short-acting hormonal methods (e.g. injections or pills),

Figure 25: Desired number of children, adolescents

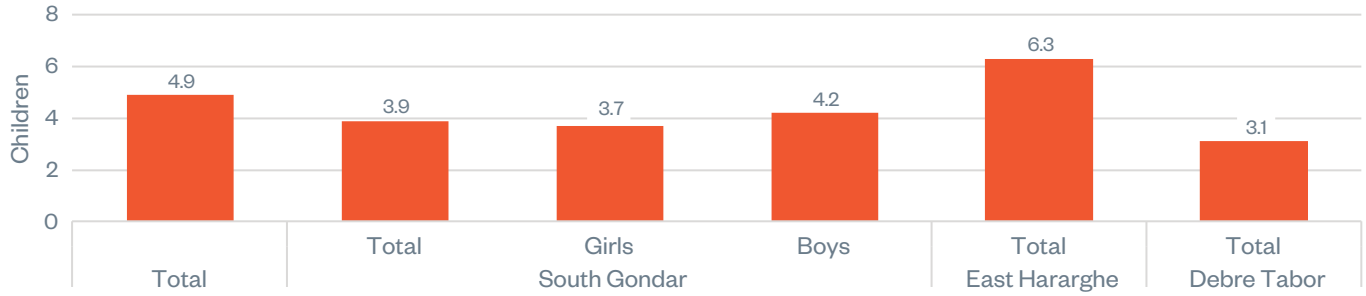


Figure 26: Ever used any method of contraception, sexually active young adults

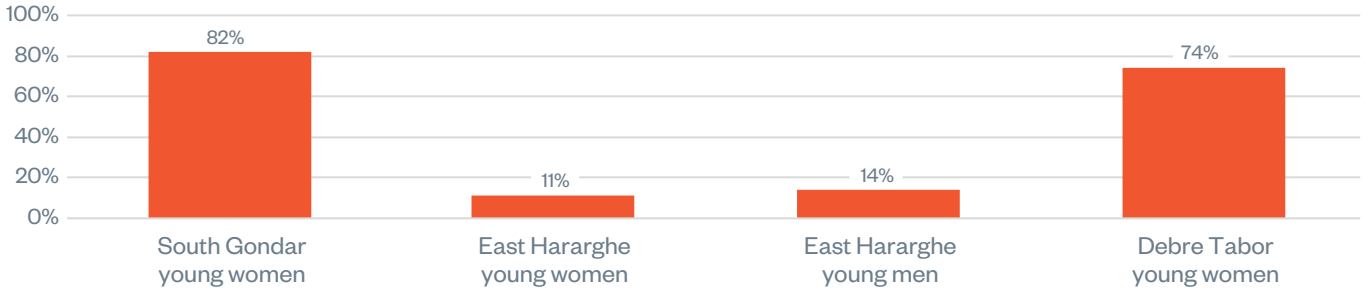
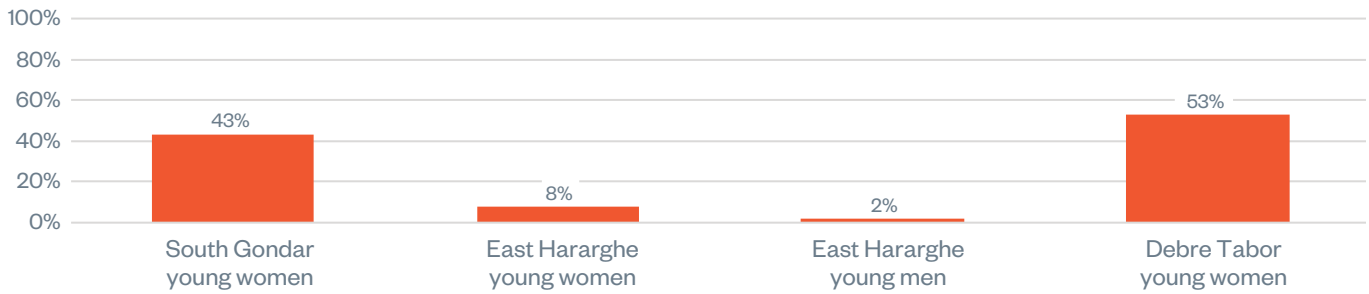


Figure 27: Currently using a modern method, sexually active young adults



rather than long-acting methods (e.g. implants or IUDs). Condom use was rare among sexually active young adults: in aggregate, only 3% of young adults reported that they had used a condom at the most recent sexual intercourse. Use in Debre Tabor (19%) was far higher than that reported in South Gondar and East Hararghe (1%).

As with adolescents, uptake of contraception is shaped by young adults' desire to have many children. In aggregate, adults reported wanted to have a mean of 4.7 children (see Figure 28). Young adults in East Hararghe (7) wanted to have more children than their peers in rural South Gondar (4) and Debre Tabor (3.5). In South Gondar, gender differences were significant; young men wanted to have more children than young women (4.3 versus 3.8).

Qualitative findings

During qualitative interviews, young people in Debre Tabor and rural South Gondar reported that contraception is widely available in the community and is used by married and unmarried young people alike. They noted that all contraceptive forms are available at pharmacies and health clinics; that costs (if any) are low; and that there is little stigma surrounding use. A 16-year-old girl from Debre Tabor stated, *'All the contraceptive methods are available at the pharmacy or clinics.'* However, this is not the case in East Hararghe, where very few young people spoke of being aware of contraception and none spoke of using it.

Young wives in South Gondar reported using contraception to delay their first pregnancy so that their body has a chance to mature, and also to ensure that they had the financial resources to support a child. A 20-year-old young woman from Debre Tabor, who was married at 17, explained that she and her husband had talked about parenthood, but had decided to wait:

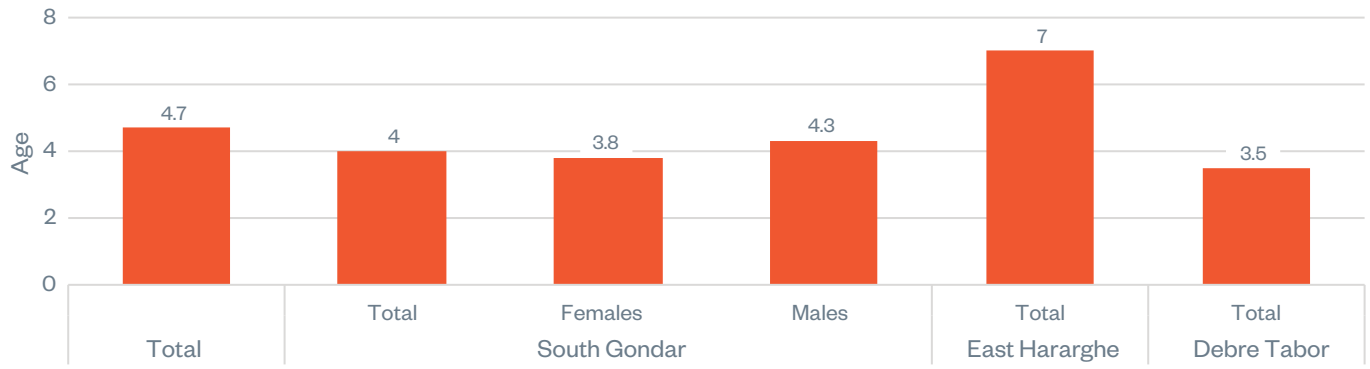
> *I start using contraceptives immediately after marriage … We talk about having kids … but we drop the idea when we think about our problems … We don't even support us well. How could we add another person into this life?*

Narratives about unmarried females' uptake of contraception in South Gondar, especially in rural areas, almost universally revolved around protection from pregnancy in the event of rape, which becomes more likely once girls begin secondary school, when they must either board at school or endure long daily commutes. A 16-year-old girl reported that girls themselves seek out contraception, without consulting their parents: *'Girls do not consult parents to use contraceptive … because she is afraid to get raped. She is afraid of getting criticised for pregnancy by the community and the shame that it brings to parents.'* An 18-year-old young man from the same location added that when parents become aware of their daughters' contraceptive use, many are supportive because they too understand the risks girls face:

> *Most of the girls start using the contraceptives when they join high school because they must walk to the school, which is far from home, and the probability of rape is higher … The people will assume she started using the contraceptive because she wanted to start having sex. But if her parents asked her about the contraceptives, she will tell them that she started using the contraceptives because she doesn't want to get pregnant if someone raped her. Currently, even the parents are advising their daughters to use the contraceptives because they know it will prevent unwanted pregnancy.*

Girls and young women in Debre Tabor and rural South Gondar primarily explained their strong preference for injectable contraceptives in terms of the side effects of other methods. A 20-year-old young woman, currently using quarterly injections, reported, *'I tried the pill but I can't handle the side effects. I had dyspepsia* [stomach

Figure 28: Desired number of children, young adults



pain] *and the pill aggravated the symptoms.'* IUDs and 3-year implants were especially singled out by females as being dangerous. Whereas some girls and young women reported that these methods *'change your behaviour … make you angry and very emotional,'* others reported that they result in sterility, '*especially for poor people*'. A mother from Debre Tabor added that for unmarried girls trying to hide their contraceptive use from parents, and young wives trying to hide their use from their husband, quarterly injections have another benefit as well: *'If they take monthly pills, they will get caught.'*

In Debre Tabor, adults reported that emergency contraception is provided primarily to boys and young men – rather than to the girls and young women who might fall pregnant without it. A health care worker explained that this is because females are embarrassed to come to the clinic for emergency contraception: *'It is usually boys that we see. They even come to ask for emergency contraceptives … Girls are usually shy and afraid to ask for such services.'*

Despite largely positive reports of contraceptive availability and uptake in Debre Tabor and rural South Gondar, a minority of respondents – including multiple key informants – noted that gaps are large and have grown in recent years, as government priorities shifted first to the Covid-19 pandemic and then to the conflict that broke out in Tigray in late 2020. An 18-year-old young man from rural South Gondar reported that his friends rarely use condoms:

> *Very few boys use condoms to protect themselves and their girlfriends from HIV and other STIs* [sexually transmitted infections]. *Most girls and boys do not take care for themselves and do not use condom to protect themselves from HIV.*

Although a mother from Debre Tabor noted that this is usually because boys and young men '*are driven by impulse*' and find it *'difficult to ask for condoms for themselves', a* health key informant admitted that *'Our major problem is shortage of condoms. In the last two years, we received no condoms.'*

Youth-friendly services are also in short supply outside of Debre Tabor. One health key informant explained:

> *There are services such as family planning given to older adolescents … classes are located in a secluded place and there is a waiting room for adolescents where they can watch TV or read as they wait. But there is no such infrastructure at the kebele* [community] *level.*

Another health key informant added that despite training, some health care workers are not providing services in a youth-friendly manner. He stated:

> *Even if we are trained to be accommodating and non-judgmental, some cannot help it but show it in their gesture and treatment. They say 'why are these girls asking for contraceptive at this age?' and so.*

In East Hararghe, even many health care workers believe that girls and young women should never use contraception until they have demonstrated their fertility by having at least one child. One health worker stated, *'They get married to have children. They don't take contraceptives before giving birth.'* Another said:

> *It is impossible for the unmarried girls to use contraceptives in our area. It is also not allowed for married girls who do not have their first child to use contraceptives. We, as the health extension workers, do not encourage unmarried and those who have married recently to use family planning.*

Although a third health care worker stated that condoms are readily available in the community, because *'at our health centre, we place condoms outside where people know and can see,'* he soon admitted that uptake is effectively non-existent, because *'it is taboo even to touch it with hand'.*

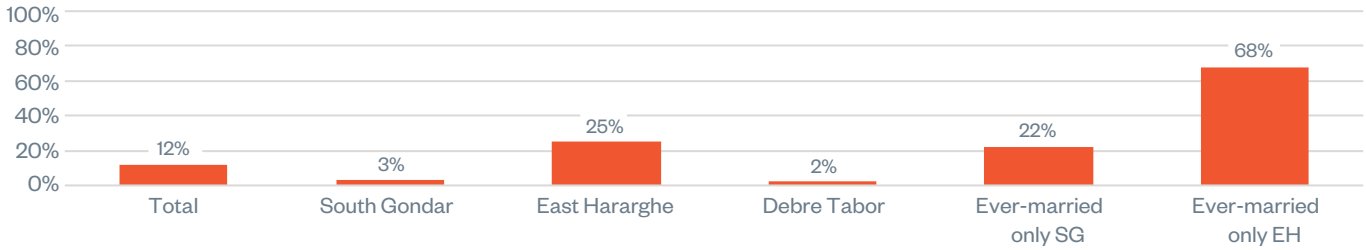
Pregnancy and motherhood

Survey findings for adolescents

The Round 3 survey found that pregnancy rates mirror marriage rates. In aggregate, 12% of adolescent girls have ever been pregnant (see Figure 29). Location differences were highly significant. For girls in Debre Tabor (2%) and rural South Gondar (3%), pregnancy was rare. For girls in East Hararghe (25%), however, it was common. Across locations, young mothers were a mean of 14.8 years old when they first became pregnant. Unsurprisingly, pregnancy rates are higher when looking only at ever-married girls. Ever-married girls in East Hararghe, who are more likely to be married and less likely to use contraception than their peers in the other two locations, were far more likely to have been pregnant than ever-married girls in South Gondar (68% versus 22%).

In aggregate, just over a quarter (26%) of adolescents reported on the Round 3 survey that they knew of a place to access abortion services (see Figure 30). Location

Figure 29: Has ever been pregnant, adolescent girls



differences were highly significant. Awareness was far higher in urban Debre Tabor (55%) than in rural South Gondar (32%) and East Hararghe (13%). Gender differences were significant only in South Gondar, where girls (36%) were more likely to know a place than boys (27%).

Of the adolescents who were aware of a place to access abortion services, most (71%) reported that those services were accessible to adolescents (see Figure 31). Accessibility was reported as significantly higher in Debre Tabor (94%) than in South Gondar (74%) and especially in East Hararghe (45%). In rural areas, girls were significantly more likely to report that services were accessible than boys.

Survey findings for young adults

The Round 3 survey found that nearly half (48%) of young women have been pregnant (see Figure 32). Pregnancy is far more common in rural areas, where young women marry early, than in Debre Tabor (16%) and is more common in East Hararghe (77%) than in rural South Gondar (54%). In South Gondar, young mothers were a mean of 17.4 years old when they first became pregnant. In East Hararghe, they were significantly younger – a mean of 15.9 years old. Looking only at ever-married young women, and unsurprising given location differences in contraceptive uptake, nearly all young women in East

Figure 30: Knows a place to access abortion, adolescents

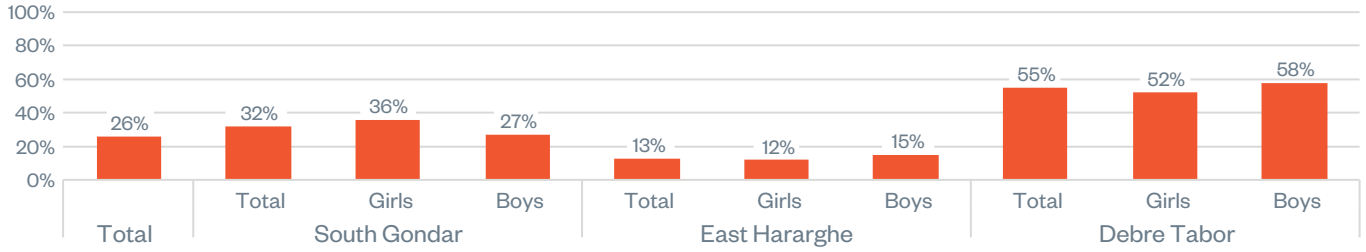


Figure 31: Abortion services are accessible, of adolescents reporting awareness

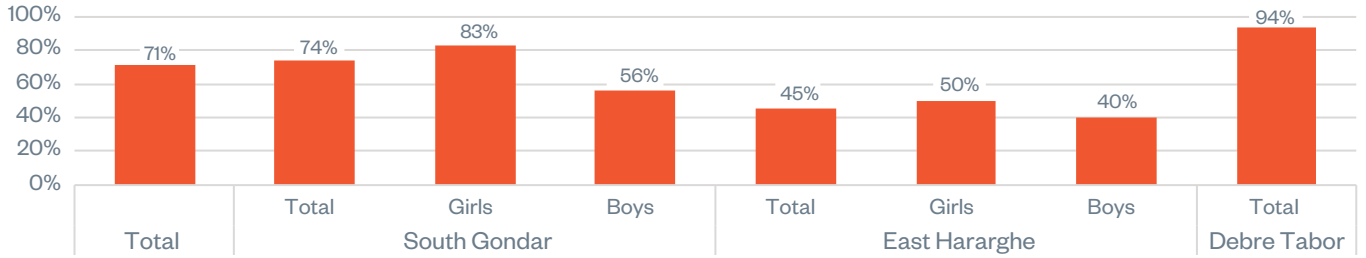
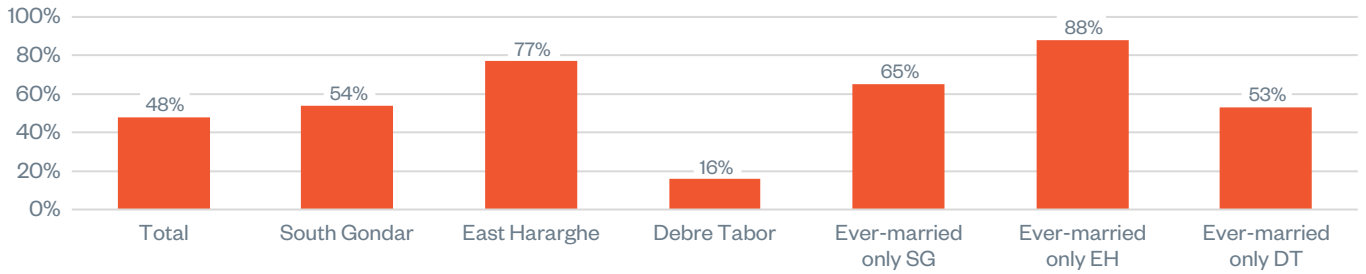


Figure 32: Has ever been pregnant, young women



Hararghe (88%) had begun childbearing, compared to two-thirds in rural South Gondar (65%) and half in Debre Tabor (53%).

Just over one-third (37%) of young adults knew of a place to access abortion (see Figure 33). As was the case with adolescents, location differences were highly significant, with those in Debre Tabor (63%) more aware than those in South Gondar (30%) and East Hararghe (13%). Gender differences were significant in both South Gondar and East Hararghe; young women in those locations were more aware of abortion services than young men.

Of young adults who reported knowing of a place to access abortion services, most (88%) reported that services were accessible (see Figure 34). Young adults in Debre Tabor (96%) were significantly more likely to report that services were accessible than their peers in rural South Gondar (81%) and East Hararghe (68%). Gender differences were not significant.

Qualitative findings

Because the Round 3 qualitative sample included very few young people who had been married, nearly all respondents who spoke of pregnancy spoke of unintended premarital pregnancies. These were, respondents agreed, so stigmatised that some girls take their own life to avoid community censure. A 17-year-old boy from Debre Tabor reported, *'Females commit suicide when they got pregnant because they feel ashamed in the community.'* A father from the same location agreed, '*We all know two girls among our neighbours who drank poison and died due to unwanted pregnancies.'*

Health key informants reported that abortion services are increasingly available – albeit only in more urban areas and for those in the very early stages of pregnancy. One key informant explained that demand is higher than supply can accommodate:

> *Abortion service is packaged in the health centres … centres perform abortions for a foetus before two months old … The demand of the service is very high … Customers come even from neighbouring woredas* [administrative divisions]. *In fact, these days we are facing shortage of instruments for performing abortion and kits for abortion. The service is being given but more is required.*

Another key informant stated that this is, in part, because health centres in more rural areas often refuse to provide abortion services because '*even if health professionals are trained … they believe that abortion is a sin in our religion*.' A mother in Debre Tabor noted that even in the city, many girls and young women are forced to rely on illegal abortions, in part because they believe these to be more secret but in part because of the attitudes of health care providers. She explained, '*Girls will be asked to bring their family or boyfriend or husband … doctors prefer to find ways to have the baby than have abortion as an option.'*

Figure 33: Knows a place to access abortion, young adults

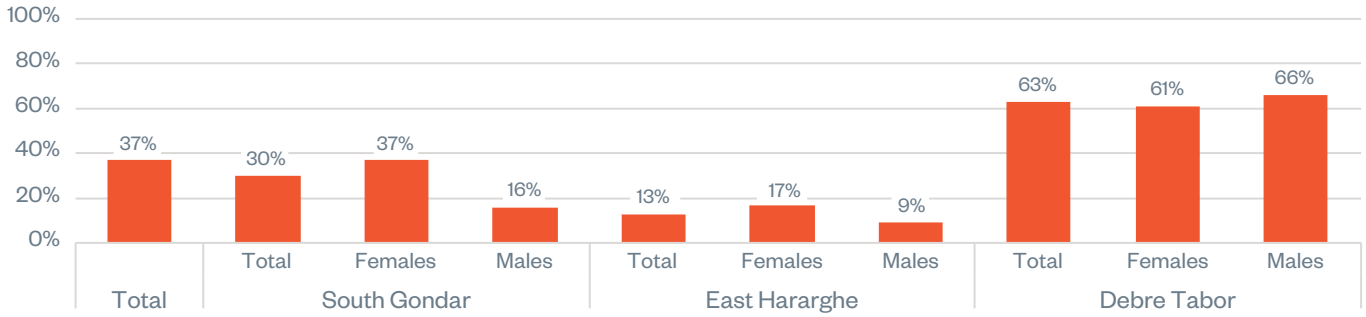
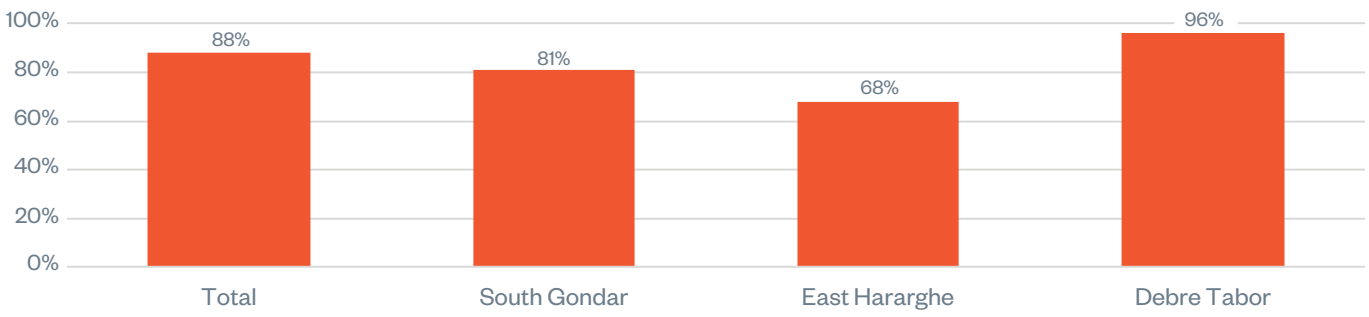


Figure 34: Abortion services are accessible, of young adults who reported awareness



Intimate partner violence

Survey findings for adolescents

The GAGE quantitative surveys collect information on a wide range of attitudes related to gender, including attitudes to intimate partner violence (IPV). The Round 3 survey found that a large majority (85%) of adolescents agreed that a woman should always obey her husband (see Figure 35). Location differences were significant, with adolescents in East Hararghe (94%) more likely to agree than their peers in South Gondar (81%) and Debre Tabor (53%). Gender differences were not significant in aggregate, but this is because patterning varies by location. In East Hararghe, girls were more likely than boys to report that a woman should always obey her husband (97% versus 90%). In rural South Gondar and urban Debre Tabor, the reverse is true.

Half of adolescents (50%) agreed that intimate partner violence is a private matter and should not be discussed outside the home. Location differences were again significant, and mirror young people's beliefs about women's obedience.

Just over a third (36%) of adolescents agreed that intimate partner violence is an acceptable way for a man to mould his wife's behaviour. Location differences were significant, with adolescents in East Hararghe (42%) more likely to agree than their peers in rural South Gondar (34%) and urban Debre Tabor (9%). Gender differences were significant in East Hararghe, where girls were more likely than boys to agree with the statement (44% versus 39%), and in South Gondar, where boys were more likely than girls to agree (39% versus 31%).

In the approximately 18 months between the Round 2 and Round 3 surveys, adolescents' beliefs about women's obedience and intimate partner violence being a private matter have remained stagnant. However, there have been some changes in beliefs about the acceptability of intimate partner violence. Girls and boys in all locations were significantly less likely to agree with the statement that 'intimate partner violence is acceptable' at Round 3 than they were at Round 2. Declines were much larger in East Hararghe than in other locations: girls were 43 percentage points less likely to agree, while boys were 32 percentage points less likely to agree.

Survey findings for young adults

At Round 3, a large majority (76%) of young adults agreed that a woman should always obey her husband (see Figure 36). Location differences were significant, with young adults in East Hararghe (97%) most likely to agree, and those in Debre Tabor (45%) least likely. In all locations, young men were more likely than young women to agree that wives should be obedient.

Just over half (51%) of young adults agreed that intimate partner violence should be kept as a private matter. Location differences were again significant, with young adults in East Hararghe (74%) most likely to agree. Gender differences were significant only in East Hararghe, where young men were far more likely than young women to agree (91% versus 62%). In South Gondar, the proportion of young women who agreed that intimate partner violence should remain private was higher than the proportion of young men who agreed with that statement. Just under a third (31%) of young adults agreed that intimate partner violence is an acceptable way for a man to mould his wife's behaviour; rates were much higher in the rural locations, and there were limited differences by gender in each location.

Figure 35: Adolescents' beliefs about intimate partner violence

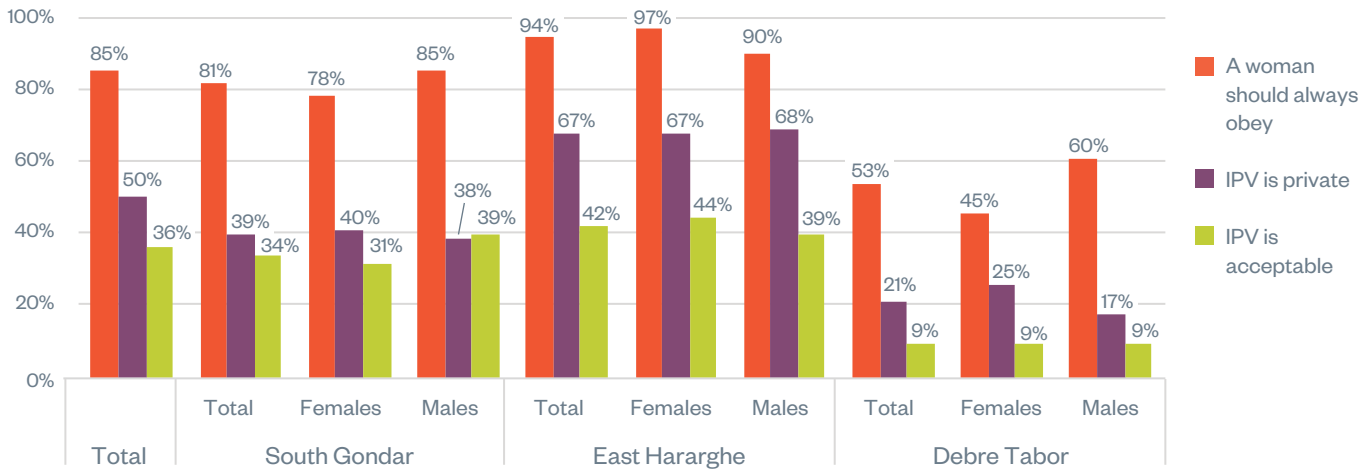
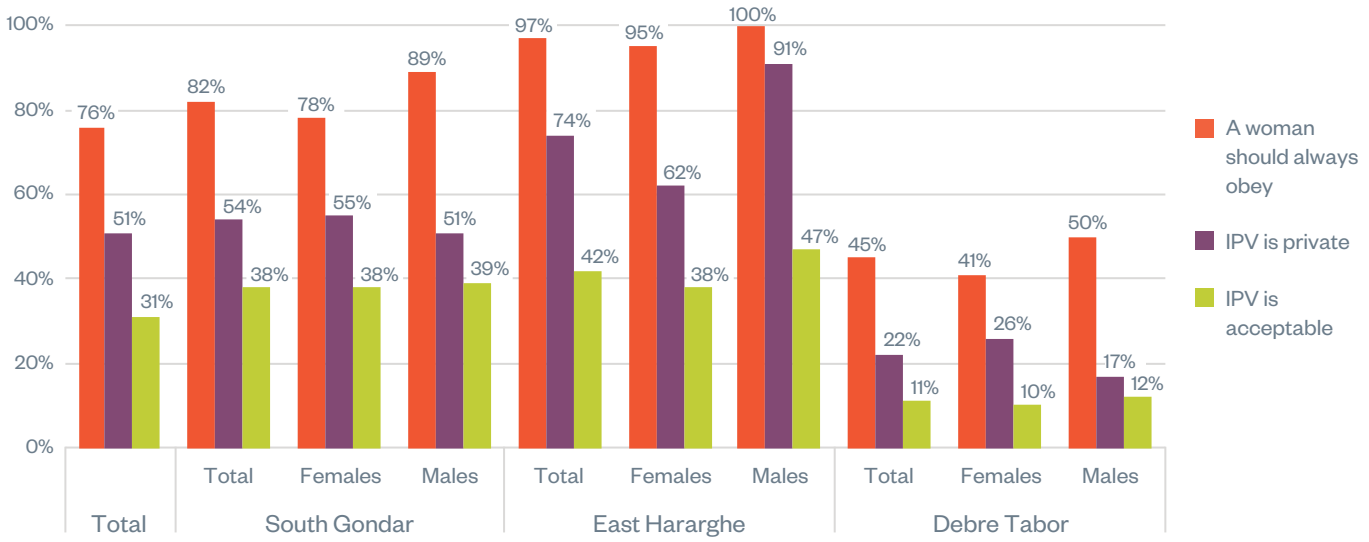


Figure 36: Young adults' beliefs about intimate partner violence



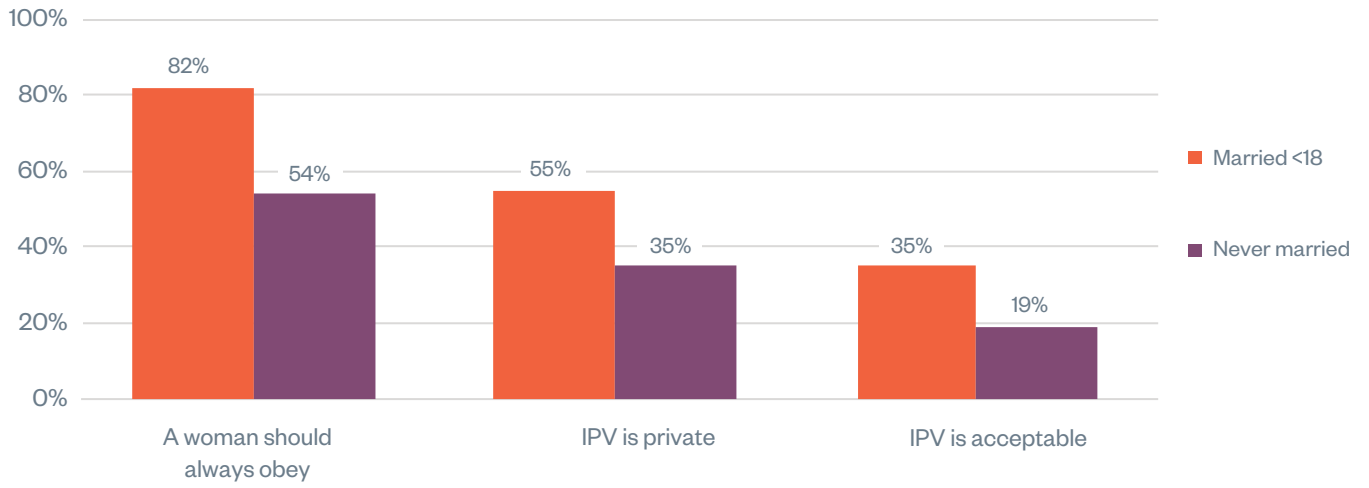
The survey also found that young women who married before age 18 were more likely than their peers who had never married to believe that a wife should always obey her husband (82% versus 54%) (see Figure 37 below). They were also more likely to believe that intimate partner violence is private (55% versus 35%), and that it is an acceptable way for a man to mould his wife's behaviour (35% versus 19%).

Young adults in East Hararghe were much less likely to agree that intimate partner violence is acceptable at Round 3 than they were at Round 2. There was a 23 percentage point decline for young women and a 27 percentage point decline for young men. At Round 3, young adults were also less likely to believe that intimate partner violence should be kept private. There were declines of approximately 10 percentage points for young women in South Gondar and Debre Tabor and young men in East Hararghe.

Qualitative findings

During individual and group interviews, young people agreed that *'insulting women is a very common phenomenon among husbands'* (16-year-old boy, South Gondar) and that *'there are those who beat very much very hard'* (14-year-old boy, East Hararghe). They also agreed that intimate partner violence is under-reported, because it is seen as men's right and because it is considered private. An 18-year-old young man from East Hararghe stated that *'as per our culture, a man has the right to show his wife the right direction … Once the female is married,* [there is] *nothing they can say.'* An 18-year-old young woman from South Gondar concurred. When asked if she would report her husband if he beat her, she replied: *'I will not report him … I decided to be with him when I decided to get married.'* A 16-year-old girl from East Hararghe added that marital rape is also un-reportable: '*It is not culturally acceptable to*

Figure 37: Young women's beliefs about intimate partner violence, by marital status



complain about rape within marriage. She keeps the issue for herself, she does not share it with anyone.'

Respondents reported that young wives who do feel able to disclose intimate partner violence have few sources of support. A 12-year-old boy from East Hararghe, for example, recalled that when his sister fled her marital home, to escape her violent husband, their father beat her until she returned to it:

> *My sister refused to stay with her husband. He was beating her all the time, then she had fled to our home several times … My father beat my sister three days with a stick.*

A 15-year-old girl from South Gondar reported that it took the extreme measure of her attempting suicide before her parents allowed her to leave her violent husband: *'I tried to commit suicide also. So they allowed the divorce after that.'* Although in Debre Tabor a key informant with the Bureau of Women, Children and Youth reported that the office manages cases of intimate partner violence in collaboration with the justice office, a Bureau of Justice official admitted that this primarily consists of *'helping them resolve their problems and reconcile through community elders'*. Indeed, an 18-year-old young man from East Hararghe explained that no matter how badly injured a woman may be, *'officials say nothing. Unless they will be divorced, they may not take it to court.'*

Conclusions and implications

Our findings underscore that Ethiopian young people have limited – and highly uneven – access to sexual and reproductive health information, services and supplies, with often large disparities between females and males, across regions, and by rural and urban residence. Across most metrics, girls and young women living in East Hararghe stand out as the most disadvantaged.

In terms of access to timely puberty education, cultural taboos mean that only a minority of young people receive any information from their parents about how their body will change and develop. Most young people instead report learning about puberty and reproductive biology at school. Adolescents in East Hararghe have more limited access to information than their peers in other locations. This is especially the case for girls, who tend to have minimal communication with their parents and regularly leave school during early adolescence (before puberty), due to parental demands on girls' time and labour. Improvements in young people's knowledge between Round 2 (2019–2020) and Round 3 (2021–2022) are related not only to their maturity and increased exposure to information at school, but also to Act with Her, an empowerment programme delivered to adolescents by two international NGOs, Pathfinder and CARE.

Wusha Tirs Girls Club, Amhara, Ethiopia © Nathalie Bertrams/GAGE 2024

In terms of environments supportive of good menstrual health, there have been substantial improvements since Round 2 in girls' and young women's use and disposal of hygienic sanitary products. There have also been improvements in knowledge about menstruation and reductions in the stigma that surrounds it. These are largely related to the efforts of school-based girls' and gender clubs, and Act with Her programming. That said, girls and young women – especially those in East Hararghe – still regularly report that they are afraid or embarrassed to ask family members for support in managing their periods.

Early sexual debut is overwhelmingly the result of child marriage. Accordingly, girls and young women – again, especially those in East Hararghe – are more likely to be sexually experienced than boys and young men. Premarital sex, which is deeply stigmatised, is uncommon, especially for girls and young women.

Due to young people's maturation – and the efforts of teachers and health extension workers – there have also been substantial improvements in young people's awareness of contraceptives since Round 2. Awareness is more limited in East Hararghe, especially among girls and young women. This is because females are often out of school and because health extension workers are hesitant to contravene local norms that preclude using contraception prior to motherhood. However, uptake of contraceptives is high among young wives in rural South Gondar and urban Debre Tabor, where messaging about the importance of delayed and spaced pregnancy is common and accepted. Uptake is very low in East Hararghe, because girls and young women are expected to demonstrate their fertility immediately after marriage, and because young people want large families. In rural South Gondar, where rape is common, girls who are not sexually active regularly use contraception to prevent pregnancy should they be assaulted.

Due to high rates of child marriage, early pregnancy is common. This is especially the case in East Hararghe, where girls tend to be married younger and where contraceptive use is frowned upon. Premarital pregnancy is not uncommon, is primarily due to rape, and is deeply stigmatised in all locations. Despite this, a minority of young people are aware that abortion services are available. Awareness is lowest in East Hararghe.

Intimate partner violence is common and supported by social norms that position men as the arbiters of their wives' behaviour, and position violence in the home as a private matter. These norms are especially strong in East Hararghe. Girls and young women who are experiencing intimate partner violence have only limited options for redress, with even their parents often declining to intervene.

Based on our research, we suggest the following key policy and programmatic actions to accelerate progress in young people's access to their full sexual and reproductive health rights:

To better support adolescents through puberty and help girls manage their periods:

- Use school and community-based classes (including through girls' clubs and gender clubs) to provide adolescents, including those with disabilities, with accurate and timely information about their maturing bodies.
- Work with boys to reduce menstruation-related stigma.
- Work with parents to improve their knowledge about adolescent development and their comfort with discussing puberty – and specifically menstruation – with their children.
- Ensure that girls are offered practical advice, in school-based and community-based venues, about how to manage menstruation (including how to make sanitary supplies and how to dispose of sanitary products hygienically).
- Ensure that all schools have spaces and supplies that female students, including those with disabilities, can use to manage their periods.

To improve young people's knowledge about sexual and reproductive health and uptake of contraception and services:

- Provide all adolescents, including those with disabilities, with age-appropriate, iterative and comprehensive sexuality education beginning no later than age 10 (it should include detailed information about reproductive biology, contraception, and HIV). Courses should be provided at school and in the community, and should be delivered in ways that encourage young people to ask questions, by teachers trained to answer those questions without judgement.
- Ensure that adolescents are taught (as part of the curriculum, in girls' clubs and gender clubs, and by health extension workers) the health risks of adolescent pregnancy and the multi-generational social and economic risks of early parenthood. This messaging should be 'standalone' and aimed at decoupling

child marriage and early pregnancy, especially in East Hararghe, where social norms push girls to demonstrate their fertility immediately after marriage.

- Use marriage as a point of intervention to work with couples to ensure that partners are knowledgeable about reproductive biology and their options for preventing pregnancy and disease. Officials could consider learning from the experience of Jordan, where the Shariah Court now offers counselling to couples (and mandatory counselling in the case of child marriages), including around sexual and reproductive health and well-being; this could be delivered by trained social workers and/or health extension workers.
- Encourage health workers to disseminate information about contraception even in areas where it is not yet welcome, taking care to work with girls and women to find methods that meet their needs and directly address their concerns about side-effects. They should also proactively target men and boys with information and advice.
- Ensure that health extension workers offer a full array of youth-friendly sexual and reproductive health services, including information, contraception (and condoms), HIV testing and treatment, and referral for abortion services. Consider making condoms available at youth centres and in schools, and consider having basic sexual and reproductive health services delivered through regularly scheduled school-based clinics.
- Ensure that abortion services are publicised at the kebele (community) level and that girls in rural areas have access to the transport that would make those services truly accessible. Pair this with stepped-up policing (especially around schools) to protect girls and young women from rape, and with awareness-raising campaigns designed to eliminate the blame that is attached to survivors of sexual violence.
- For outreach activities, consider involving the adolescent and youth councils that have been established at regional level to support improved knowledge around sexual and reproductive health issues.

To eliminate child marriage:

- Adopt a multi-pronged strategy to step-up school and community-based awareness-raising about the negative health, educational, economic and social impacts of child marriage, as well as addressing broader discriminatory gender norms and how these leave girls at risk of child marriage.
- Invest in empowerment programming for girls, including school-based girls' clubs and gender clubs, which can help girls protect themselves and their peers from child marriage. Programming must be carefully tailored to account for local practices – for example, whether marriages are adolescent-led or arranged by families.
- Provide tailored outreach to girls, especially in rural areas, about how they can report risks of impending child marriages; simultaneously, strengthen reporting chains and ensure that reports are acted upon.
- Enforce the child marriage law, including fining the parents of under-age partners, religious leaders who officiate, and adult husbands.
- Invest in capacity-building of local government officials at district and community levels so that they are aware of the provisions of the Family Law in banning child marriage, and how they can practically strengthen its implementation.

To reduce intimate partner violence:

- Invest in community conversations and mass media campaigns that address discriminatory gender norms, including the widely held beliefs that wives must obey their husband, that intimate partner violence is private, and that violence is an acceptable form of control.
- Educate parents about their responsibility to their daughters, even after they may be married, including supporting them to report intimate partner violence and seek support from one-stop centres.
- Provide tailored outreach about how girls and women experiencing intimate partner violence can report and seek support. Provide boys and young men with programming designed to encourage non-violent masculinities and address their mistaken beliefs that they have the right to be violent towards their wife.
- Expand access to one-stop centres, to ensure that survivors of intimate partner violence can receive integrated health, legal and psychosocial support.
- Strengthen the role of civil society organisations (e.g. the Ethiopian Human Rights Commission and the Ethiopian Women Lawyers Association) in addressing all forms of gender-based violence, including intimate partner violence.
- Strengthen the rule of law, ensuring that perpetrators of intimate partner violence are prosecuted and imprisoned, rather than relying on traditional justice systems, which almost universally favour men.

References

Baird, S., Hamory, J., Jones, N. and Woldehanna, T. (2020) 'Multi-level programming aimed at gender norms transformation to improve capabilities of young adolescents in Ethiopia: a cluster randomized control trial.' Pre-Analysis Plan. London: Gender and Adolescence: Global Evidence

Baird, S., Hamory, J., Gezahegne, K., Pincock, K., Woldehanna, T., Yadete, W. and Jones, N. (2022) 'Improving mental health literacy through life-skills programming in rural Ethiopia' *Frontiers in Global Women's Health* (https://doi.org/10.3389/fgwh.2022.838961)

Central Statistical Agency of Ethiopia (CSA) and ICF (2017) *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF (https://dhsprogram.com/pubs/pdf/FR328/FR328.pdf)

Hamory, J., Baird, S., Das, S., Jones, N., Woldehanna, T. and Yadete, W. (2023) 'Do layered adolescent-centric interventions improve girls' capabilities? Evidence from a mixed-methods cluster randomised controlled trial in Ethiopia.' AEA RCT Registry (www.gage.odi.org/publication/near-term-impacts-of-interventions-aimed-at-adolescent-empowerment-and-gender-norm-change-in-ethiopia)

Hamory, J., Das, S., Baird, S., Jones, N., Yadete, W. and Woldehanna, T. (2024) *GAGE Ethiopia Round 3 (2022). Core respondent module (a-e)*. London: Gender and Adolescence: Global Evidence (https://www.gage.odi.org/publication/ethiopia-round-3-survey-2021-2022)

Jones, N., Baird, S., Hicks, J., Presler-Marshall, E., Woldehanna, T. and Yadete, W. (2019a) *Adolescent well-being in Ethiopia: exploring gendered capabilities, contexts and change strategies*. A synthesis report on GAGE Ethiopia baseline findings, 2019. London: Gender and Adolescence: Global Evidence (https://www.gage.odi.org/publication/adolescent-well-being-in-ethiopia-exploring-gendered-capabilities-contexts-and-change-strategies/)

Jones, N., Presler-Marshall, E., Hicks, J., Baird, S., Chuta, N. and Gezahegne, K. (2019b) *Adolescent health, nutrition, and sexual and reproductive health in Ethiopia*. A report on GAGE Ethiopia baseline findings. London: Gender and Adolescence: Global Evidence (https://www.gage.odi.org/publication/adolescent-health-nutrition-and-sexual-and-reproductive-health-in-ethiopia)

Jones, N., Pincock, K., Yadete, W., Negussie, M., Mitiku, E. and AmdeSelassie, T. (2022) 'Sexual and reproductive health and rights in the era of COVID-19: a qualitative study of the experiences of vulnerable urban youth in Ethiopia' *Sexual Health* 19(6): 509–516 (https://pubmed.ncbi.nlm.nih.gov/35995265/)

Jones, N., Presler-Marshall, E., Tilahun, K. and W. Yadete. (2024) *Qualitative research toolkit: Round 3 Ethiopia*. London: Gender and Adolescence: Global Evidence (https://www.gage.odi.org/wp-content/uploads/2024/03/Ethiopian-Qualitative-Toolkit.pdf)

Kabeer, N. (2003) *Making rights work for the poor: Nijera Kori and the construction of 'collective capabilities' in rural Bangladesh*. Working Paper 200. Brighton: Institute of Development Studies

Ministry of Health (2021) National Adolescents and Youth Health Strategy (2021–2025). Addis Ababa: Ministry of Health, Federal Democratic Republic of Ethiopia (https://www.moh.gov.et/sites/default/files/2024-04/NATIONAL%20ADOLESCENTS%20AND%20YOUTH%20HEALTH%20STRATEGY%282021-2025%29%29.pdf)

Nguyen, N.T.K., Fan, H.Y., Tsai, M.C., Tung, T.H., Huynh, Q.T.V., Huang, S.Y. and Chen, Y.C. (2020) 'Nutrient intake through childhood and early menarche onset in girls: systematic review and meta-analysis' *Nutrients* 12(9): 2544 (doi: 10.3390/nu12092544)

Nussbaum, M. (2011) *Creating capabilities: the human development approach*. Harvard: Harvard University Press, Belknap Press

Pawson, R. and Tilley, N. (1997) *Realistic evaluation*. London: Sage

Pincock, K., Yadete, W., Girma, D. and Jones, N. (2023a) 'Comprehensive sexuality education for the most disadvantaged young people: findings from formative research in Ethiopia', *Sexual and Reproductive Health Matters* 31(2) (doi: 10.1080/26410397.2023.2195140)

Pincock, K., Yadete, W., Workneh, F., Murha, R., Tilahun, K., Gebeyehu, Y. and Jones, N. (2023b) 'Young women involved in commercial sex work in urban Ethiopia: experiences, drivers and implications for sexual and reproductive health policy and programming.' Policy brief. London: Gender and Adolescence: Global Evidence (www.gage.odi.org/publication/young-women-involved-in-commercial-sex-work-in-urban-ethiopia-experiences-drivers-and-implications-for-sexual-and-reproductive-health-policy-and-programming/)

Presler-Marshall, E., Jones, N., Dutton, R., Baird, S., Yadete, W., Woldehanna, T., Workneh, F. and Iyasu, A. (2020) *'They did not take me to a clinic': Ethiopian adolescents' access to health and nutrition information and services*. London: Gender and Adolescence: Global Evidence (www.gage.odi.org/publication/they-did-not-take-me-to-a-clinic-ethiopian-adolescents-access-to-health-and-nutrition-information-and-services/)

Presler-Marshall, E., Das, S., Jones, N., Baird, S., Yadete, W., Woldehanna, T. and Hamory, J. (2024a) '*How could I think about my education when people are dying here and there?': Evidence from GAGE Round 3 about Ethiopian young people's education*. London: Gender and Adolescence: Global Evidence (www.gage.odi.org/publication/how-could-i-think-

about-my-education-when-people-are-dying-here-and-there-evidence-from-gage-round-3-about-ethiopian-young-peoples-education)

Presler-Marshall, E., Endale, K., Jones, N., Baird, S., Yadete, W., Kasahun, T., Woldehanna, T. and Hamory, J. (2024b) *'They told us not to be afraid and that our country continues': Evidence from GAGE Round 3 about the psychosocial well-being of Ethiopian young people*. London: Gender and Adolescence: Global Evidence (www.gage.odi.org/publication/they-told-us-not-to-be-afraid-and-that-our-country-continues-evidence-from-gage-round-3-about-the-psychosocial-well-being-of-ethiopian-young-people)

Presler-Marshall, E., Das, S., Jones, N., Baird, S., Yadete, W., Woldehanna, T., Hamory, J., Workneh, F. and Birra, M. (2024c) *Adolescent bodily integrity in times of crisis in Ethiopia: Evidence from GAGE Round 3*. London: Gender and Adolescence: Global Evidence (www.gage.odi.org/publication/adolescent-bodily-integrity-in-times-of-crisis-in-ethiopia-evidence-from-gage-round-3)

Ogunbiyi, B.O., Baird, S., Bingenheimer, J.B. and Vyas, A. (2023) 'Agency and role models: do they matter for adolescent girls' sexual and reproductive health?' *BMC Women's Health* 23(515): 1–12 (https://doi.org/10.1186/s12905-023-02659-8)

Sachs, J.D., Lafortune, G., Fuller, G. and Drumm, E. (2023) *Implementing the SDG Stimulus. Sustainable Development Report 2023*. Dublin: Dublin University Press

Sen, A.K. (1985) *Commodities and capabilities*. Amsterdam: North-Holland

Sen, A.K. (2004) 'Capabilities, lists, and public reason: continuing the conversation' *Feminist Economics* 10(3): 77–80

UNFPA (2024) 'World Population Dashboard Ethiopia' (www.unfpa.org/data/world-population/ET)

UNICEF (2019) *Guidance on menstrual health and hygiene*. New York: UNICEF (www.unicef.org/media/91341/file/UNICEF-Guidance-menstrual-health-hygiene-2019.pdf)

About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a decade-long (2016-2026) longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org for more information.

GENDER & ADOLESCENCE: GLOBAL EVIDENCE

GAGE Programme Office
Overseas Development Institute
203 Blackfriars Road
London SE1 8NJ
United Kingdom
Email: gage@odi.org
Web: www.gage.odi.org

Disclaimer

This document is an output of the Gender and Adolescence: Global Evidence (GAGE) programme which is funded by UK aid from the UK government. However, views expressed and information contained within do not necessarily reflect the UK government's official policies and are not endorsed by the UK government, which accepts no responsibility for such views or information or for any reliance placed on them.

Copyright

Front cover: A 16-year-old pregnant girl in Oromia, Ethiopia © Nathalie Bertrams/GAGE 204

ISBN: 978-1-915783-59-2

UKaid
from the British people