Policy Brief

January 2026

An 18-year-old young mother in a health clinic, Oromia, Ethiopia © Nathalie Bertrams/GAGE 2026

GAGE endline findings about the health of young people in Ethiopia

Elizabeth Presler-Marshall, Kefyalew Endale, Workneh Yadete, Nicola Jones, Prabha Raghavan, Joan Hamory, Sarah Baird and Tassew Woldehanna

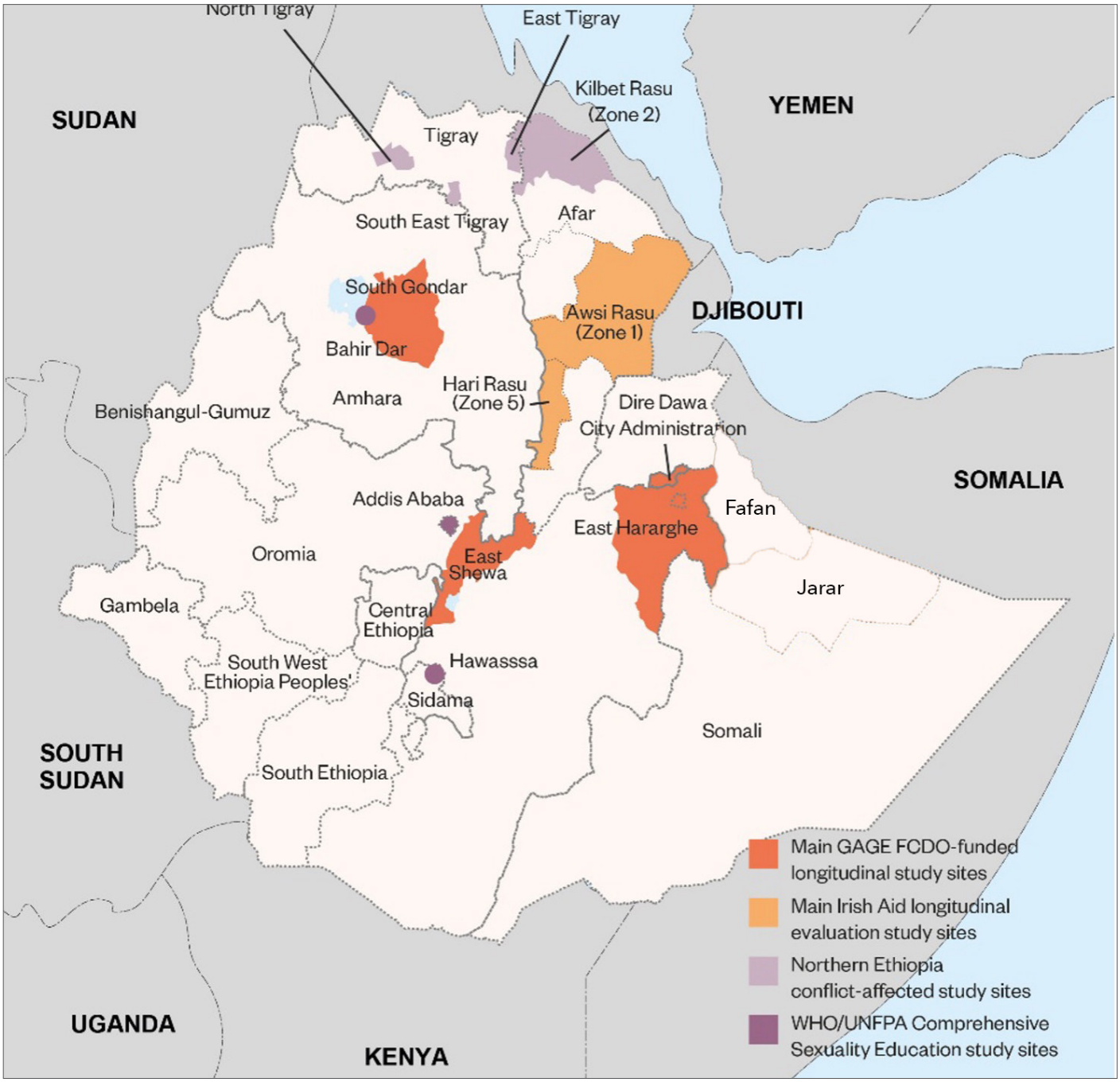
Introduction

The Ethiopian government has made a range of policy and action plan commitments to support its large and growing population of children and young people so that they can access the services, rights and work that they need to secure their own futures – and transform the country into an economic and social 'Beacon of Prosperity' for Africa (Ministry of Planning and Development, 2020). Recent events, however, have put these objectives at risk. Political and ethnic conflict have become intractable; climate change is accelerating; the government's budget is stressed by high inflation and debt load; and the Organisation for Economic Co-operation and Development (OECD) is projecting that official development assistance (ODA) will decline by up to 17% in 2025, due to cuts by major donors (OECD, 2025; UNDP Ethiopia, 2025; World Bank, 2025).

Drawing on longitudinal evidence from the Gender and Adolescence: Global Evidence (GAGE) research programme (2016–2026), this brief aims to inform policy and programme design and implementation by the Ministry of Health and its governmental and non-governmental partners. The brief summarises key findings on the health and well-being of young people from diverse communities in Ethiopia (see Presler-Marshall et al., 2025a, 2025b, 2025c), and offers recommendations on how to tailor policy and programming to improve young people's health, now, and as they make the crucial transition into young adulthood. The brief is based on mixed-methods data collected in late 2024 and early 2025. It also draws on data collected in 2019–2020 (Round 2) to show changes over time in key dimensions of young people's lives.

Suggested citation: Presler-Marshall, E., Endale, K.., Yadete, W., Jones, N., Raghavan, P., Hamory, J. , ... and Woldehanna, T. (2026) 'GAGE endline findings about the health of young people in Ethiopia'. Policy brief. London: Gender and Adolescence: Global Evidence

Figure 1: GAGE research sites



Methods

The research sample covers six locations in Ethiopia, three rural and three urban: 20 *kebeles* (clan leaders) in 5 *woredas* (administrative zones) in rural Hari Rasu (Zone 5), Afar; 80 *kebeles* in 4 *woredas* in rural East Hararghe, Oromia; 80 kebeles in 5 *woredas* in rural South Gondar, Amhara; 23 sub-kebeles/menders in urban Debre Tabor (in South Gondar, Amhara); 22 menders in 4 kebeles in urban Batu (in East Shewa, Oromia); and 20 menders in 7 *kebeles* in the chartered city of Dire Dawa (see Figure 1).

The endline research surveyed 6,673 young people: 4,565 in a younger cohort (aged 10–12 years at baseline, with an average age of 18.3 years at endline); and 2,108 in an older cohort (aged 15–17 at baseline, with an average age of 22.5 years at endline) (see Table 1).

The tracking rate at endline was very high, 88% overall, and involved interviewing young people who had moved throughout the country and also internationally. In South Gondar, due to security challenges, surveys and qualitative interviews were carried out by phone only. Attrition in rural South Gondar was also considerably higher, leaving the endline sample with more boys, young adults, and unmarried young people. Results should be interpreted accordingly.

Qualitative research included 959 interviews. Of these, 416 were individual interviews (IDIs) conducted with young people who were selected from the larger quantitative sample, deliberately oversampling the most disadvantaged individuals in order to capture the voices of those at risk of being 'left behind' (see Table 2). Individual interviews were also conducted with the caregivers (235) and siblings (58) of these 'core' young people, as well as with key informants (130), including *kebele*-level officials and service providers and woreda and regional sector officials.

To keep the two cohorts distinct, in this brief we refer to the younger cohort as 'adolescents' and the older cohort as 'young adults'. Female adolescents are called 'girls'; male adolescents are called 'boys'. Female young adults are called 'young women'; male young adults are called 'young men'. When the sample is referred to as a single group, they are called 'young people'. When girls and young women are jointly discussed, they are called 'young females'; when boys and young men are jointly discussed, they are called 'young males'. Group interviews were conducted with young people who were not part of the larger GAGE sample (79 groups), caregivers whose children were not part of the larger GAGE sample (22 groups) and community leaders and service providers (19 groups).

The GAGE research design and tools were approved by ethics committees at ODI Global and George Washington University, and the Ethiopian Society of Sociologists, Social Workers and Anthropologists. Verbal consent was obtained from caregivers and married adolescents; verbal assent was obtained for all unmarried adolescents under the age of 18. There was also a robust protocol for referral to services, tailored to the different realities of the diverse research sites.

Table 1: Quantitative sample

	Adolescents	Young adults	Sub-sample married < 18	Sub-sample with disabilities (at Round 2)	Total
Female	2547	1139	1281	211	**3686**
Male	2018	969	159	197	**2987**
Total	**4565**	**2108**	**1440**	**408**	**6673**

Table 2: Endline qualitative research sample

Interview Types	Location	Young people – IDIs		Young people – FGDs		Sibling IDI	Parent IDI	Parent FGD	Influencers FGD	KII	Total
		Females	Males	Females	Males						
Face to face interviews	East Hararghe	68	50	17	16	15	41	11	9	43	270
	Batu	17	12	9	8	-	15	3	3	9	76
	Dire Dawa	24	21	8	7	1	21	4	3	8	97
	Afar	35	24	6	8	17	40	4	4	16	154
Phone Interviews	Debre Tabor	17	17	-	-	-	21	-	-	7	62
	Ebenat Woreda	74	57	-	-	25	97	-	-	47	300
	Total interviews	235	181	40	39	58	235	22	19	130	**959**

1. Physical health

Many young people – especially girls and young women – are not adequately nourished

- In aggregate, 19% of young people live in food-insecure households. Rates of food insecurity are similar in rural and urban locations.
- The proportion of young people who report being hungry in the past month is broadly unchanged since baseline – except in South Gondar, where it has more than doubled (from 10% to 23%), due to the impacts of ongoing conflict.
- Girls and young women consume fewer meals that contain protein than boys and young men: 36% versus 47%. This is often because young females eat after young males.
- In urban areas, 8% of boys and young men and 18% of girls and young women are overweight, using World Health Organization (WHO) criteria. This is likely in part because 41% of young males and 62% of young females report not taking regular exercise in the past week. Restrictions on young females' physical mobility are partly to blame for this gap.

> *Food shortage and spending time without food has become common for me, particularly since two years ago.*
>
> (18-year-old young man, South Gondar)

Most young people are healthy, but many face high and rising barriers to accessing health care

- In aggregate, 88% of young people report that they are in good health. Rates are lower in South Gondar (81%) than other locations, due to the impacts of ongoing conflict.
- Malaria is spiking in many communities, because of climate change but also because of climate change but also because the provision of bed nets has been depriorotised, as has community mobilisation to reduce the standing water in which mosquitoes breed.
- In rural areas, 49% of young people report that cost is a barrier to seeking health care; the figure in urban areas is 40%. Costs are high in part because although health insurance is mandatory, public clinics are poorly stocked with needed medications, which must then be purchased out of pockets.
- In rural areas, 39% of young people report that distance is a barrier to seeking health care, in urban areas, the figure is 9%.
- At endline, young people were 10 percentage points more likely to report that cost is a barrier to obtaining healthcare than they were at Round 2.

> *We do have health insurance... They force us to pay for insurance. They will even imprison you if you do not pay it... However, here at the clinic, we are not able to benefit from the insurance as they instruct us to purchase medicines from other places, rendering it useless.*
>
> (18-year-old young man, South Gondar)

Young males are at risk of substance abuse disorder

- Young males in East Hararghe are most at risk – 67% of boys and young men chew *khat* every day, compared with 11% of their female peers. Daily *khat* use is rarely perceived as problematic.
- In South Gondar, 31% of young males and 18% of young females drink alcohol on a weekly basis.
- In urban areas, 14% of young males and 5% of young females drink alcohol weekly. Only 2% of young males – and 0% of young females – chew *khat* weekly.
- In Hari Rasu, rates are significantly lower – 11% of young males and 1% of young females chew *khat* weekly.

> *When I chew khat, it sharpens my focus and keeps me alert – almost like it 'opens my eyes' to the world around me. If I don't chew it, I lack that heightened awareness* (mirqaanaa)*, and my mind feels foggy or sluggish. Chewing khat also seems to steady me physically. I feel less dizzy and more grounded, especially during long days of work or social gatherings.*
>
> (24-year-old young man, East Hararghe)

Young people with disabilities are at greater risk of malnutrition and ill health – and despite this, they have less access to health care.

- Compared to their peers without disabilities, young people with disabilities are twice as likely to report being hungry in the past month (39% versus 20%).
- Young people with disabilities are 31 percentage points less likely to report being in good health (59% versus. 90%).
- Young people with disabilities are 23 percentage points more likely to report that cost is a barrier to health care (69% versus. 46%).
- Young people with disabilities are 13 percentage points more likely to report that distance is a barrier to health care (69% versus 46%).
- Young people with disabilities are 17 percentage points less likely to have a source of information about puberty (72% versus 89%).

> *'They did not take me to a health facility.'*
>
> (18-year-old young woman with a mobility impairment, East Hararghe)

An 15-year-old patient, South Gondar, Ethiopia © Nathalie Bertrams/GAGE 2026

Figure 2: Health care is increasingly difficult to access in South Gondar

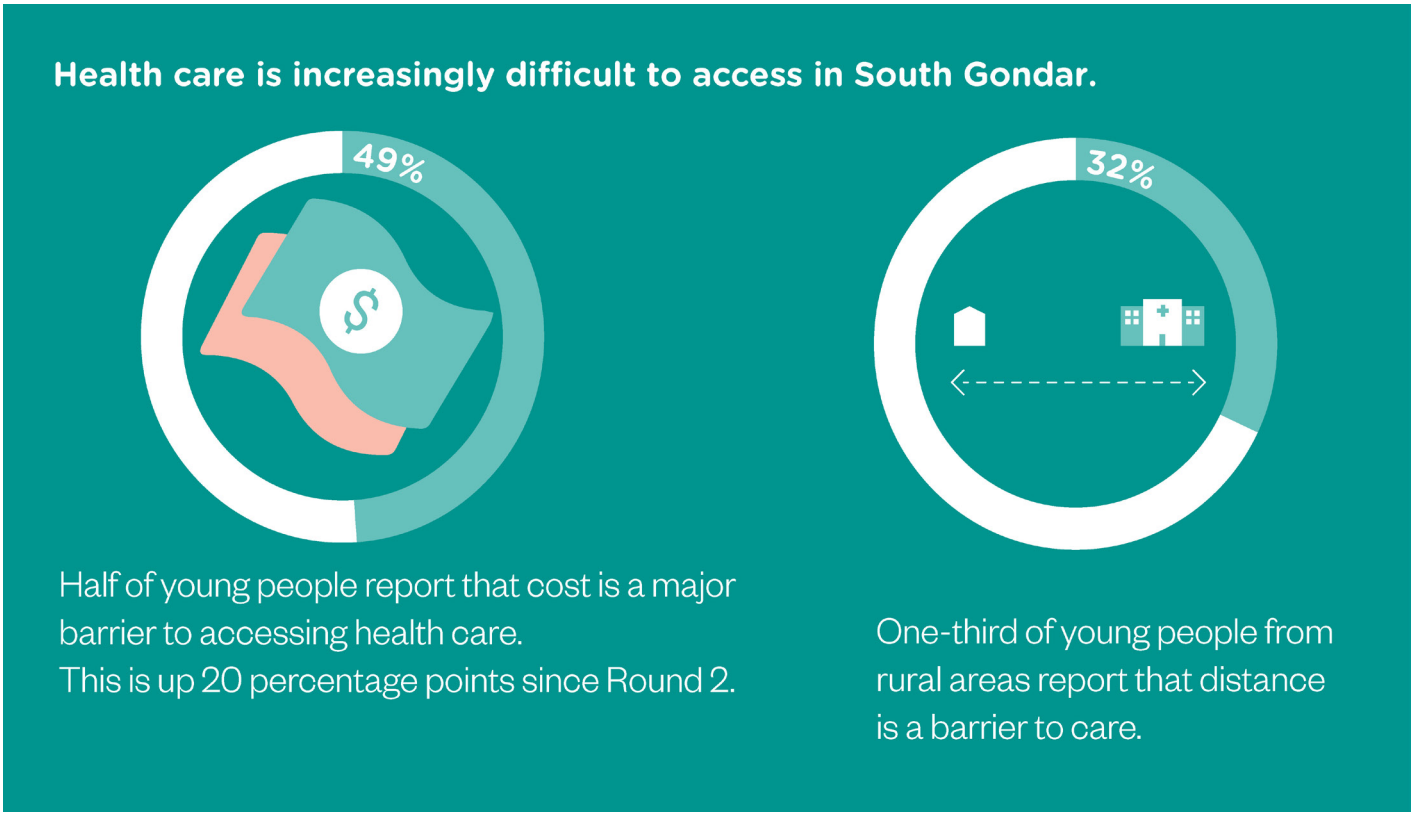
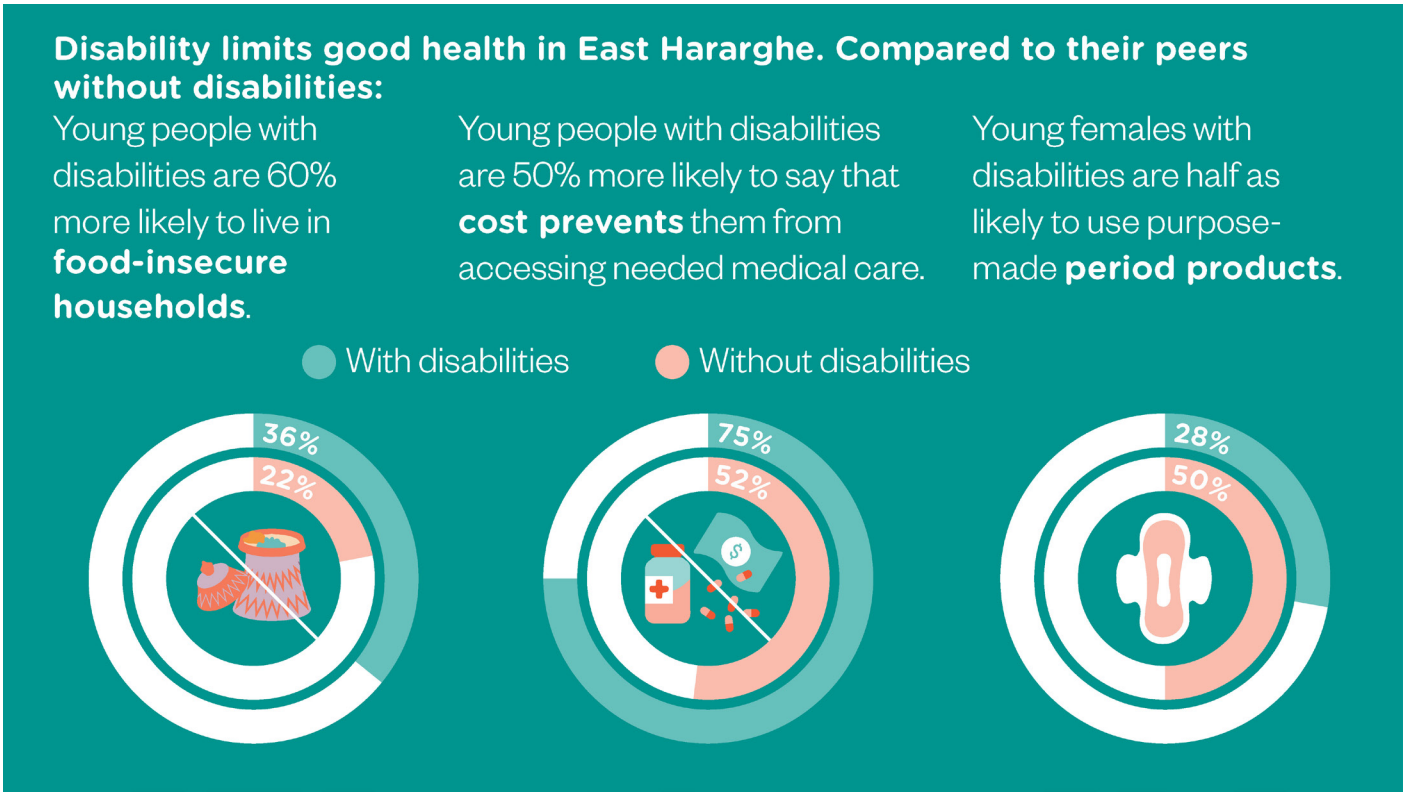


Figure 3: Disability limits good health in East Hararghe



2. Sexual and reproductive health

Most young people do not receive accurate information about their developing bodies as they reach puberty

- In rural areas, the plurality of young people (40%) learn about puberty from their friends.
- In urban areas, the plurality of young people (43%) learn about puberty from their teachers.
- Across locations, it was rare for young people to learn about puberty from their mother (10%) or father (4%), due to taboos about discussing sexual topics.
- In East Hararghe, young females are significantly disadvantaged compared to young males. They are 9 percentage points less likely to have any source of information about puberty; 6 percentage points less likely to know that menarche means that a girl can become pregnant; and 9 percentage points less likely to be aware that adolescent pregnancy can be dangerous.

> *We feel shame to talk about this [menstruation].*
>
> (Mother, South Gondar)

Many young females struggle with menstrual health

- Although 90% of young females in urban areas use purpose-made disposable or reusable products to manage their periods, this is true of only 49% of young females in rural areas. Young females in Hari Rasu (18%) are especially unlikely to use purpose-made period products.
- Of young females who are enrolled in school, only 46% reported that their school has facilities or supplies to help them manage their periods while at school. Female students in Hari Rasu are especially disadvantaged (16%).
- Three-fifths (61%) of young females in rural areas, and one quarter (25%) of their urban peers, are afraid or embarrassed to ask family members for support with managing their periods.

> *I use torn clothes for my period because I can't afford sanitary pads.*
>
> (17-year-old girl, Debre Tabor)

Premarital sex is not uncommon, especially among young males.

- Outside of East Hararghe, where premarital sex is extremely uncommon (due to cultural taboos and because young people marry so early), young people are likely to become sexually active prior to marriage. In aggregate, 37% of unmarried boys and young men and 20% of unmarried girls and young women have had sex.

> *I started at the age of 12... I have had sex with nearly 15 females so far.*
>
> (20-year-old young man, Hari Rasu)

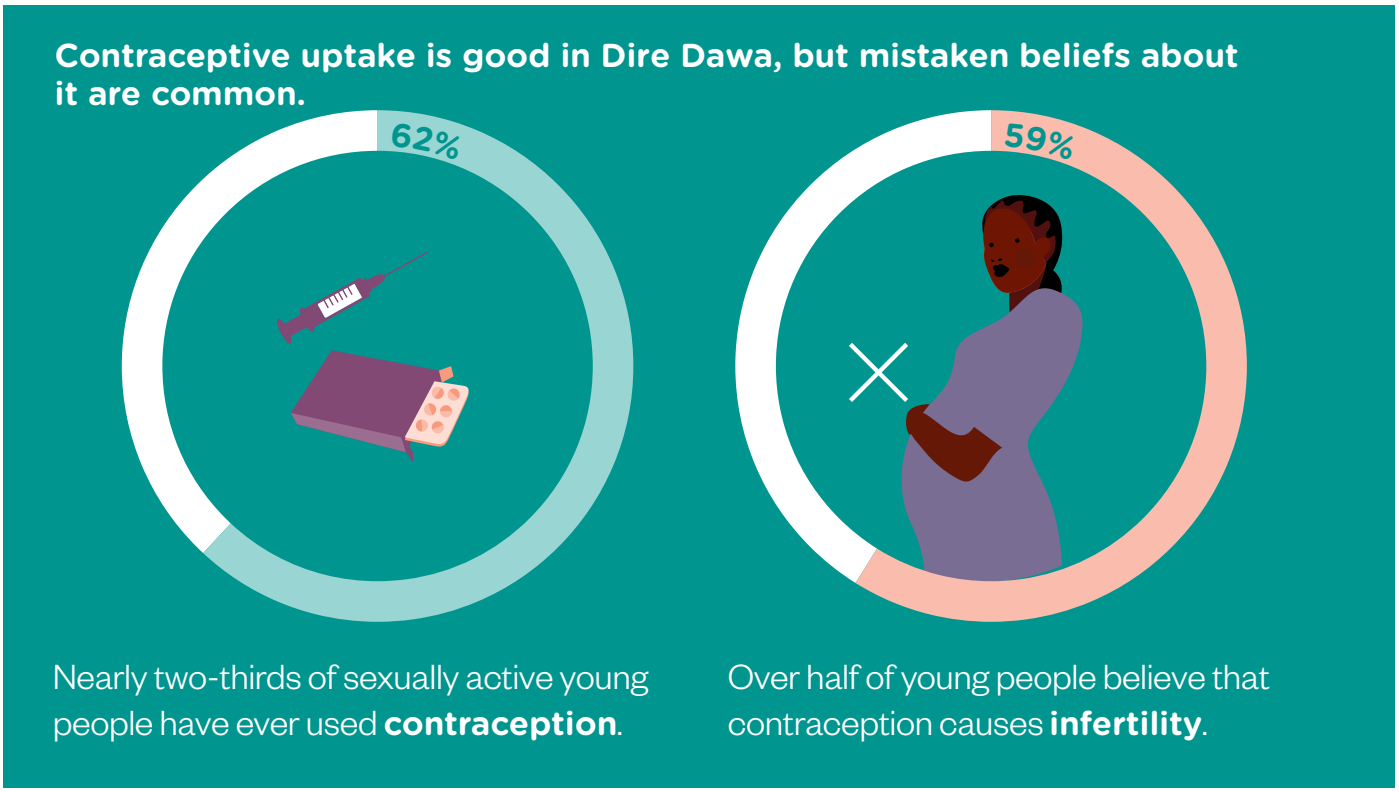
Most young people are aware of their contraceptive options, but misinformation is rampant

- Nearly all young people in urban areas (90%) and South Gondar (86%) can correctly name a modern method of contraception. This is true of only two-thirds of their peers in Hari Rasu (67%) and East Hararghe (70%). Overall, young people were 27 percentage points more likely to be able to name a method at endline than they were at Round 2.
- In aggregate, 58% of young people believe that contraception causes infertility and 39% believe that it can cause babies to have deformities.
- Young males are 10 percentage points more likely than young females to believe that contraception causes infertility. They are 12 percentage points more likely to believe that it causes birth defects.

> *I do not think contraceptives are good. They can lead to infertility. It is better to have children than to use contraceptives.*
>
> (17-year-old girl, Dire Dawa)

Figure 4: Premarital sex in South Gondar

Figure 5: Contraceptive uptake in Dire Dawa



Contraceptive uptake among young people varies significantly across regions

- Overall contraceptive uptake among young people is better in South Gondar and urban areas than in East Hararghe and Hari Rasu.
- In South Gondar, 56% of sexually active young people were currently using a modern method of contraception. Young couples prefer to delay parenthood until they are financially secure, and girls' bodies are fully developed. Unmarried girls often use contraception to prevent pregnancy should they be raped.
- In urban areas, 44% of sexually active young people were currently using a modern method of contraception.
- By contrast, in Hari Rasu, only 13% of sexually active young people were currently using a modern method of contraception. This is because of widespread beliefs that contraception is haram (forbidden).
- In East Hararghe, only 6% of sexually active young people were currently using a modern method of contraception. This is because of widespread beliefs that contraception is *haram* and strong preferences that young brides prove their fertility immediately after marriage.
- Across all locations, use of long acting contraception is very rare. Only 3% of sexually active young people are using a form of LAC.
- In aggregate, sexually active young people were no more likely to be using a modern method of contraception at endline than they were at Round 2.

> *My wife and I discussed family planning. We have a plan to have a baby in one to two years in the future... We want to work and raise money. We want to run a business.*
>
> (22-year-old young man, South Gondar)

Condom use is rare in rural areas.

At endline, of those reporting current contraceptive use, only 1.7% of rural boys and young men reported using condoms, compared with 21% of those in urban areas. Young people report that condoms are difficult to access in rural areas and that young males do not like them.

> *People are not afraid of HIV at this time. It has been ignored.*
>
> (Health extension worker, Batu)

Teenage pregnancy is closely linked to child marriage – and low demand for contraception

- Overall girls in East Hararghe are most at risk: child marriage is common and contraceptive uptake is very rare, and 48% of young females have ever been pregnant. Young mothers first became pregnant at a mean age of 16.1 years. Of all young mothers, 10% became pregnant before age 15.
- In Hari Rasu, where child marriage is common and contraceptive uptake is rare, 49% of young females have ever been pregnant. Young mothers first became pregnant at a mean age of 17.2 years. Of all young mothers, 5% became pregnant before age 15.
- By contrast, in South Gondar, where child marriage has become less common and contraceptive uptake is relatively high, 15% of young females have ever been pregnant. Young mothers first became pregnant at a mean age of 18.5 years. Of all young mothers, just 1% became pregnant before age 15.
- In urban areas, where child marriage is rare and contraceptive uptake is relatively high, 16% of young females have ever been pregnant. Young mothers first became pregnant at a mean age of 19 years. Of all young mothers, again just 1% became pregnant before age 15.

> You don't truly know your wife until she gives birth'
>
> (Key informant, East Hararghe)

Access to maternity care remains limited in rural areas

- In urban areas, 88% of young mothers received antenatal care (a mean of 4.7 visits) and 91% delivered in a facility.
- In Hari Rasu, only 41% of young mothers received antenatal care (a mean of 1.2 visits) and only 16% delivered in a facility.
- In East Hararghe, 69% of young mothers received antenatal care (a mean of 2.4 visits) and 52% delivered in a facility.
- We do not have endline data for South Gondar, because the survey was shortened due to the conflict.

> Pregnant women in this community give birth at home. No one will go to the health facility unless they face severe birth complications.
>
> (Religious leader, Hari Rasu)

9

3. Public health implications of child marriage and FGM

The risks of FGM vary significantly by location, and have major public health implications during adolescence and across the life course

- In Hari Rasu, 98% of young females have undergone FGM, usually before the age of 5. Most underwent Type 3/ infibulation with scar tissue and consequently have higher lifetime risk of urinary and gynaecological infection, sexual pain, and obstructed childbirth. Practices are gradually becoming less severe, in large part due to the efforts of religious leaders who are preaching against infibulation (and for clitorectomy.
- In East Hararghe, 92% of young females have undergone FGM, usually in late childhood or early adolescence. Most underwent Type 2/ excision, with lifetime consequences for their sexual health. There is no evidence that FGM is becoming less common or shifting to a less severe form.
- In South Gondar, 60% of young females have undergone FGM, usually as infants. Most underwent Type 1/ clitorectomy, with lifetime consequences for their sexual health. Incidence has fallen over the past decade, with today's babies at far lower risk of FGM. This is primarily due to the efforts of health extension workers, teachers, and other government messengers.
- FGM practices in urban areas are varied and reflect the diversity of cities. In aggregate, 31% of young females have undergone FGM. The practice is becoming less common – and less severe – in urban areas.

> *When you are first mutilated, you feel burned when you pee. Whenever you give birth, it is torn again and it pains you.*
>
> (19-year-old young woman, Hari Rasu)

Girls' risk of child marriage varies significantly by location, with spillover risks for maternal and infant morbidity and mortality

- Girls in East Hararghe are most at risk –at endline, 54% of adolescent girls had married before age 18; 23% had married by age 15. Three-quarters of young brides (76%) made their own marriage decisions – albeit under heavy pressure (and often threats of violence) from their male (and sometimes female) peers.
- In Hari Rasu, 39% of adolescent girls had married before age 18, and 8.3% had married by age 15. Young people marry a maternal cousin, and young brides rarely (5%) have any say over who or when they marry.
- In South Gondar, 8% of adolescent girls had married before age 18, and 6% had married by age 15. Most marriages are arranged by parents (80%) and girls who are not in school have limited say over marriage decision-making.
- In urban areas, 3% of adolescent girls had married before age 18, and 0.6% had married by age 15. Three-fifths (60%) of young brides made their own marriage decisions.

> *Getting married is better than education... Because otherwise, you will have a chance of only falling into the hands of old husbands, and that is really bad.*
>
> (15-year-old girl, East Hararghe)

An 15-year-old boy herding, South Gondar, Ethiopia © Nathalie Bertrams/GAGE 2026

Marital violence is widely viewed as acceptable, especially in rural areas, with implications for girls' and women's risk of injury and broader health

- In Hari Rasu, 50% of young people believe that wife-beating is acceptable. There are no gender differences. A similar proportion (53%) believe that marital violence is private and should not be disclosed. More females believe this than males.
- In South Gondar, 39% of young people believe that wife-beating is acceptable and 34% believe that marital violence is private and should not be disclosed. There are no gender differences in either.
- In East Hararghe, 48% of young people believe that wife-beating is acceptable and 71% believe that marital violence is private and should not be disclosed. Males are more likely than females to believe both.
- In urban areas, 16% of young people believe that wife beating is acceptable and 25% believe that marital violence is private and should not be disclosed. There are no gender difference in either.
- In aggregate, 10% of young brides report having ever been physically assaulted by their husband.
- In aggregate, between Round 2 and endline, the proportion of young people who believe that wife-beating is acceptable fell by 20 percentage points.

> *Husbands in urban areas are aware of women's and girls' rights, the family law, the penal code, etc. Besides women and girls in urban areas are aware about their rights, how to keep their rights, where, how and to whom to report violence cases. However, in rural areas, women and girls are still disadvantageous.*
>
> (Teacher, South Gondar)

An 15-year-old girl fetching water from dry hole, Afar, Ethiopia © Nathalie Bertrams/GAGE 2026

Policy and programming implications

In order to improve the health and well-being of young people in Ethiopia, it is critical for the Ministry of Health to undertake the following priority policy actions:

- Supervise and monitor the implementation of all health strategies, policies and action plans as they pertain to adolescents and youth.
- Strengthen coordination and collaboration with other sectors to ensure that young people are able to fulfil their rights to health and sexual and reproductive health and well-being.
- Continue to strengthen policy and programming decisions based on robust research evidence in order to ensure maximisation of scarce resources and outreach to all young people, and especially those with intersecting needs – including young people with disabilities, girls who married as children and those living in conflict-affected communities.
- Leverage the Youth Council of the Ministry of Health to continue to expand the Ministry's engagement with young people so that they can shape decision-making that is adolescent – and youth-responsive.

To promote young people's physical health and nutrition:

- Expand access to health care by ensuring that health institutions are well-staffed and stocked, including with medications and clean water.
    - Invest in a cadre of Afar health extension workers to promote uptake of health services among adolescents.
    - In Amhara, accelerate efforts to rebuild health infrastructure and restore the health services destroyed by conflict.
- Ensure that health insurance is a benefit and not a burden by reducing cost-sharing for poorer households.
- Provide young people and their parents with education about the risks of substance use, focusing on the physical and psycho-emotional risks of substances such as alcohol and *khat*. Pair this with expanded options for treatment for addiction, especially in urban areas.
- In urban areas, develop awareness-raising campaigns about the importance of physical exercise, especially for young females, to tackle rising rates of over-weight young people. Pair this with support for the Ministry of Culture and Sport to develop walking and cycling routes that are well-lit and policed.
- Address food insecurity by investing in nutritional support, expanding school feeding, and – in South Gondar – stepping up emergency aid. Pair this with education about why females' nutrition is especially important, given life-course impacts of malnutrition on maternal and child health.
- Prioritise malaria prevention by providing bed nets, insecticides and draining and filling swampy areas through community mobilisation and working to raise awareness about how disease spreads.
- Prioritise young people with disabilities, supporting their households to access the Productive Safety Net Programme (PSNP) to improve nutrition and access to health care. Pair this with expanded access to specialist care and assistive devices, alongside efforts to address the fatalism that surrounds disability, by encouraging families to seek health care.

To strengthen young people's sexual and reproductive health knowledge, services and rights

- In line with the Teenage Pregnancy Roadmap, provide young people (including those with disabilities) with school- and community-based sexual and reproductive health education that addresses puberty, and the stigma that surrounds menstruation, while offerings girls practical instruction on how to make safe and sustainable period products.
    - Pair this with programming aimed at supporting parents to openly discuss sexual and reproductive health topics with their children.
    - In addition, collaborate with the Ministry of Education to ensure that all schools have clean, secure toilets that are provisioned with water and free period products.
- Ensure that young people (including those with disabilities) receive detailed, accurate, and iterative information about contraception. Education should be provided at school and in the community (at venues such as market kiosks, one-stop-centres, youth centres, health centres, private clinics, pharmacies) and should cover how each method works. It should also address young people's concerns about possible side effects, safety and infertility risks.
- Build demand for contraception, especially in communities where contraceptives are not culturally acceptable, by targeting young people and their broader communities with education about the benefits (for babies, mothers and families) of delayed, spaced and limited pregnancies.
    - Work with religious leaders to counter beliefs that family planning contravenes Islamic law.
    - Try to build demand for long-acting contraceptives, given that these reduce females' risk of pregnancy as well as public health expenditures.
    - Critically, many health extension workers need refresher training on contraception, as they share

young people's concerns about the risks of infertility of contraceptive use.

- Step up awareness-raising (at school and in the community) about how to prevent HIV, and link this with improved and free access to condoms, including in the public spaces that young people visit.
- Expand access to youth-friendly sexual and reproductive health rights and services, using special times or locations and ensuring that health extension workers are trained to communicate sensitively with young people, and take the time to work with individuals to find products that work for them.
- In rural areas, build demand for and access to antenatal care and skilled delivery by ensuring that regular care is locally available, that care includes more than vaccines and cursory exams (e.g. allowing mothers to hear the foetal heartbeat and providing them with education on infant care and child development), and that ambulance transport is available to labouring mothers.

To address the public health implications of child marriage, FGM and all kinds of gender-based violence, including intimate partner violence:

- Work with the Ministry of Women and Social Affairs to raise young people's awareness (at school and in the community) about their right to be free from child marriage, FGM and gender-based violence, and how to access support – including from one-stop-centres.
  - Pair this with expanded training for health extension workers on how to recognise violence, girls at risk of child marriage and FGM (or survivors of these violations), and make any necessary referrals, emphasising that health extension workers have a duty to report violations.
  - Ensure that alongside thier efforts to encourage contraceptive uptake, health extension workers, midwives and health officers are working to discourage child marriage as a means of reducing adolescent pregnancy and lowering girls' lifetime risk of violence.
  - Actively promote contraceptive counselling for newly married couples, including through the Smart Start programme, highlighting the economic, health and social benefits of family planning and birth spacing, and raise awareness about how to prevent intimate partner violence.
  - Expand training for health extension workers, midwives and health officers on the consequences of FGM for girls and women's health throughout the life course, and how they can support survivors to proactively notice, report and manage health risks.
  - Ensure that maternity service providers are aware that young mothers who have undergone FGM– especially those who have been infibulated – not only require specialised medical care, but also specialised psychosocial support, to help them cope with trauma.
  - Ensure that health extension workers are counselling parents and young people about the health risks of FGM (especially infibulation). Efforts should engage with mothers (who arrange cutting), fathers (who could refuse to allow it), girls (to reduce peer pressure and related demand), and young males (to address their beliefs about female sexual purity and preferences for a wife who has been cut).
  - Ensure that health professionals are banned from carrying out FGM in health institutions or any other location as per Ministry of Health guidelines

A young couple on their honeymoon, East Hararghe, Ethiopia © Nathalie Bertrams/GAGE 2026

References

Presler-Marshall, E., Raghavan, P., Workneh, Y., et al. (2025a) Young people's development and well-being in Dire Dawa City Administration: GAGE endline evidence. Report. London: Gender and Adolescence: Global Evidence (https://gage.odi.org/young-people-s-development-and-well-being-in-dire-dawa-city-administration-gage-endline-evidence/)

Presler-Marshall, E., Raghavan, P., Endale, K., et al. (2025b) Young people's development and well-being in Afar, Ethiopia: GAGE endline evidence. Report. London: Gender and Adolescence: Global Evidence (https://gage.odi.org/young-people-s-development-and-well-being-in-afar-ethiopia-gage-endline-evidence/)

Presler-Marshall, E., Raghavan, P., Endale, K., et al. (2025c) Young people's well-being and development in East Hararghe, Oromia region, Ethiopia: GAGE endline evidence. Report. London: Gender and Adolescence: Global Evidence (https://gage.odi.org/young-people-s-well-being-and-development-in-east-hararghe-oromia-region-ethiopia-gage-endline-evidence/)

OECD (2025) 'Cuts in official development assistance:

UNDP Ethiopia (2025) Quarterly economic profile, April 2025. (https://www.undp.org/sites/g/files/zskgke326/files/2025-04/ethiopia_quarterly_economic_profile_april_2025.pdf)

World Bank (2025) The World Bank in Ethiopia (https://www.worldbank.org/en/country/ethiopia/overview)

A 17-year-old girl family planning at health centre, Dire Dawa, Ethiopia © Nathalie Bertrams/GAGE 2026

This brief 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.

ISBN: 978-1-917476-27-0