

# **‘They did not take me to a clinic’: Ethiopian adolescents’ access to health and nutrition information and services**

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## Introduction

The Ethiopian government has recently taken a number of important steps to protect and promote adolescent health. These steps are in line with the commitments of: Sustainable Development Goal (SDG) 2, which calls for zero hunger; SDG 3, which aims to promote good health and well-being for all at all ages and specifically targets the provision of sexual and reproductive health information and services; and SDG 5, which includes a commitment to universal access to sexual and reproductive health and reproductive rights (UN, 2018). They are also in line with the World Health Organization's (WHO) global standards for quality health care services for adolescents (WHO, 2015). The government has also developed a National Adolescent and Youth Health Strategy and established a dedicated Department for Adolescent Health (Ministry of Health, 2016). With a strong focus on family planning, antenatal care, and HIV prevention, some dimensions of adolescent health are also part of the nationwide health extension package comprising 16 key services delivered at community level (Mullan, 2016). The 2016 Ethiopia Demographic and Health Survey (DHS) highlights that efforts are paying off, with adolescents' contraceptive knowledge and uptake steadily improving over time – and adolescent fertility falling in tandem (CSA and ICF, 2017). The DHS also, however, highlights that there remains much room for progress, with adolescent outcomes – from rates of anaemia to condom use – uneven across regions (ibid.).

This report synthesises findings from the Gender and Adolescence: Global Evidence (GAGE) programme's 2019/2020 midline data collection to explore changes in Ethiopian adolescents' physical health, including nutrition and sexual and reproductive health, in the two years since the baseline. We pay careful attention to gender, and urban–rural and regional differences in how young people aged 12–19 are able to keep themselves healthy and access the information and services they need. We then discuss key actions needed to accelerate progress and ensure that all adolescents have good access to health and well-being, including their rights to sexual and reproductive health.

## Methods

This report draws on mixed-methods research undertaken in late 2019/early 2020 as part of GAGE's midline data collection in rural and urban sites in three regions of Ethiopia: Afar, Amhara and Oromia. Rural communities (*kebeles*) – of which two were in pastoralist Zone 5 (Afar), five were in South Gondar (Amhara), and five were in East Hararghe (Oromia) – were chosen for their combination of economic and social vulnerabilities (varying levels of food insecurity and high prevalence of child marriage). Varying distances from district towns also allowed us to explore the relative importance of distance to services and markets. The three urban settings – Batu/Ziway in East Shewa (Oromia), Debre Tabor in South Gondar (Amhara), and Dire Dawa City Administration – are similarly diverse. Differences in their location, cultural and religious diversity, size, and migration patterns shape adolescents' access to health and nutrition.

GAGE's Ethiopian midline sample for this report includes 7,526 successfully surveyed adolescents (out of a possible 8,555) as well as their caregivers (see Appendix for more details on the sampling). The sample was divided into two cohorts: younger adolescents (majority aged 12–14 at midline) and older adolescents (majority aged 15–19 at midline). To ensure that the sample was consistently drawn from across sites and to minimise the risk of overlooking the most disadvantaged adolescents (e.g. out-of-school adolescents, married adolescents, and adolescents with disabilities), a door-to-door listing was undertaken in all research sites, following a specific protocol, and was complemented with purposeful sampling, with a specific focus on early marriage and disability (see Table 1). The qualitative sample – of 278 core adolescents – was selected from the larger quantitative sample, again deliberately oversampling the most disadvantaged in order to capture the voices of those at risk of being 'left behind'. It also included caregivers, grandparents and siblings, government officials, and service providers (see Table 2).

**Table 1: GAGE midline quantitative sample of adolescents**

	Overall	Urban	Rural
All	7526	1987	5539
Male	3199	933	2266
Female	4327	1054	3273
Older cohort	3207	1370	1837
Younger cohort	4319	617	3702



**Table 2: GAGE midline qualitative sample**

	DD	DT	Batu	SG	EH	Zone 5	Sub-totals
Girls younger	9	6	–	24	25	12	76
Girls older	14	8	11	3	5	8	49
Boys younger	5	8	–	22	16	12	63
Boys older	12	8	10	6	4	5	45
Married adolescents	2	2	1	30	30	18	83
Adolescents with disabilities	2	8	5	16	12	9	52
IDPs	6	–	7	–	7	–	20
Total adolescents	50	20	34	101	99	64	388
Parents IDI	5	3	–	8	–	–	16
Key informants	5	4	21	39	51	9	129
FGDs adolescents	21	20	48	54	60	16	219
FGDs parents	36	–	28	117	133	68	382
Sub-totals	117	67	131	319	343	157	1134

Data was collected in face-to-face interviews by enumerators who were trained to communicate with adolescents, and spoke the local language (Amharic, Afar Af, Afaan Oromo and, in the case of Dire Dawa, also Somali). Analysis of the quantitative survey data focused on a set of indicators related to physical health, including nutrition and sexual and reproductive health (data tables are available on request). Sampling weights, reflecting the probability of selection into the study sample, were used to make the results representative of the target population in the study area. Statistical analysis was conducted using Stata15.1. All differences cited in the text are significant at least at the  $p=0.05$  level.

Qualitative tools consisted of an array of interactive activities such as timelines and body mappings, which were used in individual and group interviews (see Jones et al., 2019d). Preliminary data analysis took place during daily and site-wide debriefings. Interviews were transcribed and translated by native speakers and then coded thematically using the qualitative software analysis package MAXQDA.

Prior to commencing research, we secured approval from ethics committees at the Overseas Development Institute and George Washington University, as well as from the relevant regional research ethics boards in Ethiopia. We also secured informed assent from adolescents aged 17 and under (minors under 18 are not legally able to give



Community in Oromia © Nathalie Bertrams / GAGE 2020


consent) as well as informed consent from their caregivers and from adolescents aged 18 and 19 years.

## Key findings

### Health

#### General health

The midline survey found that nearly all Ethiopian adolescents (89%<sup>1</sup>) report being in good health. This is unchanged from baseline (87%) and not unexpected, given that adolescents – unlike many of their parents (see Box 1) – are generally healthy. Overall, boys are more likely to report good health than girls (91% versus 87%), younger adolescents are more likely to than older adolescents (91% versus 86%), and those in rural areas are more likely to than those in urban areas (88% versus 84%, among the older cohort). However, our qualitative research nuances these findings, and highlights that young people face a variety of gender- and location-specific threats to their health. For example, girls are more prone to urinary and gynaecological infections, largely related to inadequate water and sanitation facilities. *'We prefer taking a bath with water from the pipe, since the water from the river causes itching,'* explained a 14-year-old girl from South Gondar. Girls in East Hararghe – where some are having to travel up to five hours each day to reach a water source

 We prefer taking a bath with water from the pipe, since the water from the river causes itching.

(A 14-year-old girl from South Gondar)

– emphasised that hygiene practices were particularly challenging. Boys, on the other hand, are more likely to have serious injuries than girls – largely a result of their greater mobility and their involvement in risky types of work, as well as violence. Broken bones, burns and traffic accidents were all relatively common. *'I started running here and there. Then my leg was broken,'* recalled a 13-year-old boy from Dire Dawa of his attempts to escape ethnic violence last year. Health risks also vary by location. In rural areas, parasites and malaria are common, especially in the rainy season. A 13-year-old boy from South Gondar noted, *'We have parasitic problems... always, especially during the rainy seasons.'* A 12-year-old boy from Zone 5 (Afar) added that he had nearly died from malaria: *'I was very ill. I had a severe headache and I was unable even to open my eyes... My family were searching for me, they were unable to find me. Finally, it was another shepherd that showed them where I was, and they carried me home.'* Boys living in lowland rural areas where water is very scarce also mentioned that they have been facing recurrent skin diseases. A 19-year-old boy in South Gondar mentioned that *'We have faced serious skin problems on our hands and other parts of our bodies.'*

#### Box 1: Adult ill-health shapes adolescent trajectories

Mulunesh is an 18-year-old girl from rural South Gondar who lives with her parents and four younger siblings. While she would like to be a doctor, so that she can *'treat the ill'*, her longer-term plans are at risk because of parental health issues (her mother is going blind, and her father has a hearing impairment).

She is so interested in a medical career that she has already started comparing different universities' reputations. *'I heard that Gondar University is well known in providing medical education,'* she reported. But she is concerned about her ability to pursue her dreams. Her mother's disability is impacting how much time Mulunesh can spend studying, while her father's illness may cost the family income.

Of her mother's condition, Mulunesh says, *'She said that the pain would simply go... [but] it is worsening... If she gets ill and stays in bed... I would have to do much work... I wouldn't have time to study,'* she explained.

Her father, she added, is going deaf: *'My father has a hearing problem... It has been about five years... I think it is mumps.'* She is worried that if he loses his hearing entirely, he may lose the 800 Ethiopian birr that he makes each year from being a priest, which would make it hard to continue to pay for her schooling.

While Mulunesh understands the value of her chosen career in modern medicine, her parents are less convinced. *'There is not much awareness in rural areas,'* she observed.

<sup>1</sup> This figure represents only the adolescents who were also included at baseline – in order to make longitudinal comparisons.

## Substance use

Our survey found that substance use is a concern for boys, though the type of substance used varies by region. East Hararghe, for example, grows *khat*<sup>2</sup> and is predominantly Muslim, which means that alcohol is frowned upon, while South Gondar does not grow *khat* and is largely Ethiopian Orthodox, which permits alcohol. Of older adolescents in East Hararghe, 59% of boys and 14% of girls reported using *khat*. Of their peers in South Gondar, 47% of boys and 5% of girls admitted to consuming alcohol. In Afar, which is also primarily Muslim, 14% of boys chew *khat*, whereas girls rarely reported substance use (see Figure 1). Substance use is also common in urban areas: 30% of older boys and 12% of older girls admitted to consuming alcohol, with 6.6% of older urban males consuming *khat*, a rate that is higher in Dire Dawa at 10%.

Boys in East Hararghe agreed that *khat* chewing is a nearly universal way of passing the time with friends, and one in which girls are rarely included. 'The boys enjoy chewing *khat* till the girls cook dinner,' explained a younger boy. Indeed, a father reported that boys' use of *khat* is now so regular that *khat* farmers prefer to hire girls to work: 'The *khat* farm owners are more interested in girls since they don't chew *khat*. Boys would ask you for a break to chew *khat*; but once girls start pruning, they would not stop till

**They may use anything to get a relief from their sorrow.**

(An 18-year-old boy from Batu)

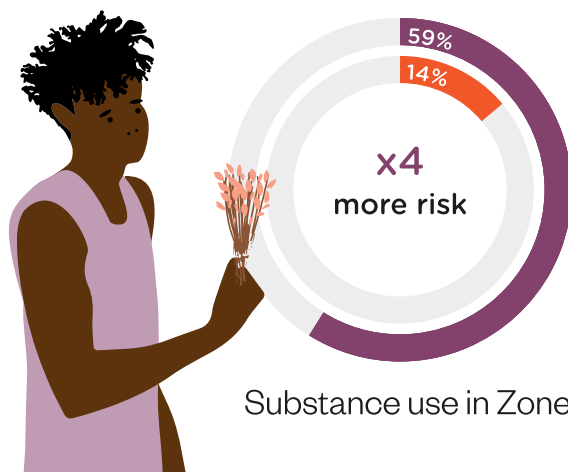
5pm. They would not take a break.' In South Gondar, where returning migrants are bringing *khat* with them but alcohol remains more common, there is concern that substances are fuelling recent violence. 'In our place, getting drunk is normal. Then after that it is fighting, what else could there be?' asked a 23-year-old woman from South Gondar. Girls were clear that while they were often victims of alcohol-fuelled violence perpetrated by fathers, brothers and husbands, social norms prevented their consuming alcohol. 'It is disgraceful for a woman to go to a drinking house. It is only allowed for men,' observed a 13-year-old girl. Adolescents living in urban areas reported a wider variety of 'addictive activities' (19-year-old boy, Debre Tabor), including marijuana, glue and benzene. Young people noted that unemployment and disillusionment about the future are driving substance use, which is in turn fuelling violence. 'They may use anything to get a relief from their sorrow,' explained an 18-year-old boy from Batu. 'Since they chew *khat*, in the morning their mind does not work properly. So they fight each other at that time,' added a 17-year-old boy from the same city.

Figure 1: Substance use among adolescents

## Substance use is gendered and differs across regions

**Boys** are far more at risk of substance use than **girls**:

In East Hararghe they chew *khat*.



Substance use in Zone 5 (Afar) is rare.

In South Gondar they drink alcohol.



<sup>2</sup> *Khat* is a plant commonly grown in the Horn of Africa, the leaves of which are chewed for a stimulant effect.



**Table 3: Barriers to healthcare**

	Total n=7497	Girls n=4314	Boys n=3183	Younger n=4301	Older n=3196	Urban n=1983	South Gondar n=2466	East Hararghe n=2249	Zone 5 n=799
Distance is a barrier	38%	38%	37%	40%	33%	13%	38%	53%	35%
Cost is a barrier	37%	38%	35%	34%	42%	33%	32%	46%	29%

## Health service access

Adolescents' access to health care is shaped by where they live and how much their families can afford to spend. Across locations and age groups and including both boys and girls, 38% of young people reported that distance was a barrier to care-seeking and 37% reported cost (another 16% reported difficulty obtaining permission) (see Table 3). All barriers were more pronounced in rural areas compared to urban areas and were especially high in East Hararghe, where communities and service provision have been significantly impacted by ongoing political violence (with 53% of adolescents citing distance as a barrier, 46% cost, and 23% permission). Older adolescents, who are less likely to live at home, were more likely to report cost as a barrier than their younger peers (42% versus 34%). Girls were more likely to report cost as a barrier than boys (38% versus 35%), with married girls especially likely to do so (48%). *'I was suffering from severe pain and infection in flank area... I did not visit a health facility since my mother*

*has no money,'* recalled an 18-year-old girl from Batu. While Ethiopia's Health Extension Worker programme is a model for global good practice, and has enabled the government to rapidly scale up access – even in remote communities – for routine and preventive care (such as vaccinations), adolescents living in more distant communities have very limited access to other services. *'He gives children medicinal syrup and he gives us injections as well,'* reported a 19-year-old girl from Zone 5, when asked what services the local health worker provides. A 17-year-old girl who is deaf, now living in Debre Tabor but from rural South Gondar, added that more complicated care is out of reach because it requires both travel to urban hospitals as well as fee-for-service medical care – neither of which her family could afford (see Box 2). She explained: *'Since they [my family] are living in a rural area they're not used to spending money for hospital care and they couldn't easily access money at that time... When they finally decided to take me to the hospital [following an ear infection] it was too late.'*



Adolescent boy with a physical disability in Amhara © Nathalie Bertrams / GAGE 2020

## Box 2: Health inequities for adolescents with disabilities

Our findings highlight that adolescents with disabilities are less likely to be healthy than their peers without disabilities, as only 71% report good health (compared to 91% of those without disabilities). Indeed, our qualitative work suggests that disability and ill health are interrelated. In our sample, the vast majority of disabilities were caused by untreated childhood illnesses and accidents. At the same time, those with disabilities are both more likely to experience illnesses and accidents as a result of their different abilities and less likely to receive adequate treatment due to disability-related stigma. *'Since last year, I have developed leg pain... The pain is getting worse from day-to-day,'* noted an 18-year-old boy with an orthopaedic impairment from Batu. *'Able-bodied youth can better keep their health... Those normal ones can manage their personal hygiene by themselves,'* added a 17-year-old girl with a visual impairment from rural South Gondar. Adolescents with disabilities (and their caregivers) were also more likely than their peers without disabilities to report cost as a barrier to accessing health care (51% versus 37%). *'We paid a lot for treatment. But we couldn't afford it anymore,'* recalled the mother of an 11-year-old boy with multiple disabilities in East Hararghe. Individual interviews suggest that fatalism may be even more of an issue than cost, and also a longstanding reliance on traditional healers. *'They did not take me to a clinic... I think that Allah will open my eyes,'* reported a blind 11-year-old boy from Zone 5. *'I started to take her to a traditional healer [Sheikh]. It was because people told me that it is Satanic,'* added the mother of a 12-year-old girl, from the same woreda (district), referring to her daughter's intellectual disability.

**Table 4: Health of adolescents with disabilities**

	Ever hungry in past 4 weeks	Food Insecurity Experience Scale (FIES) (0-8)	Self-reported good health	Cost as a barrier to healthcare	Distance as a barrier to healthcare
Adolescents with disabilities	29% n=571	3.8 n=578	71% n=579	51% n=563	43% n=563
Adolescents without disabilities	20% n=6936	3.0 n=6837	91% n=6938	36% n=6928	37% n=6928

Adolescents with disabilities were also more likely than their peers to report going hungry in the past month (29% versus 20%) and to live in food-insecure households (3.8/8 versus 3/8 on the Food Insecurity Experience Scale<sup>i</sup> (FIES)). In our qualitative sample, this difference was primarily the result of older adolescents who were living on their own in order to attend one of the special needs schools that the government has recently opened in urban areas. These schools, which provide self-contained classrooms for students in grades 1–4 and offer rural students a small stipend to offset the costs of room and board, are deeply appreciated by the young people who attend them. However, because stipends are low and rents are high, young people must make trade-offs in spending. *'There is a shortage of food,'* explained a 15-year-old girl with a hearing disability from South Gondar.

i The FIES, produced by the Food and Agriculture Organization (FAO) of the United Nations, consists of eight questions regarding people's access to adequate food. Mid-range scores indicate compromised diet quality and high scores indicate hunger.

## Nutrition

### Diet sufficiency

Food insecurity is common in Ethiopia, especially in East Hararghe, which has suffered devastating and recurrent drought in recent years. On the FIES, an average household in our midline panel survey in East Hararghe scores 5.2/8 (versus 3.3 in South Gondar and 1.5 in Zone 5) – even higher than at baseline (4.7/8). Our qualitative work highlighted that households are most concerned about dietary diversity rather than quantity. In South Gondar and East Hararghe, most calories come from grain (teff, wheat, sorghum, millet, corn and rice). A 10-year-old girl in

East Hararghe, when asked whether her family consumes proteins such as milk, eggs and meat, responded: *'We don't eat such food! Only a few households who have certain petty business like me eat eggs just sometimes.'* In pastoralist Zone 5, on the other hand, adolescents, and especially boys, emphasised milk as a primary food source. *'I like milk, I'd rather drink milk than eat another thing,'* noted a 12-year-old boy. Young people added that they only rarely consume vegetables or fruit, which are not locally grown and tend to spoil quickly when imported.

Hunger was also widely reported, especially in drought-prone East Hararghe, where more than a third (34%) of young people reported being hungry in the past month,



### Box 3: From everything to nothing

Furdos is a 12-year-old ethnic Somali girl living in a camp for internally displaced persons (IDPs) near Dire Dawa with her mother and her six siblings. She and her family were displaced several years ago, during ethnic violence that left her father dead and their property destroyed. With no resources of their own, and dwindling government support, Furdos and her family are now often hungry.


Before Furdos and her family were forced to flee, they were able to support themselves and eat nutritiously. *'We could buy anything we wanted to have,'* she explained. *'We had everything... We had farmland. We harvested sorghum. We had mango.... We could also drink milk when we needed. We could slaughter goat and have meat in our dish... We had water,'* she continued.

In the months immediately after displacement, the federal government ensured that IDPs were fed, providing not only food but useful advice about how to cook it to minimise the chances of food-borne illness. Furdos recalled, *'When we first came, the government provided us with dishes, and all the vegetable and materials we needed for cooking. They also provided us with soap and firewood. We used to boil rice in big dishes and we ate in large groups. The rice was not well cooked because the firewood was not enough to cook it well. Later the government stopped us not to eat left over food.'*

Now, Furdos added, because *'they stopped the service'*, her family is surviving on rice alone – bought with money sent by relatives back home. *'We eat the white rice alone. We don't add anything to it because we can't afford to,'* she noted.

Furdos is afraid of what happens next. When the money runs out, she concluded, *'We starve again.'*

compared to 8% in South Gondar and Zone 5. Gender differences were notable and varied by region. In East Hararghe and South Gondar, boys were more likely to be hungry than girls. In Afar, the reverse was true (see Table 5). Regional differences are partly driven by the large numbers of internally displaced persons (IDPs) living in a remote community in East Hararghe. These displaced people –

 **Now the government provides food when there is drought. There is also the safety net programme. They give us wheat and edible oil.**

(A teacher from Zone 5)

ethnic Oromos forced to flee their homes in Somali region due to ethnic violence – are extremely food insecure as they have no access to land or livelihoods. IDPs living near Dire Dawa reported the same level of destitution (see Box

3). Adolescents in East Hararghe explained that boys are more likely to be hungry than girls because they have to do hard physical labour, and also because girls are prioritised for feeding in the household due to a perception that they are weak. *'Boys can survive better than girls... because boys are stronger than girls,'* explained an 11-year-old girl from East Hararghe. Boys in Zone 5 noted that they are rarely hungry because they are almost always with livestock and can have milk whenever they want.

### Nutrition services

The Ethiopian government has been working to address hunger and food insecurity (this will be discussed in more depth in a forthcoming GAGE brief on economic empowerment and social protection). In addition to feeding programmes for malnourished children and pregnant women, implemented by health extension workers, some kebeles benefit from the national Productive Safety Net

**Table 5: Food insecurity among midline sample**

	Total		Urban		South Gondar		East Hararghe		Zone 5	
Food insecurity Experience Scale (FIES) (0-8)	3.8 n=7415		3.3 n=1947		3.2 n=2470		5.3 n=2232		1.5 n=766	
Ever hungry in past 4 weeks	G	B	G	B	G	B	G	B	G	B
	16% n=4319	25% n=3188	22% n=1054	31% n=931	5% n=1472	10% n=1001	25% n=1319	41% n=930	10% n=474	5% n=326



Girls' club in Amhara © Nathalie Bertrams / GAGE 2020

Programme (PSNP) (Ethiopia's flagship social protection programme) and school feeding programmes. 'Those households who don't have enough resources to survive on, they survive on the aid,' explained a 19-year-old girl in East Hararghe. A teacher from Zone 5 noted that as part of the national Productive Safety Net Programme (PSNP): 'Now the government provides food when there is drought. There is also the safety net programme. They give us wheat and edible oil.' However, respondents noted that both school feeding and the PSNP do not always reach the poorest people due to problems with targeting and infrequently revised lists of eligible households, as well as reported corruption in the distribution chain. 'It [school feeding] is not a sustainable programme,' reported a key informant from Amhara. 'Even when the government sends us food, it is stolen on the road. It is only sometimes that we get it,' added a 12-year-old boy from Zone 5.

When I had [my period] for the first time, I welcomed it, accepting that it is the period that females in my neighbourhood talk about.

(A 15-year-old married girl from East Hararghe)

## Support for puberty

### Access to information

Younger adolescents are more likely to have a source of information about puberty at midline (77%) than at baseline (52%). This is not unexpected, given that they are now two years older and more likely to have begun puberty. At midline, urban adolescents fare better than their rural peers (90% versus 75%) and those in South Gondar (84%) are better informed than those in East Hararghe (71%) and Zone 5 (61%). We found no significant gender differences.

Responses to a question about who provides young people with information on puberty reveal some interesting patterns by gender and region. Mothers are rarely cited as a source of information, but girls report them as primary sources more than boys (8% versus 2%) and they are more important in remote Zone 5 (18%) than in South Gondar and East Hararghe (3%). While just under 30% of adolescents (girls and boys) report that a teacher is their main source of puberty education, when disaggregated by location, it emerges that teachers are disproportionately important in urban areas (56%) and in South Gondar (34%), where adolescents are more likely to be enrolled in school at the time of puberty, than they are in East Hararghe (16%) or Zone 5 (8%). Boys were more likely to cite friends as a source of information about puberty than girls (45% versus 27%), as were adolescents in East Hararghe and Zone 5 (59%) compared with those in South Gondar (22%) (see Figure 2).



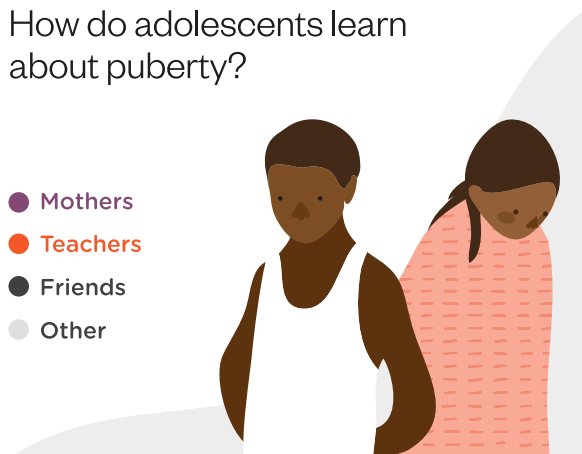
Figure 2: Puberty and contraception knowledge among adolescents

## Adolescents' knowledge about sexual and reproductive health is highly variable

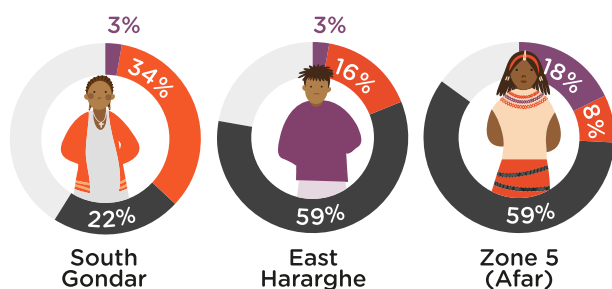
### Puberty

How do adolescents learn about puberty?

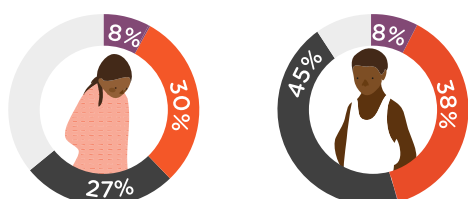
- Mothers
- Teachers
- Friends
- Other



It varies by where they live...



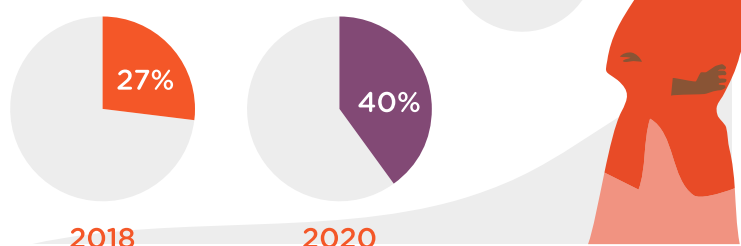
...and whether they are a girl or a boy.



Our qualitative work explored this patterning and found that while boys almost universally welcome maturation (being openly proud of their beards and other outward signs of manhood), for girls, puberty remains fraught due to limited information and deeply entrenched gender norms that restrict girls' mobility and behaviours at this stage of life. Most girls – even those who purport to have a source of information and to be happy about growing up – receive little timely instruction on what puberty and menstruation involve, and are expected to learn by observation. A

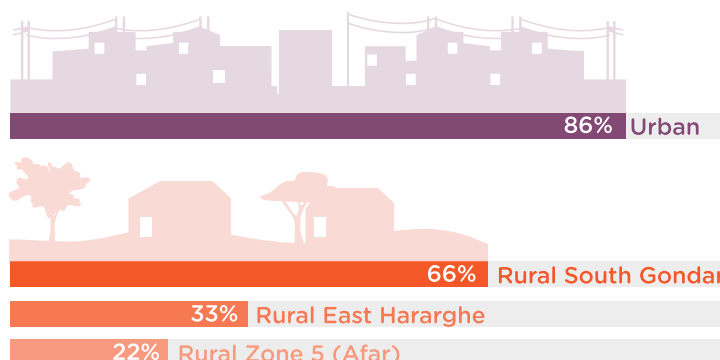
### Contraception

Adolescents' knowledge about contraception is improving as they get older. Compared to two years ago, more can name a modern method.



However, there are huge discrepancies in knowledge between rural and **urban areas** and across **rural regions**.

Who can name a method of contraception?



15-year-old married girl from East Hararghe, when asked how she felt when she recently began menstruating, replied: *'I felt nothing. I perceived that it is a period because I had heard it when females in the neighbourhood talk about it. When I had it for the first time, I welcomed it, accepting that it is the period that females in my neighbourhood talk about.'* Other girls were fearful of puberty. In two of our study sites, where menarche is still either regularly seen as a sign that girls have already become sexually active (South Gondar) or must immediately be married (Zone 5),

#### Box 4: Normalising menstruation through gender synchronised programming – emerging evidence from Act With Her

Act With Her is a five-year programme being implemented by Pathfinder International (in partnership with CARE and the Ethiopian government) in several regions of the country, including Amhara, Oromia and Afar. It provides adolescents and their caregivers with information on a wide range of topics, including health, nutrition, education, safety, gender and economic empowerment, and is working in different ways in different communities in order to find how best to create change. GAGE is evaluating the programme, which aims to reach 50,000 young people by 2022.

Although still in its early stages, preliminary findings suggest that the programme is helping to prepare girls for menarche and is normalising menstruation. Girls report less shame and better knowledge, both of which contribute to better menstrual hygiene and improved school attendance. *'I would be ashamed when I had my menstruation and become absent from school. But after I joined Pathfinder, I understand that menstruation is nature's gift and I don't get ashamed,'* explained a 13-year-old girl from South Gondar. *'We learn to manage menstruation with a clean piece of cloth so that we can attend class conveniently. The menstrual flow will not spill down on our legs,'* added a younger girl from East Hararghe. Boys in South Gondar, where the programme has been operating for longer, also report improved attitudes and behaviours. A younger boy noted, *'We used to perceive menstruation as something wrong and we used to laugh at girls when they had their period. But I am no longer laughing at girls as I understood it is a normal process.'*

girls admitted that they tried to keep their periods a secret. *'I saw blood on their cloth when we played together and when I asked them what it was, they warned me not to tell,'* explained a 12-year-old girl from Zone 5.

#### Menstrual health practices


Girls were quite likely to report that their daily activities were restricted by menstruation. Interestingly, older urban girls reported more restrictions than their rural peers (35% versus 17%, among older girls). Our qualitative work suggests that restrictions are born of a confluence of girls' daily activities, their access to sanitary supplies, and menstruation-related stigma. In rural areas, where stigma is higher and girls are still regularly harassed if they are seen with blood on their clothes (leading many to stay away from school while they are menstruating), girls are less likely to experience restrictions because they are less likely to leave home. Enrolment rates are also lower in rural areas, marriage rates are higher, and domestic workloads are heavier. In addition, as modern hygiene supplies are not available in many rural areas, girls are more likely to use cloth to manage menstruation. *'I wash and change my cloth until it stops... I change and wash again and again,'* explained a married 18-year-old from South Gondar. In urban areas, where girls are more likely to be out of the

house due to attending school or working, and so less able to continuously wash and change, the cost of menstrual hygiene products is more keenly felt. *'The girls cannot purchase it because of lack of money,'* noted a 13-year-old girl from a town in East Hararghe.

#### Puberty education

Driven by its commitment to improve girls' access to education, the Ethiopian government is working to ensure that young people receive puberty education and that girls are supported through menarche and with their monthly needs. The biology curriculum addresses the former and some schools – more likely in urban areas and those in South Gondar – provide sanitary supplies (which are often donated by NGOs) and changing rooms, and offer girls' clubs that provide continuous education and support. *'They teach us to be ready for when menstruation will start. They also teach us how to handle it,'* explained a 13-year-old girl from Debre Tabor. *'Our teacher taught that we can prepare for it using cloth,'* added a girl of the same age from South Gondar.

Our midline research, however, highlights that current provisioning reaches too few adolescents, and often at the wrong time. While in South Gondar, 91% of younger adolescents are still enrolled in school, in East Hararghe and Zone 5, many have already dropped out (22% and 39% respectively). These children appear to have no community-based sources of information, except in the rare cases where non-governmental organisations (NGOs) are running programming for adolescents (see Box 4); hence their reliance on friends. Our qualitative work

 The girls cannot purchase [menstrual hygiene products] because of lack of money

(A 13-year-old girl from East Hararghe)



Young adolescent boy in Afar © Nathalie Bertrams / GAGE 2020

suggests that education needs to be practical and more repetitive. Girls in both rural and urban areas reported that even if they knew to expect menstruation, they did not know how to use cloths or pads to prevent leakage. An 18-year-old girl from Debre Tabor, for example, admitted that she could not make pads work for some months because she did not know to remove the cover to expose the adhesive: *'I put it on the wrong side. Then it kept sliding when I wore my clothes. I didn't have underwear. I was wearing my trousers and the pad kept sliding.'* Other girls noted that the timing of puberty education had done them little good, either because they had already begun menstruating before they received it (most common in rural areas where girls start school late and are years 'over-grade') or because they were too young at the time and had not paid sufficient attention (common in food-insecure areas where girls often experience menarche at a later age).

## Sexual and reproductive health

### Contraceptive knowledge

Mirroring adolescents' improved access to puberty information, young people (two years older than at baseline) are now, not surprisingly, more likely to be able to name a form of contraception (40% compared to 27% at baseline, among the younger cohort). Those in South Gondar (66%) are more aware than their peers in

East Hararghe (33%) and Zone 5 (22%). Though gender differences among the older cohort are still significant – with girls better informed than boys (70% versus 65%) – they are less marked than one might have expected given that girls are much more likely than boys to have ever been married (35% versus 7%, among the older cohort) or be sexually active (34%<sup>3</sup> versus 14%). Interestingly, married and unmarried older girls are equally likely to be able to name a method of contraception (70%). This reflects not only governmental efforts to slow fertility and stop the spread of HIV – which has led to widespread messaging, including in the school curriculum – but also the reality that married girls are comparatively shut off from sources of information. Half of married girls, compared to only a quarter of their unmarried peers, report relying on friends for information about puberty (and presumably other sexual and reproductive health issues too) (see Figure 2).

### Access to sexuality education

Our qualitative work explored differences in adolescents' contraceptive knowledge and found that adolescents use the same information channels as they do for puberty knowledge. Young people reported that they learned


<sup>3</sup> Girls are slightly more likely to have been married than to be sexually active due to the custom of *geyid*, which prohibits sexual activity within marriage until girls are physically mature.

about contraceptive methods at school, that they paid attention when their older peers and relatives are talking among themselves, and that they pass information between friends. *'There is injection and tablets... I know it since I learnt it at school,'* reported a married 19-year-old boy from East Hararghe. A married 17-year-old girl from South Gondar added, *'My mother and my friends told me.'* In South Gondar, where the Health Extension Worker programme is especially well developed, health workers play a major role in disseminating information about contraceptives to adolescents. They not only provide community-based education that focuses on how well-timed pregnancies (including those that are delayed until adulthood as well as those that are spaced several years apart) result in better outcomes for mothers and babies, but also run information sessions inside schools. *'Health extension workers are doing great in this regard. They are creating awareness in each school,'* explained a key informant from the Education Bureau in Debre Tabor. In East Hararghe and Zone 5, community- and school-based contraceptive education is far more limited – partly because services are more limited overall and partly because of a cultural and religious preference for large families. A married 15-year-old in East Hararghe, when pressed about whether she had received any information on how to delay first pregnancy, reported that she had never even heard of contraception. Older boys in Zone 5 responded similarly, *'All these things you are talking about are new for us. We don't know these things in our locality, because as you know there is no school or health institution here.'* A married 17-year-old girl from the same community was clear that even if services were available, she did not want to learn about contraception, which she saw as *'haram'* (forbidden by God). She explained, *'other education is good, but education about family planning is not useful.'*

## Contraceptive uptake

Adolescent girls' uptake of contraception lags behind their contraceptive knowledge. Of older girls who are sexually active (nearly all of whom are married), only 41% have ever used any form of contraception and only 28% are currently using a modern method. Unsurprisingly, current use is higher in urban than rural areas (42% versus 23%) and higher in South Gondar (54%) than in Zone 5 (9%) and East Hararghe (4%) (see Table 6).

Our qualitative work again highlights that health extension workers in South Gondar play a critical role. Boys and girls alike understand that early pregnancy is medically and financially risky. This means that not only do newly married couples generally agree to delay parenthood until the girl's body is mature and their livelihoods more established, but that unmarried girls regularly use contraception to avoid becoming pregnant if they are

 **If someone rapes her... she will be protected from getting pregnant. The injection will control the pregnancy.**

(A married 18-year-old boy from South Gondar)

raped. *'If someone rapes her... she will be protected from getting pregnant. The injection will control the pregnancy. That is why it is needed,'* explained a married 18-year-old boy from South Gondar. In East Hararghe and Zone 5, where public messaging is more often framed around ensuring that infants are well nourished rather than around risks to girls' health, contraceptive uptake is far lower (see Box 5). Girls in East Hararghe reported that they wanted to have a baby soon after marriage – and that they were afraid not to, for fear of being branded as infertile. *'They fear their husbands. They are discouraged to use it for their husbands expect that they will give birth. Previously, a lot of mothers used to use it when the contraception was*

**Table 6: Contraceptive use among older cohort girls who reported ever having sex**

	Total	Unmarried girls	Married girls	Urban	South Gondar	East Hararghe	Zone 5
Ever used a contraceptive method	41% n=808	72% n=23	39% n=785	62% n=200	79% n=231	7% n=257	11% n=120
Currently using a modern contraceptive method	28% n=802	19% n=23	29% n=779	42% n=198	54% n=231	4% n=253	9% n=120



### Box 5: Unanticipated effects

Ayantu is a 17-year-old married girl living in rural East Hararghe with her husband and his family. She observes that while contraception has not ‘*caught on*’ in her community, even for the youngest girls, access to better maternity care has effectively undermined efforts to end child marriage.

Ayantu has been married for two years and is yet to become pregnant. This is not, however, because she is using contraception. Indeed, as she wants six children as quickly as possible, she was all but incredulous when asked whether she has used any form of family planning to delay her first pregnancy. *‘Why should I use it?... I didn’t have a baby yet!’* she asked. Besides, she added, her husband would not approve: *‘He will be angry and talk at me. He will say, “why don’t you deliver children?”’*

Ayantu observed that access to sexual and reproductive health care is quite good in her location. *‘They have injectables and implants,’* she reported. This is, however, a double-edged sword. Safe deliveries are also easy to access – and are saving the lives of the youngest mothers. Ayantu added that as caesarean births have become more common, efforts to prevent the youngest girls from marrying have fallen by the wayside. She explained: *‘In the past they used to say early marriage causes problems. But now there is no problem... girls who get married early are delivering now, with no problems. You go to a health facility. You can deliver through an operation, for instance. You can also deliver normally there. Now you deliver at a health facility, not at home.’*

*introduced for the first time. It declined later on,’* explained a 13-year-old. In Zone 5, a 17-year-old girl reported *‘There are no people using contraception... It is because people do not want to use contraception because it is regarded as haram’*. Although a few adolescents in Zone 5 later admitted that some of their peers use contraception in secret, a divorced 19-year-old girl added that this is solely true of unmarried girls. She explained, *‘married women don’t use pills because their husbands won’t let them. They’ll be furious at them if they take those pills.’* Indeed, even younger girls in urban areas – those too young to be sexually active themselves and living in environments where contraceptives are accepted – understand that secret contraceptive use is dangerous. *‘She can take it in secret. But if he finds out, they might get into a fight,’* noted a 12-year-old girl from Dire Dawa.

Across locations, our qualitative work highlighted a need to address concerns about side effects more directly.

In East Hararghe and Zone 5, there was widespread concern that using contraception before the first or second pregnancy might result in permanent sterility. In South Gondar, girls were often afraid of longer-acting contraceptives such as implants and preferred shorter-term injectables. *‘There is a family planning method for three years but I am afraid to use it since I spend time in the heat of the sun... I have seen the side effects from those who are using it. Their hair falls out, their skin colour changes, and their behaviour changes, they become less tolerant,’* explained an 18-year-old married girl from South Gondar. While many concerns are valid – in that different forms of contraception are tolerated differently by different people – there appears (based on girls’ narratives) to be little attempt to directly tackle more egregious misunderstandings.

## Adolescent fertility

Within our sample, 38.3% of married girls have ever been pregnant and 37.9% have given birth at least once (see Box 6). In urban locations, 59% of married adolescents had been pregnant compared to 38% of married adolescents girls in East Hararghe, 43% in Zone 5, and 25% in South Gondar.

Our qualitative work found that while many young mothers (especially those in South Gondar, where there is good access to health extension workers) receive at least minimal antenatal care, many do not. A pregnant 15-year-old in East Hararghe, now separated from her husband, admitted that she had never told anyone, not even her mother and sister, that she was approaching the last trimester of her pregnancy: *'They know it for they can observe my stomach.'* And while the government is working to provide ambulances to carry labouring mothers to health facilities for delivery, this service is again most developed in South Gondar, leaving the majority of young mothers in our sample to give birth at home, sometimes with tragic results. *'I gave birth at home. I did not go to the health facility... I was sick in the evening... and I gave birth the next day. Then the dead baby was born,'* explained a married 17-year-old from a remote community in Zone 5.

## HIV awareness and prevention practices

Our survey found that except in South Gondar, few sexually active adolescents talk to their partners about HIV, and even fewer use condoms (which are primarily used to prevent disease rather than pregnancy). In South Gondar, 51% of sexually active older adolescents reported having spoken to their most recent sexual partner about HIV. Married young people were far less likely to have done so – only 33%. In East Hararghe and Zone 5, only 14% of sexually active older adolescents had spoken to their partner, with rates the same for unmarried and married adolescents. Across regions, only 17% of sexually active older boys – about half of whom were married – reported using a condom during their most recent sexual intercourse. Our qualitative work found that while young people in the most remote communities in South Gondar remain uninformed, the region as a whole is not only reaching adolescents at school with information about how to prevent HIV, but has made progress towards making HIV testing a requirement for marriage. *'We were taught by our teacher about the prevention methods for HIV/AIDS including the use of condoms... We were told to have a condom, which should not be only men's mandate... Our teacher told us girls should hold condoms too... It is mostly*

### Box 6: Access to abortion services increasingly recognised as a right

Ethiopian abortion law was last revised in 2005. While abortion remains illegal in most cases, it is available on-demand for all girls who state that they are under the age of 18 and are unable to care for child (Blystad et al., 2019). Health officials in both rural and urban areas, often more interested in protecting girls' health and educational futures than in upholding religious norms, reported actively referring girls to 'safe abortion services' (district level key informant, East Hararghe). An official in Dire Dawa explained that while services used to be relatively difficult to access, over the past two years there have been efforts to ensure *'the service is provided at every health centre'*.

Girls, while acknowledging that abortion is increasingly common and perhaps becoming more so, were largely unaware of formal services – even in urban areas. Several reported having tried a succession of home remedies to terminate a pregnancy they did not want. A 22-year-old mother of two from Batu explained that she had tried everything to abort, because she did not feel she could afford a second child: *'I tried so many things to abort the pregnancy. They told me khat will terminate the pregnancy and I tried to take that...I also took a 500 mg pill of antibiotics with coca cola.'*

► We were taught by our teacher about the prevention methods for HIV/AIDS including the use of condoms... We were told to have a condom, which should not be only men's mandate... Our teacher told us girls should hold condoms too.

(A 15-year-old girl from South Gondar)

*girls who hold condoms for fear of HIV/AIDS infection... These days, girls buy condoms from a shop or they can get them from a health centre freely,'* explained a 15-year-old girl. Respondents observed that officials in South Gondar have stepped up their efforts due to fears that returning agricultural migrants – many of whom are young men and many of whom keep mistresses – will infect their wives (and children), who have almost no capacity to ask their

husbands to use condoms. A 19-year-old adolescent boy explained: *'It is a common practice for a man to have a wife at home, and a mistress in another place... When these persons engage in such adultery practices with an HIV-infected person, they will be infected with HIV and they may bring this disease to other family members.'* Efforts to prevent the spread of HIV in East Hararghe and Zone 5, where premarital sex is more common according to adolescents (because young people may start sexual relationships at sadah, the local all-night cultural dances), are far more limited; many adolescents know only that AIDS is a *'certain disease'* (15-year-old married girl, East Hararghe) because HIV education *'is rarely provided at the current time'* (14-year-old boy, East Hararghe). Adolescents who are aware of HIV added that testing services are not available. As an 18-year-old boy in Zone 5 explained: *'We do not take an HIV test due to problems. But in other areas it is impossible to marry each other without an HIV test.'*



Adolescent girl who is married selling coffee in Oromia © Nathalie Bertrams / GAGE 2020



## Policy and programming implications

Our findings underscore that Ethiopian adolescents have highly uneven access to health and nutrition information and services, with differences between urban and rural areas and by region, and adolescents in remote rural areas and pastoralist communities among the most disadvantaged. The findings also highlight significant health inequities based on gender and disability, pointing to an urgent need to invest in more tailored outreach and service provision to tackle these disparities. If Ethiopia is to realise the vision behind SDG 3, of health and well-being for all at all ages, our research suggests four priority areas for action as follows.

### 1 Invest in scaled-up nutrition and health education.

- Use school- and community-based classes to teach adolescents how to keep their own bodies healthy, especially as they transition to adulthood, providing practical, age-appropriate information for girls and boys (including how to make and use sanitary supplies). Ensure that education is provided regularly over the course of early adolescence so that young people have information in a timely manner as they progress through puberty.
- Work with parents to raise awareness about how to keep their children healthy, and when and how to seek medical care.
- Invest in substance use campaigns to help boys understand the risks of alcohol and *khat*. In addition, help parents to better support their sons to find alternative ways of coping with unemployment and economic dependency as they transition towards early adulthood.
- Work with religious leaders to encourage them to advocate that their congregation avail themselves of medical care from health care providers, rather than relying solely on spiritual healing.

### 2 Continue to expand the Health Extension Worker programme and tailor it to the health needs of different groups of adolescent girls and boys.

- Continue to expand and scale up the Health Extension Worker programme (especially in emerging regions) and build the health infrastructure (health centres, health posts, hospitals and ambulances) that will

overcome the barriers to rural adolescents accessing timely and affordable health care.

- Ensure that the Health Extension Worker programme provides youth-friendly, age-tailored education and services appropriate for very young and older adolescents and that it targets girls and boys. This should include a full array of sexual and reproductive health services – including contraception (and condoms) and HIV testing.
- Encourage health workers to disseminate information about contraception even in areas where it is not yet welcome, going door-to-door as necessary to reach homebound wives, to directly address common misunderstandings about efficacy and side effects, and to specifically target boys and men with contraceptive information and awareness raising.

### 3 Scale up social protection to ensure that the poorest are sustainably reached with support for good nutrition.

- Expand investments in the PSNP and school feeding programmes to address food insecurity and under-nutrition.
- Expand programme coverage and improve targeting to reach the most vulnerable in rural and pastoralist areas, but also in poor urban communities, especially those hosting internally displaced persons.

### 4 Strengthen investments in efforts to change gender norms around child marriage, adolescent child-bearing and safe sex.

- Directly tackle the gender norms that leave girls at high risk of child marriage and adolescent pregnancy, and of contracting HIV, by providing comprehensive sexuality education (including communication and consent) in schools and non-formal education settings, and through community outreach and engagement with parents, religious leaders and community elders.
- Use marriage as a point of intervention to work with couples to ensure that both partners are knowledgeable about reproductive biology and contraception.



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Adolescent boys in Afar © Nathalie Bertrams / GAGE 2020

## Appendix

The GAGE Ethiopia baseline sample comprised 6,956 female and male adolescents, from three different subsamples of interest, living in East Hararghe (Oromia Region), South Gondar (Amhara Region), Zone 5 (Afar Region), and the urban areas of Debre Tabor, Batu/Ziway, and Dire Dawa. The largest subsample (6,647 adolescents) were chosen through randomised selection from a household listing exercise. During the listing exercise, survey enumerators followed a detailed protocol for making door-to-door visits to households in the study sites in order to identify adolescents aged 10-12 and 15-17 years of age living in the community (in rural areas, only adolescents aged 10-12 years old were sought). Once a list of these eligible adolescents had been made, a random sample of male and female adolescents from each of the two age groups was drawn, with equal numbers selected across research communities. GAGE researchers then purposefully sought and selected additional adolescents in these communities to be included in the data collection in order to ensure sufficient voice from particularly marginalised youth, such as those out of school, married or parents prior to age 18, and those with disabilities. This approach created two additional subsamples of adolescent respondents - a group of 'additional qualitative extra-nodal adolescents' who were chosen to take part in a series of qualitative interviews as well (119 adolescents not already selected to be part of the random sample), and a group of adolescents with physical disabilities (190 adolescents not already selected as either of the previous samples). Although the random subsample of GAGE adolescents is representative of adolescents in the focal age group from the study areas, the overall GAGE sample

overweights adolescents who are out of school, married, or have disabilities, as these are areas of particular interest for the research team. 6,825 adolescents from the overall baseline sample were interviewed during baseline data collection.

During midline data collection, the GAGE research team attempted to interview the entirety of the baseline sample of 6,956 female and male adolescents, including the random and purposefully selected samples. Furthermore, the researchers endeavored additionally to enlarge the sample along various characteristics of interest. In particular, during midline data collection, GAGE researchers sought to recruit additional adolescents who were married prior to age 18 (including several who were married prior to age 15), additional adolescents with physical disabilities, and adolescents in rural areas who were aged 15-17 at the time of the baseline data collection. After these various sample expansions, the GAGE Ethiopia midline sample comprised 8,555 female and male adolescents, from four different subsamples of interest. The random sample drawn prior to baseline data collection was unchanged (6,647 adolescents), but the sample of additional qualitative adolescents increased (for a total of 369 adolescents not part of the random sample), and likewise for the subsamples of adolescents with disabilities, those married prior to age 18, and those aged 15-17 during the time period of baseline data collection in rural areas. Once again, for the midline data collection, although the random subsample of GAGE adolescents is representative of adolescents in the focal age group from the study areas, the overall GAGE sample overweights adolescents who are out of school, married, or have disabilities.





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## About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a nine-year longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit [www.gage.odi.org.uk](http://www.gage.odi.org.uk) for more information.

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