

Young people's physical health: findings from GAGE multi-country longitudinal evidence

Elizabeth Presler-Marshall, Nicola Jones, Sara Luckenbill, Jennifer Seager,
Stella Leung, Bassam Abu Hamad, Wafa Alamaireh, Sarah Alheiwidi,
Sarah Baird, Anita Ghimire, Silvia Guglielmi, Magdalena Harrison,
Khadija Mitu, Joost Vintges, Workneh Yadete and Sally Youssef

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Key messages: adolescent food security and health

1. **Food insecurity affects many young people**, with some going hungry and others forced to rely on inexpensive but largely 'empty' calories.
2. **Overweight and obesity are growing concerns**, especially for young females, who – due to restrictions on their mobility – have little opportunity to take exercise.
3. **Most young people report they are healthy**, although there is a gender gap that disadvantages girls and young women, especially after marriage, driven by gynaecological issues and the fact that young brides' households are more likely to be extremely poor.
4. **Many young people struggle to access health care**, primarily because it is too expensive but also – for young females – because they are embarrassed or do not have the time to focus on their own needs.
5. **Substance use is a problem for boys and young men**, who smoke, drink and chew *khat* (depending on context) to 'fit in' with their peers and to relieve stress.
6. **Most young people have a source of information about puberty**, but that information is often not timely, accurate, or delivered by trustworthy adults.
7. **Although improving, menstrual health management remains a challenge for the poorest and most rural girls and young women**, because period products are not available (or affordable) and because menstruation remains stigmatised.
8. **Many young people are not aware of contraception**, and even those who are often hold mistaken beliefs about its safety and impacts on longer-term fertility.
9. **Only a minority of married couples use contraception**, and not all young brides have a say. Most young couples soon become young parents.
10. **Disability increases young people's risk of food insecurity and ill-health and limits their access to health care**. This is primarily due to the reality that disability can be expensive (because of added costs for assistive devices, specialist care, and supplies like nappies), but is also shaped by the stigma that surrounds disability.
11. **Conflict has devastating impacts on young people's health**, including disrupted access to information and services, and conflict-related injuries – that if not treated risk becoming permanent disabilities.

Introduction

Health is foundational to any serious effort to build the healthier, more equitable world envisioned in the 2024 Pact for the Future.¹ Yet adolescent health has historically attracted relatively little investment – partly because adolescents are generally healthier than under-5s, and because the antecedents of adult ill health are usually overlooked in the broad brush strokes that paint adolescence as a time of good

health. It is only in the past decade that adolescence has been more widely recognised for what it is: a critical window for establishing good nutrition and healthy habits, reproductive health knowledge, and patterns of health care use that shape longer-term adult outcomes. For young people navigating poverty, child marriage, disability, or conflict and displacement, that window is narrower, the risks are greater, and the absence of adequate information and services is more likely to translate into lasting harm.

The Gender and Adolescence: Global Evidence (GAGE) research programme, funded by the UK's Foreign, Commonwealth and Development Office (FCDO), has generated longitudinal, mixed-methods evidence on the health of adolescents and young adults across Bangladesh, Ethiopia, Jordan, Lebanon, Nepal and Palestine (Gaza). By combining large-scale surveys with in-depth qualitative research, GAGE captures not just health outcomes and how they evolve over time, but the structural inequalities and gender norms that shape them.



Gender club in Afar, Ethiopia © Nathalie Bertrams/GAGE 2026

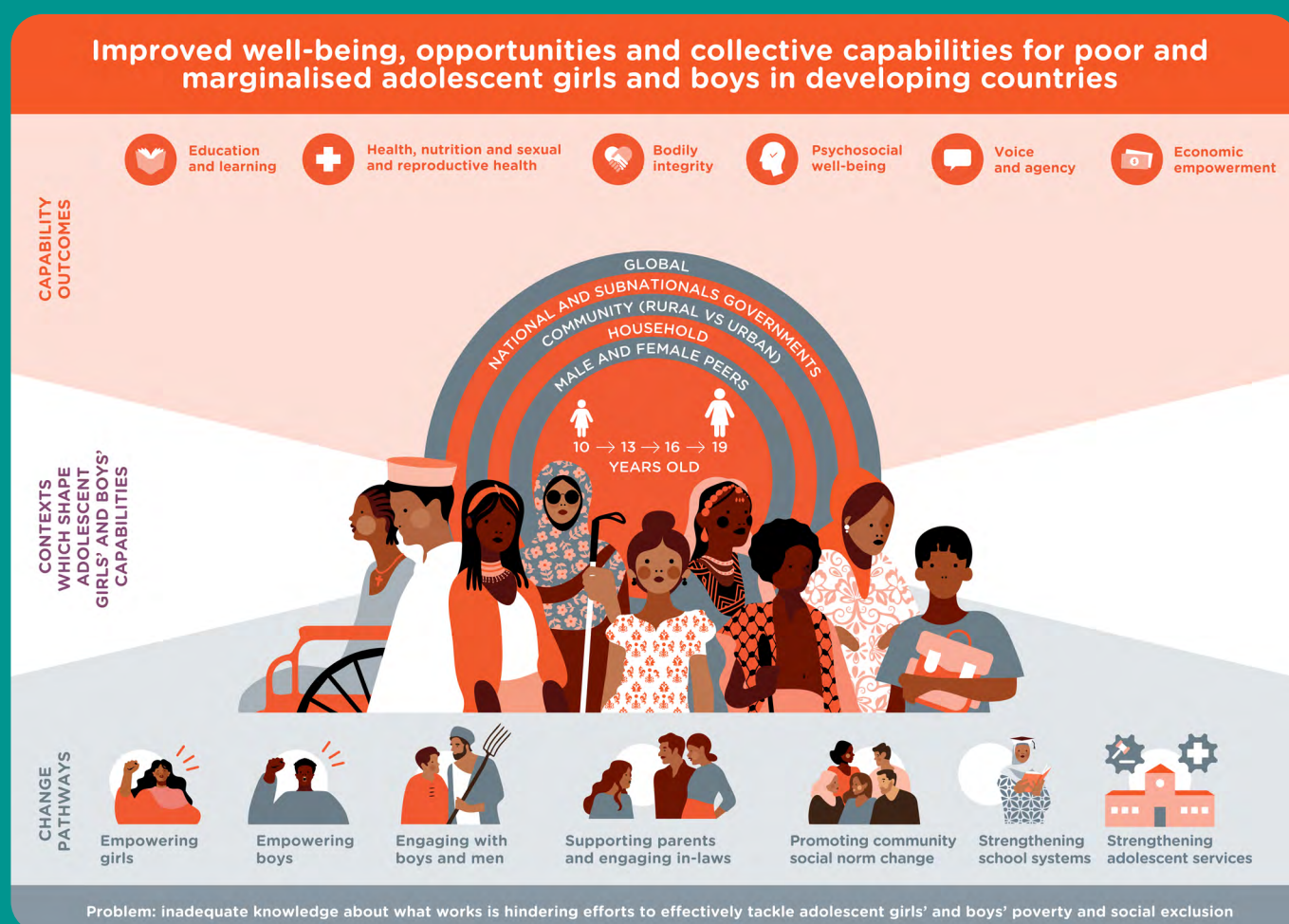
This product primarily draws on GAGE's endline data, collected in 2024 and 2025, to examine young people's health across the programme's six research contexts. To identify trends over time, it also includes some data from earlier data collection rounds. We begin by introducing GAGE's conceptual framework, and sample and methodology. We then turn to carefully disaggregated research findings on nutrition, physical health and access to health care, substance use, puberty education, menstrual health management, and knowledge about and uptake of contraception and maternity care. We conclude with cross-cutting recommendations aimed at supporting young people's good health, now and in the future.

GAGE focus and conceptual framing

The GAGE research programme has generated mixed-methods, longitudinal evidence about the diverse experiences of adolescents and young adults living in low- and middle-income countries (LMICs). Paying careful attention to the interconnectedness of what we call the ‘3 Cs’ – capabilities, change strategies and contexts (see Figure 1) – GAGE has explored the opportunities and challenges facing young people as they transition through adolescence and into young adulthood. The programme has endeavoured to identify what works to support young

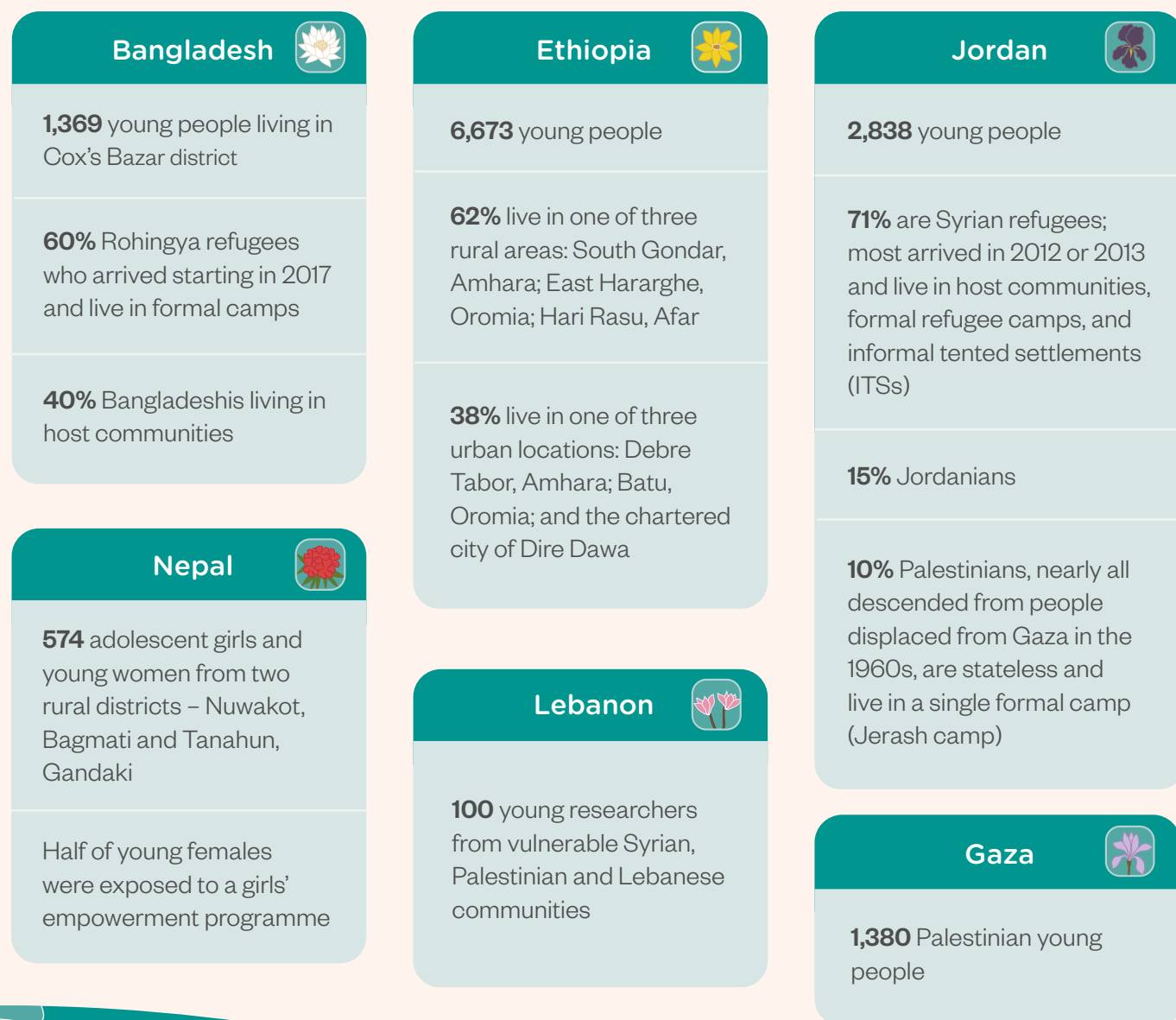
people to develop their full capabilities for education, physical health, bodily integrity and freedom from violence, psychosocial well-being, voice and agency and economic empowerment. Critically, GAGE research has included those young people who are most at risk of being left behind, including girls who are (or have been) married, young people who have been forcibly displaced by conflict, and young people with disabilities.

Figure 1: GAGE conceptual framework



GAGE sample and methodology

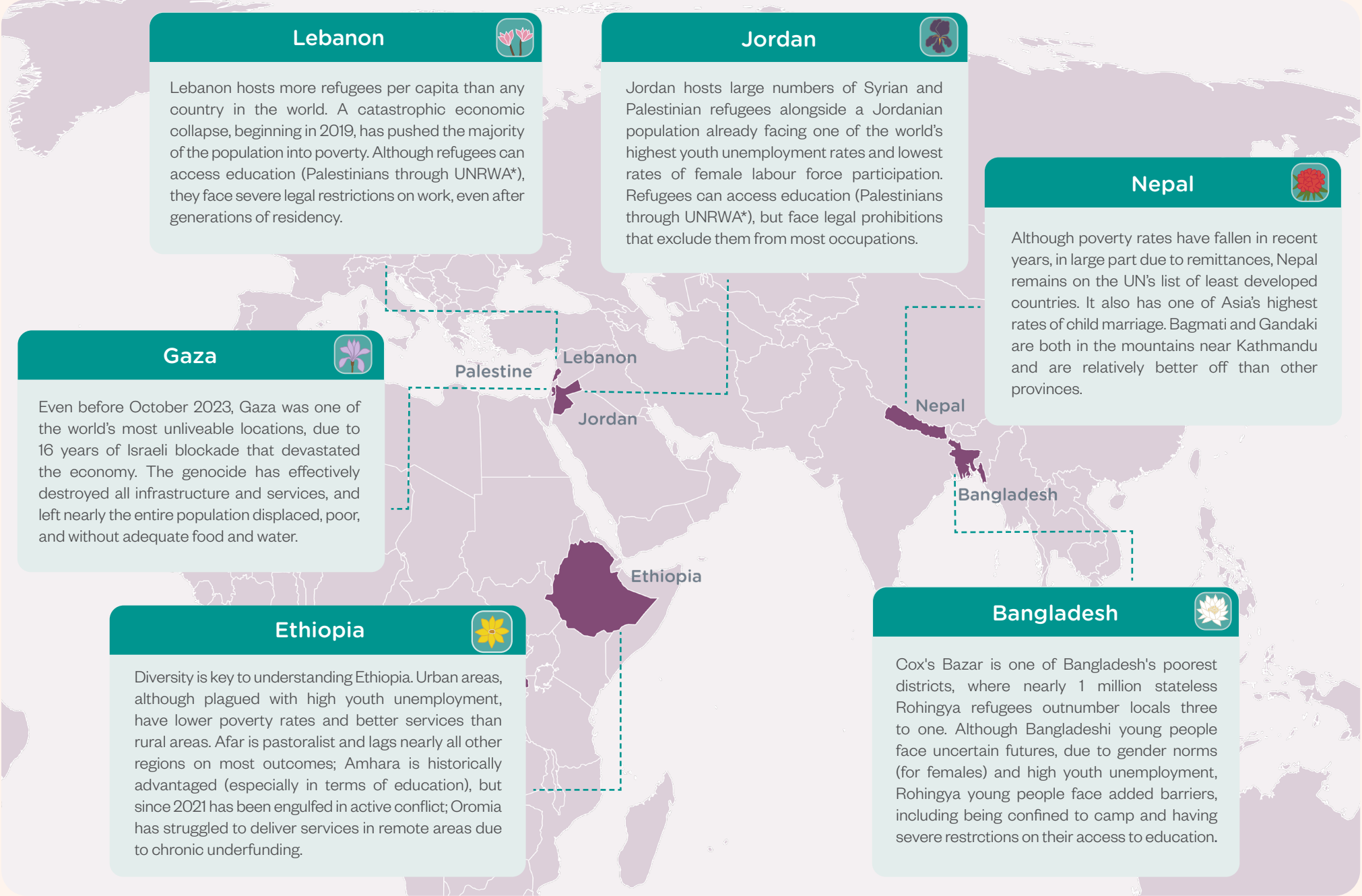
This brief primarily draws on endline data collected in 2024 and 2025, and highlights similarities and differences in findings across six countries: Bangladesh, Ethiopia, Jordan, Lebanon, Nepal and Palestine (Gaza) (see Figure 2).



Data from Bangladesh,² Ethiopia and Jordan is roughly analogous. Samples are large, include both females and males and two cohorts (a very young adolescent cohort aged 10–12 years at baseline, and called 'adolescents' in this product; and an older adolescent cohort aged 15–17 years at baseline and called 'young adults'), and used similar mixed-methods tools. In the three other contexts, the samples are differently shaped and the approach was tailored to understand specific aspects of adolescent well-being and empowerment programming. In Nepal, the sample is smaller and includes only females who were (mostly³) enrolled in grade 6 at baseline; in addition, the research was primarily focused on girls' education. In Lebanon, the sample is small and includes a single cohort (aged 15–19 at baseline) of vulnerable young people. Research was participatory, focused on experiences of forced displacement, and used photography and interview tools that young researchers helped develop. In Gaza, the sample includes three age cohorts (aged 10–14, 15–19, and 20–24 at baseline, in 2024) and tools were adapted to reflect experiences of active conflict.

² GAGE has a second Bangladesh sample, in Chittagong and Sylhet Divisions, not used in this product. See: <https://gage.odi.org/growth-mindset-bangladesh/>
³ Some girls, mostly in the control sample, were enrolled in grades other than grade 6.

Figure 2: GAGE research locations



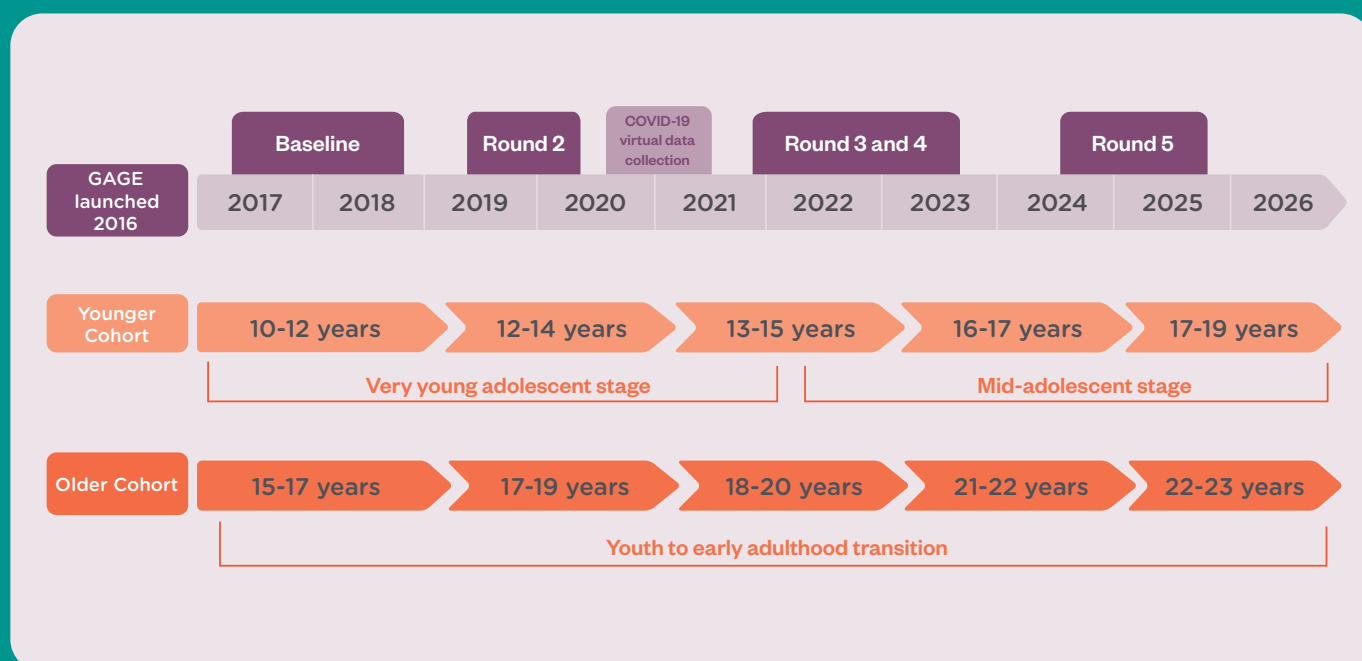
*The United Nations Relief and Works Agency for Palestine Refugees in the Near East

To capture change in young people's lives over time, this brief also includes some longitudinal data⁴ (see Figure 3). For Bangladesh (2019), Gaza (2024), and Jordan (2018–2019), comparisons are made to baseline.⁵ For Ethiopia, they are made to Round 2 (2019–2020).⁶ Where longitudinal data is presented, it includes only the young people who were sampled in both rounds – which, across contexts, is approximately 83% of the full baseline sample.

As noted, the GAGE programme uses mixed-methods research, predominantly face-to-face, but via phone if necessary.⁷ With the caveat that surveys were tailored to context, all include attention to nutritional status and food security, broader physical health and access to health care, substance use, puberty education, menstrual health management, knowledge about and uptake of contraception, and young motherhood and access to maternity care.⁸ A subset of young people were selected to take part in individual and group interviews, during which we used a variety of interactive tools⁹ to explore young people's experiences with and beliefs about these same topics. Surveys and interviews were also conducted with young people's caregivers, and interviews were conducted with key informants at local and national levels.

The GAGE research design and tools were approved by ethics committees at ODI Global, George Washington University, and country-level bodies. Consent (written or verbal as appropriate) was obtained from caregivers, young people over 18 and married adolescents; written or 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.

Figure 3: GAGE timeline



⁴ Longitudinal data is not presented for Nepal, because most of the girls and young women who dropped out of school were lost to follow-up.

⁵ For a few indicators, baseline data is not available for Bangladesh and Jordan, and comparisons are instead made to midline data, which was collected after the Covid-19 pandemic ended, in 2022–2023.

⁶ We use Round 2 rather than baseline data because we added hundreds of new young people to the Ethiopia sample between baseline and Round 2.

⁷ Phone interviews were used in the early phases of the Covid-19 pandemic, when young people had migrated or been forcibly displaced, and when active conflict compromised the safety of researchers.

⁸ Surveys can be found here: <https://gage.odi.org/publications/?publication=knowledge-products&knowledge-products=survey-instruments>

⁹ Toolkits can be found here: <https://gage.odi.org/publications/?publication=knowledge-products&knowledge-products=methodological-toolkits>



Findings

Many young people are food insecure

The GAGE survey included a tool designed to measure household food security.¹⁰ In Bangladesh (21%), Ethiopia (19%), and Jordan (31%), a large minority of young people were living in households experiencing severe food insecurity (see Figure 4). In Gaza, this was true of most (see Box 1). Some young people spoke of skipping meals entirely; others spoke of diets devoid of protein and fruits and vegetables.

'Some people can't even afford bread, let alone fruits, vegetables or meat.'
(Palestinian key informant, Jordan)

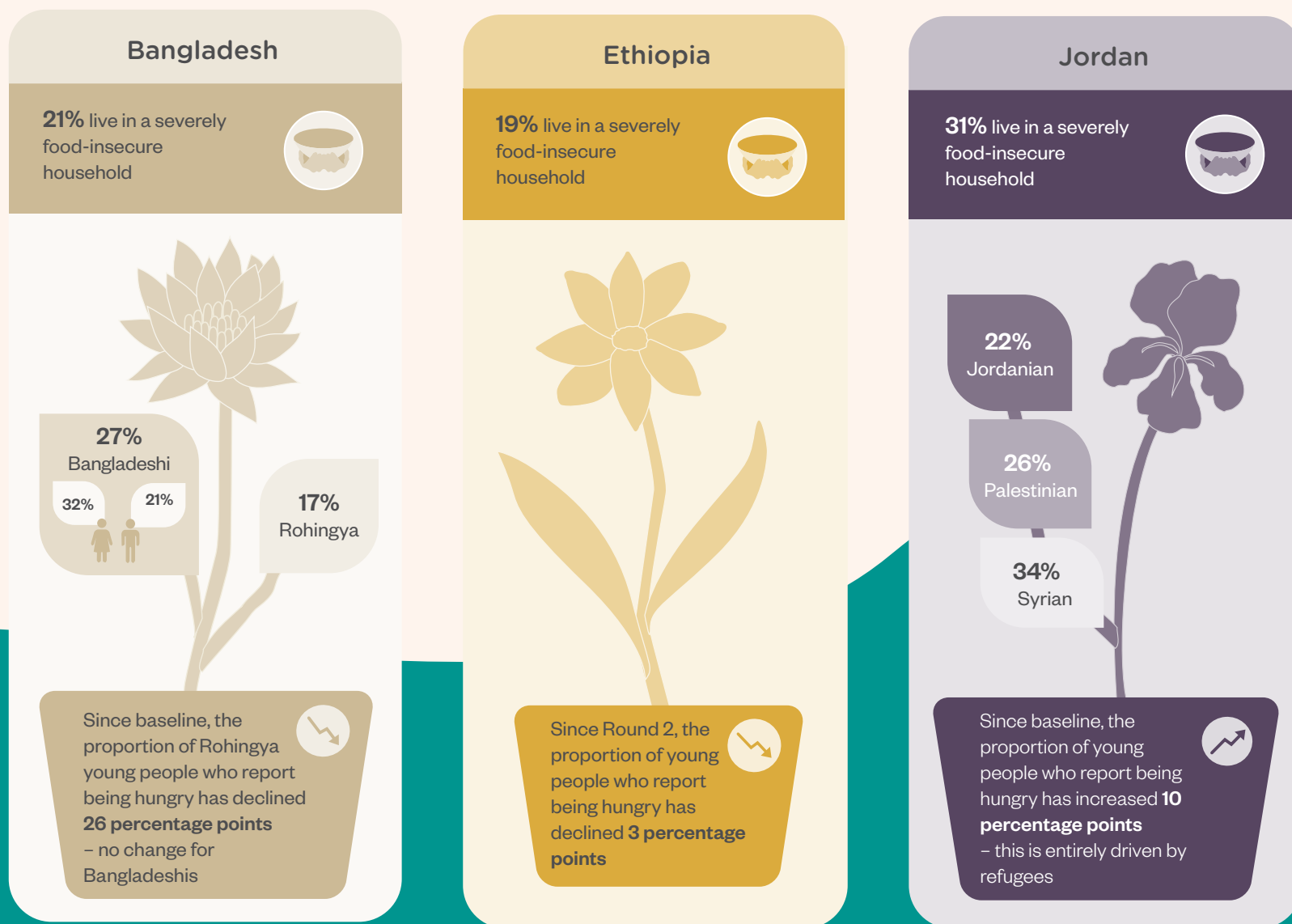
'I saw next to my house that a man has three daughters but he feeds all the good food to his sons. They don't give girls good food.'
(21-year-old Bangladeshi young woman)



Food security is shaped by myriad factors. In Jordan, although refugees (especially Syrians) have relatively better access to social protection that supports nutrition, the severe limits they face on employment mean that Jordanian (22%) young people are less likely than their Palestinian (26%) and Syrian (34%) peers to report food insecurity. In Ethiopia, rates of food insecurity are similar across locations – partly because while incomes in urban areas tend to be higher than those in rural areas, work is intermittent and food is expensive; and partly because young people in Afar have low expectations about nutrition. In Bangladesh, Rohingya refugees (17%) are far less likely to be food insecure than Bangladeshis (27%), because of aid provided by the international community (which many couple with informal work, despite restrictions). Among Bangladeshis, girls and young women (32%) are disadvantaged compared to their male peers (21%), because of gender norms that prioritise the nutrition of (potential) breadwinners.

¹⁰ Specifically, the Household Food Insecurity Access Scale see: <https://www.fantaproject.org/monitoring-and-evaluation/household-food-insecurity-access-scale-hfias>

Figure 4: Proportion of young people who live in a severely food insecure household



Box 1: Conflict has devastating impacts on young people's health

The impacts of active conflict on young people's health are most evident in Gaza and in South Gondar (Ethiopia). In Gaza, 89% of young people reported that lack of food has been a major challenge for their household since the onset of the war, 70% reported being hungry in the past two weeks, and 43% reported going without needed health care. In South Gondar, hunger in the past month doubled between baseline and endline, rising to 25%.

'Diseases have increased. If there are clean drains or toilets, if they had cleaned them like before, then people would have been saved from diseases. This is what needs to be done, number one. If what should be clean is not clean, then everyone will get sick.'

(Rohingya key informant, Bangladesh)

'My health is not like before the war because of the famine... I used to get dizzy, I feel it gets dark whenever I stand up and I feel no energy.'

(16-year-old girl, Gaza)



The longer-term impacts of conflict and displacement on young people's health are evident in Bangladesh, Jordan and Lebanon, where overcrowding and lack of access to care is reflected in myriad outcomes. In Bangladesh, although refugees are better nourished than Bangladeshis (due to aid from the international community), Rohingya young people are twice as likely to have had a serious illness in the past year as their Bangladeshi peers (11% versus 6%), primarily due to close confinement and shared toilets. As noted earlier, in Jordan (and Lebanon), refugees – especially Syrians – are more likely to be food insecure and to struggle to access health care. Both problems are worsening over time, as funding gaps have forced donors to cut back.

Overweight and obesity are growing concerns, especially for young females

Alongside high rates of hunger are growing rates of overweight and obesity. This is related not only to changing diets, but also to decreasing levels of physical activity among young people. Rates of overweight and obesity are especially high in Jordan, which is more urban, where high-calorie food and drink is common, daily screen time is high, and 35% of young people – and 52% of married girls (see Box 2) – have a body mass index (BMI) above the 'normal' range (see Figure 5).

In all contexts, girls and young women are more likely to be overweight and obese than boys and young men, primarily due to restrictions on girls' mobility that tighten at puberty and tighten again upon marriage. Not only are young females not supported to play sports or engage in purposive exercise, but many are also not allowed to leave home.

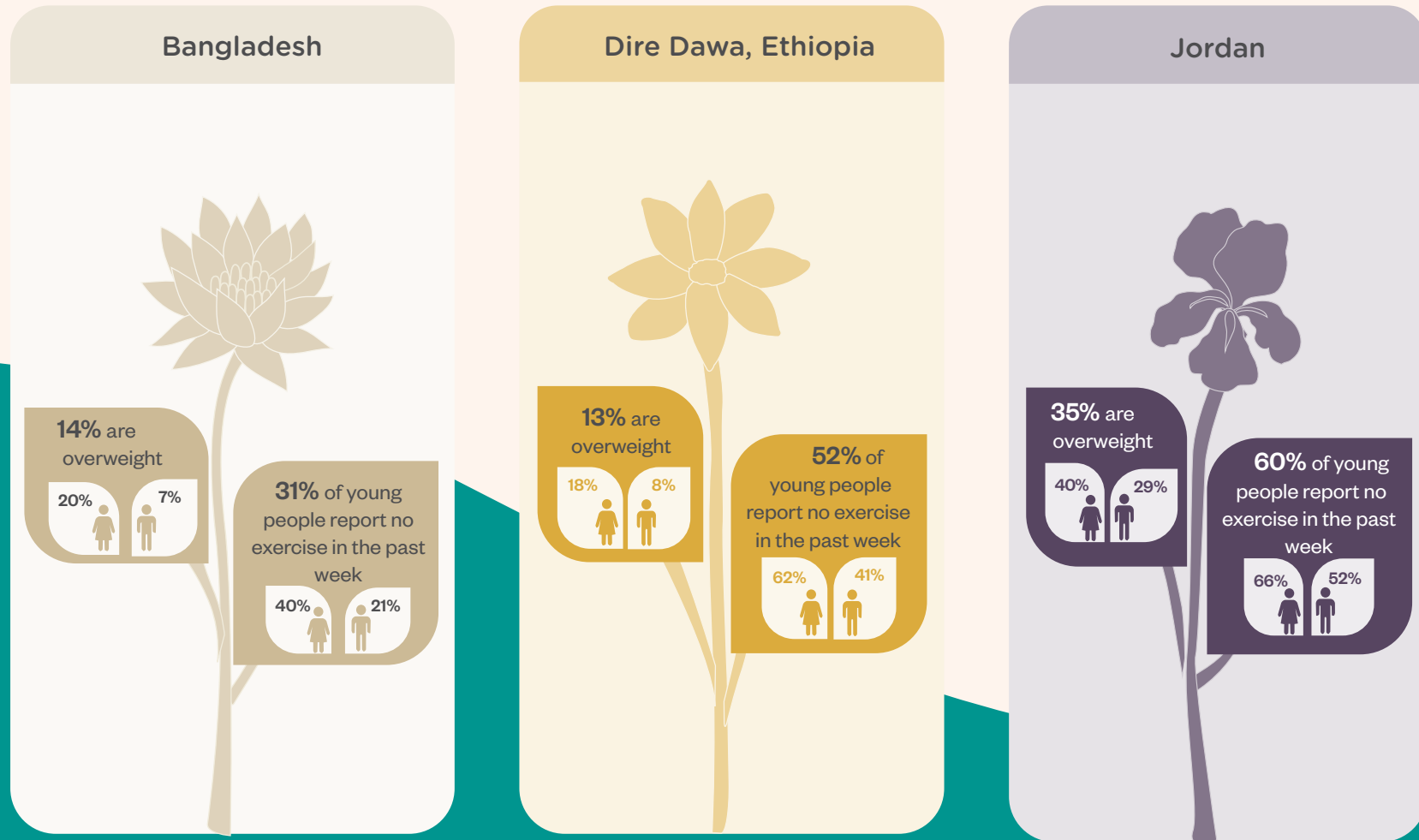


Adolescent girl in a clinic in Amhara, Ethiopia
© Nathalie Bertrams GAGE 2026

'Girls are forbidden from exercising. If a girl exercises in the street and someone sees her, he will curse her family. A girl who exercises in the street brings shame on her family.'
(15-year-old Syrian boy, Jordan)



Figure 5: Proportion of young people who are overweight and take no regular exercise

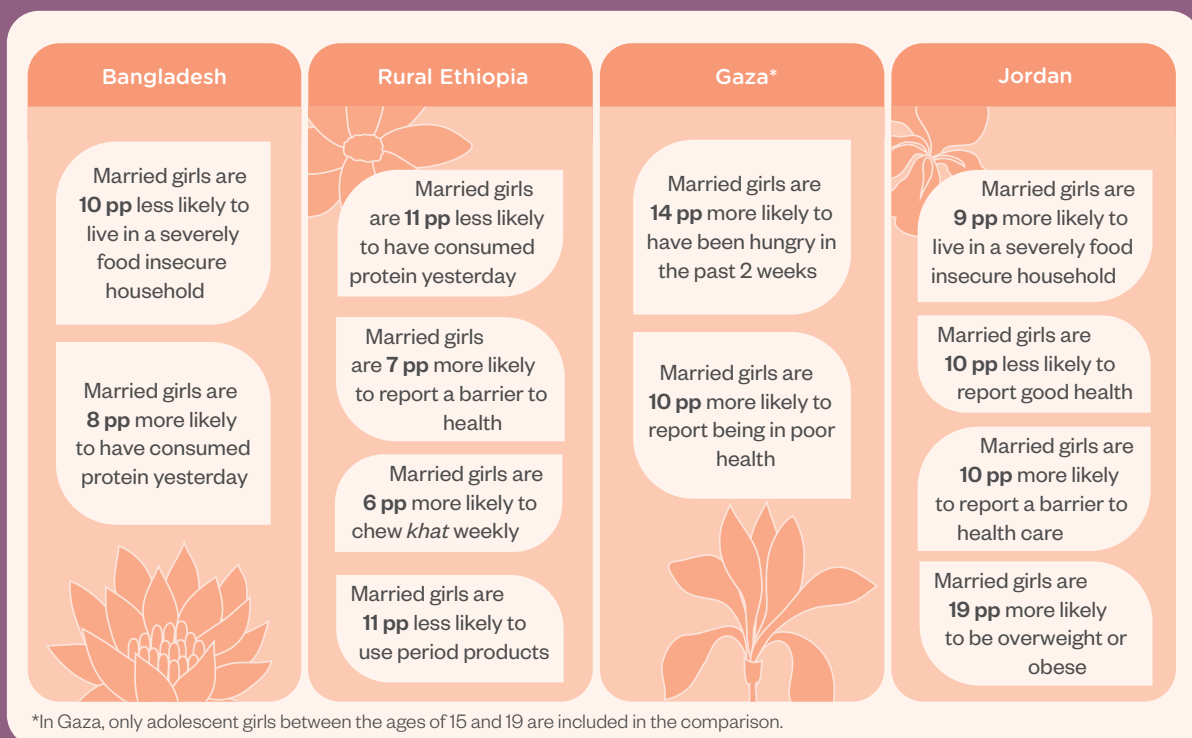


Box 2: Marriage has diverse impacts on adolescent girls' health

The impacts of marriage on adolescent girls' physical health depends on where they live. In rural Ethiopia, Gaza, and Jordan, impacts are universally negative. In rural Ethiopia, for example, married girls are 11 percentage points (pp) less likely to have consumed protein the day before, 7 pp more likely to report that cost or distance limits their access to health care, 6 pp more

likely to chew *khat* weekly and 11 pp less likely to use period products (see Figure 6). In Bangladesh, however, and despite the fact that their needs are deprioritised by their marital families, married girls are 10 pp less likely to report severe food insecurity than their non-married peers (likely because these families are marrying off their daughters due to economic hardship).

Figure 6: Health indicators, by adolescent girls' marital status



Married girls' disadvantage is shaped by two factors. First, on the whole, recently married couples are especially likely to be poor, because of expenses related to marriage and setting up a household and because young workers earn less than older, more experienced workers. The poverty gap tends to grow as young families have children. Second, young brides' needs tend to be more ignored by marital than natal families.

'I look after my children's health, but not my own.'
(21-year-old Syrian mother, Jordan)



Most young people are healthy, but girls and young women are disadvantaged

Across all contexts, a large majority of young people reported being in good health. Rates were highest in Ethiopia (89%) and lowest in Jordan (75%) (see Figure 7). Within locations, different groups of young people were more or less likely to report good health. In Jordan, Syrians living in host communities and informal tented settlements – who have the least access to subsidised health care – were less likely to report being healthy. In Ethiopia, rates were shaped by awareness and expectations. Young people in Afar and Oromia, most of whom consider infections that run their course simply part of life, were more likely to report being in good health than their peers in urban areas and in Amhara (where conflict has decimated

access to health care, see Box 1). In all locations where there were gender differences in good health, females were disadvantaged – because of gynaecological concerns (which become more pronounced once they begin childbearing), because they are more likely to be overworked and underfed, and because they have less access to health care. In Bangladesh, Bangladeshi girls and young women were less likely to report good health than all other groups.

Young people who reported health concerns primarily spoke of poverty-related diseases such as malaria and water-borne illness (which have been exacerbated by climate change), and of physical health issues induced by stress – and also rooted in poverty.

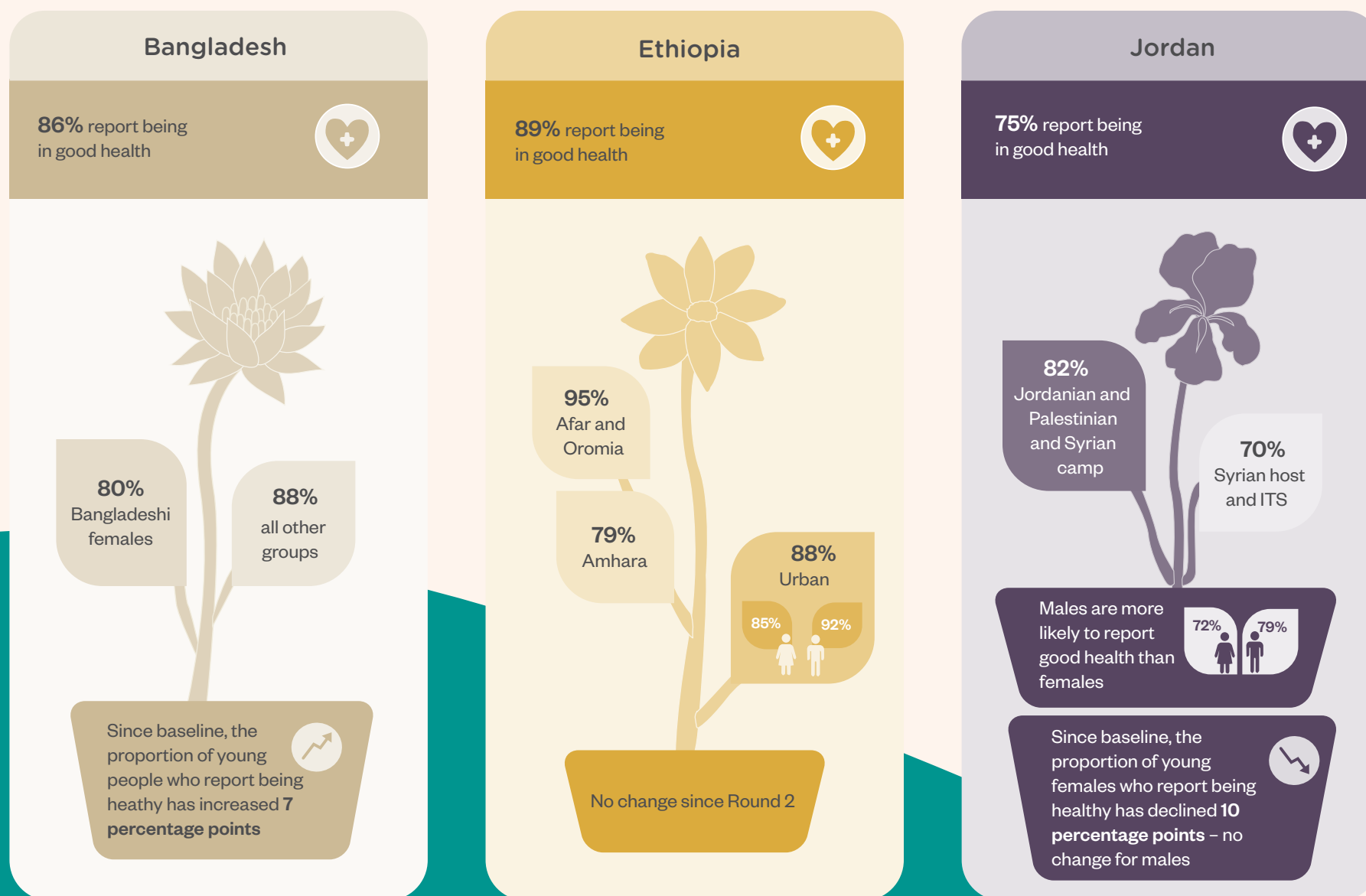
'I have pain in my heart, my blood pressure increases and my lungs hard in respiration... because of mental pressures... There isn't any work or anything.'
(21-year-old Syrian young man, Jordan)

'The water is clean. But the problem is with the limited water we are provided with. We don't get enough water to clean ourselves and clean the household items. So, the chances of getting sick increase... As we can't wash ourselves on a daily basis, we are infected with many skin diseases like scabies with skin rashes and red spots. All our family members are getting affected by these skin diseases.'
(Bangladeshi mother)



Adolescent girl in Bangladesh © Nathalie Bertrams/GAGE 2026

Figure 7: Proportion of young people who report being in good health



Young people often struggle to access needed health care

Across locations, many young people – approximately half in Ethiopia (53%) and Jordan (48%) – reported that cost or distance prevents them from obtaining needed health care (see Figure 8). In Ethiopia, where many permanent disabilities are due to the lack of timely, quality care (see Box 3), location is the primary delimiter of access, with rural young people less able to access health care than their urban peers. This is partly because of where clinics are located, but is also driven by rural households' deeper poverty. In Jordan, nationality shapes access to health care. Jordanians receive subsidised care at government facilities (through a public health insurance scheme) and Palestinians are provided with basic care through UNRWA. Although humanitarian organisations provide free basic care to Syrians living in camps, registered refugees living in host communities and informal tented settlements are treated as uninsured Jordanians and must pay for services at government clinics – although at a subsidised rate compared to the full foreigner rate.¹¹ In Bangladesh, it is girls and young women – and Bangladeshi girls and young women in particular – who are most disadvantaged. They face tight restrictions on their mobility and are not allocated their fair share of household resources.

'The hospital takes 60 dinars or 65 dinars from a Jordanian, but when a Syrian has to pay, they take from him 125 dinars.'

(Jordanian key informant)

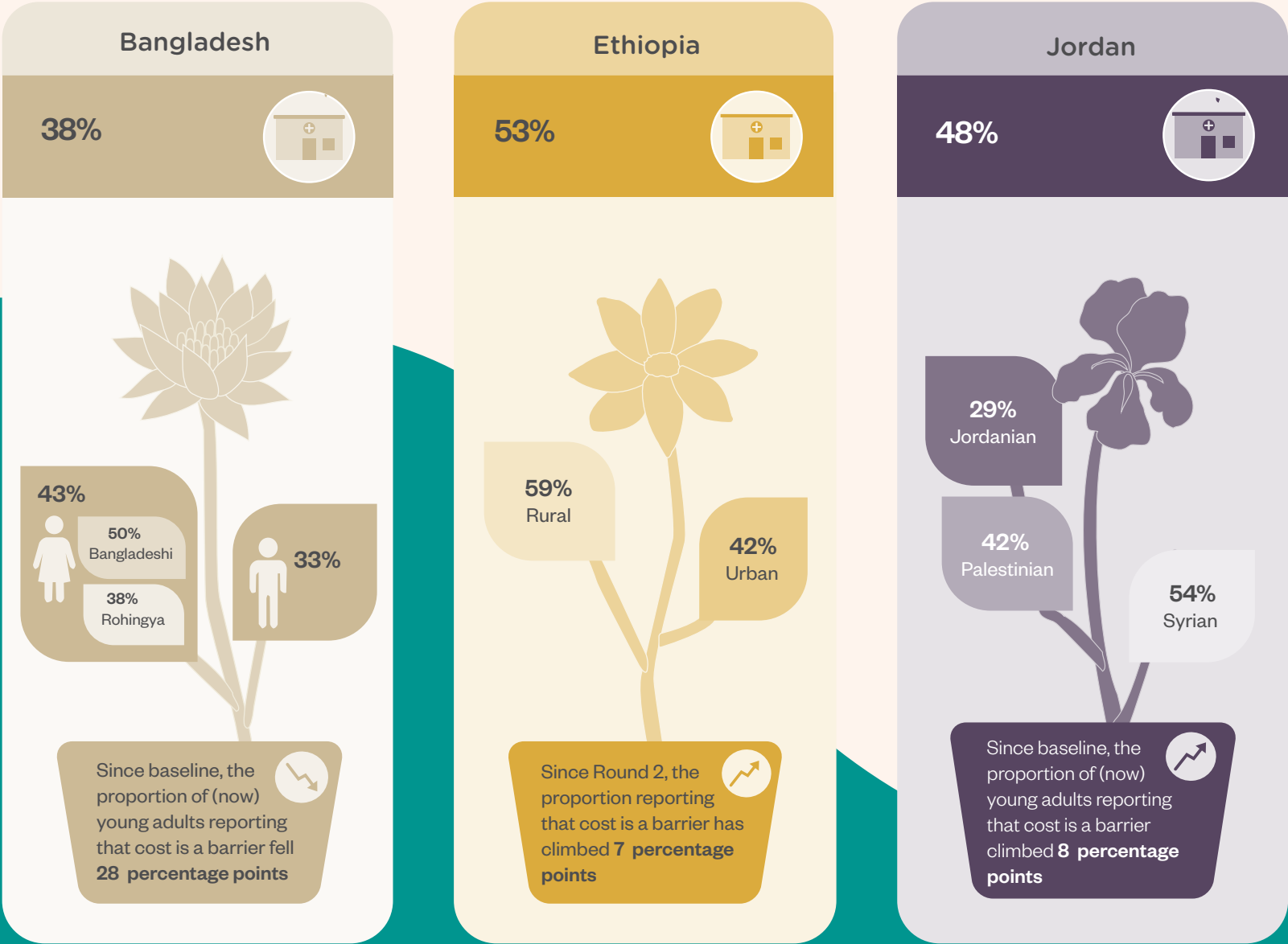
'Boys get a bit more support from the family, girls get a bit less.'
(20-year-old Bangladeshi young woman)

'People are also suffering from death because of even minor illnesses, because of absence of health services and facilities in the area.'

(24-year-old young man, Afar, Ethiopia)

¹¹ See del Mar Logrono Narbona, M. (2025) 'Jordan's healthcare divide: a system aggravating social tensions'. *Global Social Policy* 25(3): 556–561.

Figure 8: Proportion of young people who report that cost or distance is a major barrier to seeking health care

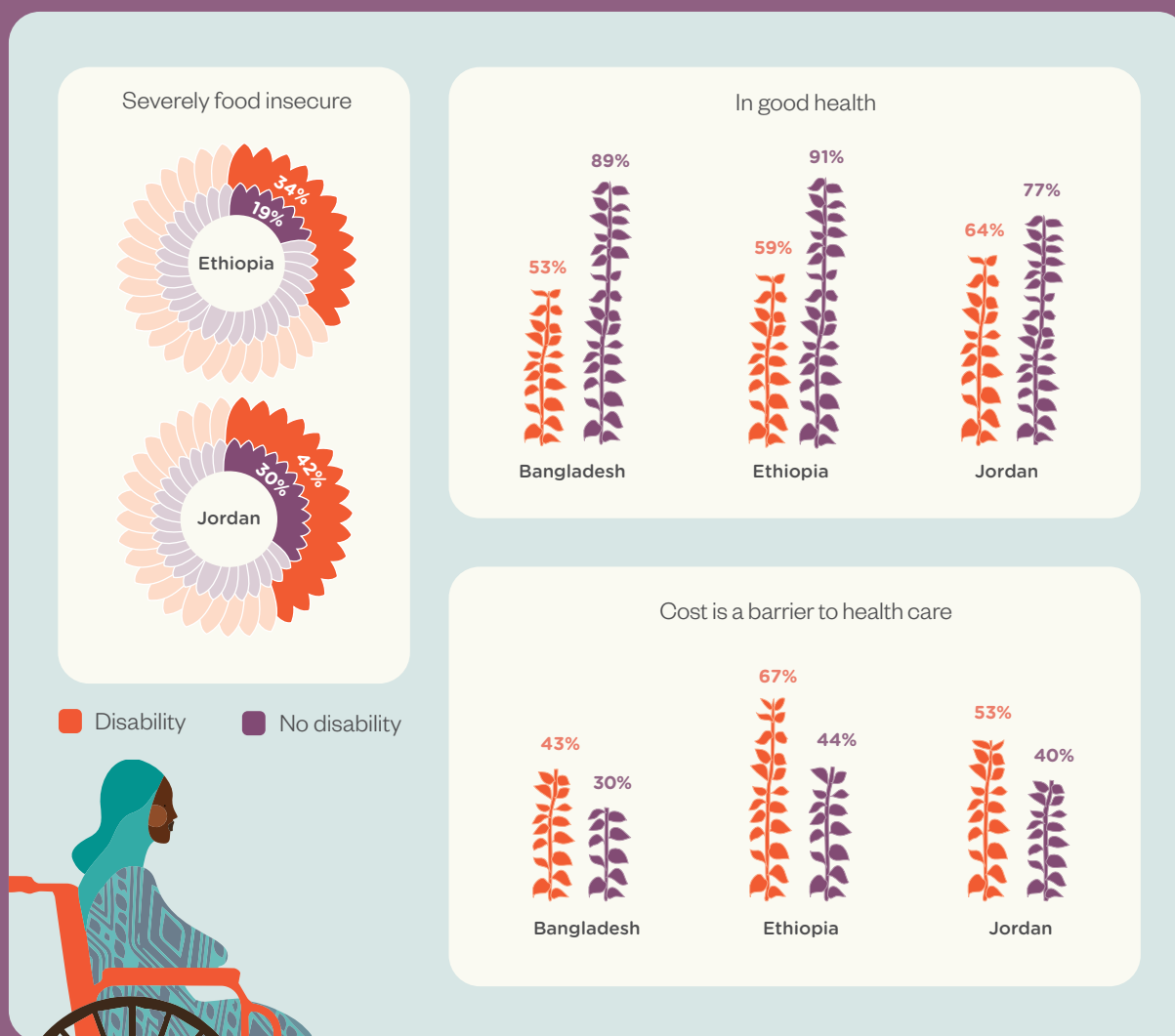


Box 3: Disability shapes young people's health outcomes

Across contexts, young people with disabilities have worse health outcomes – and worse access to health care – than their peers without disabilities. In Ethiopia (34% versus 19%) and Jordan (42% versus 30%), young people with disabilities are disproportionately likely to live in severely food-insecure households (see Figure 9). In all three core locations, they are less likely to report being in good health and more likely to report that cost is a barrier to health care.

'If a child is born with a disability, whether the child is male or female, they don't take the child to a health facility. Instead, they say that it is the work of God, and there is no need to take them to a health facility.'
(20-year-old young woman with a vision impairment, Oromia, Ethiopia)

Figure 9: Health indicators, by disability status



Although some young people with disabilities have health conditions related to their disability, most of the disparities in nutrition and health are related to the reality that disability is expensive and deepens household poverty (especially in Ethiopia, where it often results from household poverty) – and to the stigma and fatalism that surround disability. Assistive devices (e.g. spectacles, crutches and hearing aids) and specialised treatment are costly, and employment opportunities for those with disabilities are rare. Moreover, young people with disabilities are often deprioritised for household spending, because disability is

seen as an act of God or because they are seen as less valuable than those without disabilities, and communities (and services) are both socially and physically inaccessible to those with disabilities.

Young people with disabilities who live in conflict-affected contexts are doubly disadvantaged. In Gaza, with many primary care clinics closed or damaged and disability-specific services almost entirely unavailable, 97% of young people with disabilities reported that their health has deteriorated during the war. Indeed, young people with disabilities were nearly twice as likely as their peers without disabilities (69% versus 39%) to report that they have been unable to access needed health care.

***'I cannot go to the doctor.
Who will take me? I need to be
lifted, carried into a vehicle,
taken out again – someone
has to carry me!'***
(26-year-old Rohingya young
woman, Bangladesh)

***'There is no medicine,
no money, no transport.'***
(22-year-old young woman with
a physical impairment, Gaza)



Adolescent girl with a physical disability, Jordan © Nathalie Bertrams/GAGE 2026

Substance use is a problem for young males

Depending on location, many boys and young men smoke cigarettes, drink alcohol or chew *khat*.¹² Smoking is most common in Jordan, where 32% of all young males – and 65% of Palestinian young men – are daily smokers (see Figure 10). Smoking is also common among Rohingya young men living in Bangladesh (26%). In Ethiopia, different substances are used in different locations. *Khat* use is most common in Oromia, where 81% of young males use *khat* weekly and 67% use it daily; alcohol use is most common in Amhara, where 45% of young males drink weekly.

Boys and young men reported various reasons why they smoke, drink and chew. These include to spend relaxing time with friends, to demonstrate to their friends that they are 'manly', and to help mitigate the anxiety and depression that results from being unable to find the steady work that supports independence.

'The guys are losing their way... People are tired of poverty and the life they are living... They use [drugs] to escape reality.'
(21-year-old Palestinian young man, Jordan)

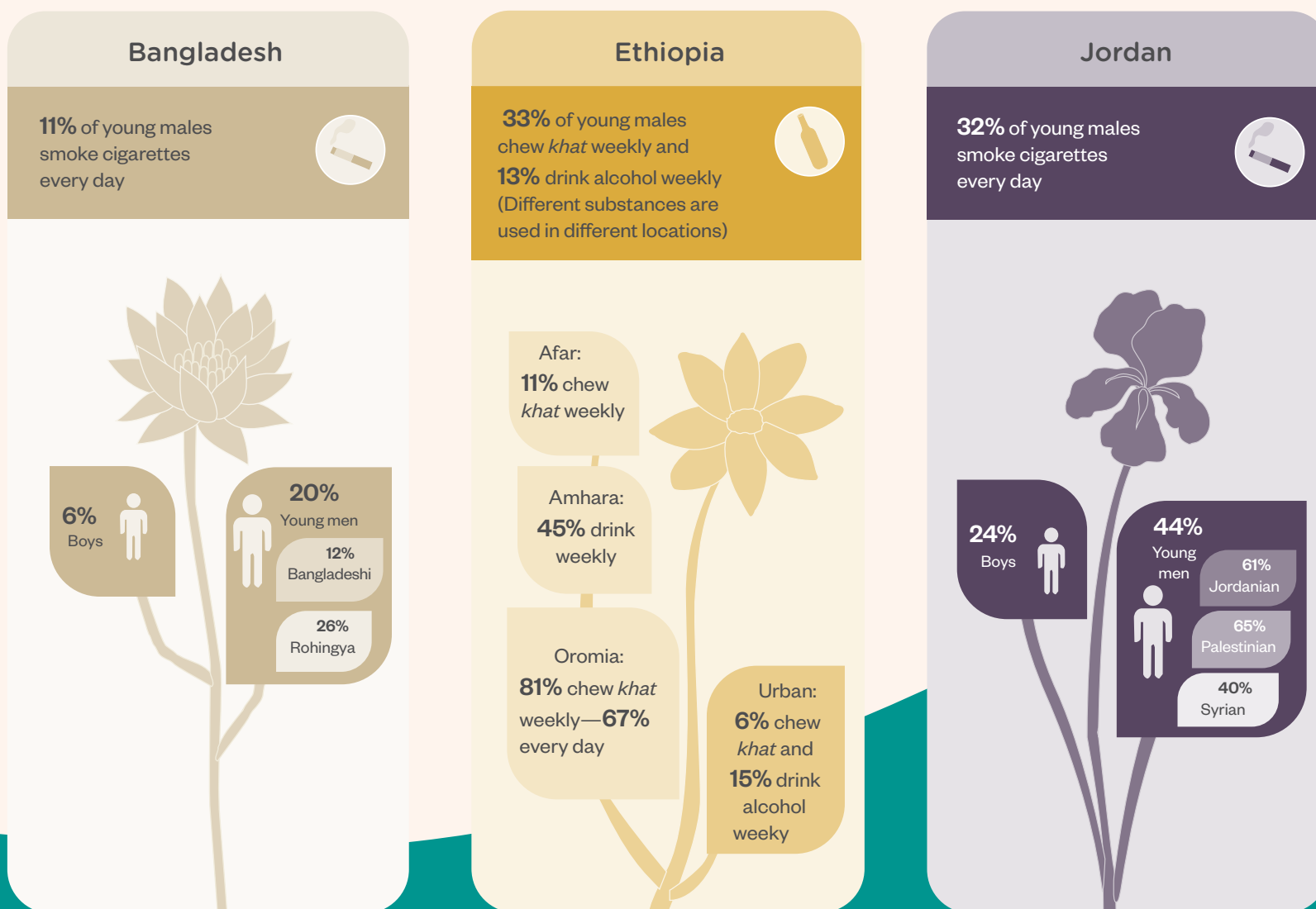
'My friends and I chew khat together and sit together... We start chewing khat at 7 pm and chew until 10 pm.'
(17-year-old boy, Oromia, Ethiopia)



Young men in Bangladesh © Nathalie Bertrams/
GAGE 2026

¹² *Khat* is a shrub grown in the Horn of Africa, whose leaves are chewed for a stimulant effect.

Figure 10: Proportion of males who report regular substance use



Most young people had a source of information about puberty, but that information was often not timely, accurate, or delivered by adults

Across all contexts, approximately 9 in 10 young people had a source of information about puberty. In Bangladesh (95% versus 89%) and Jordan (96% versus 85%), girls and young women were more likely to have had a source of information than boys and young men (see Figure 11). In Ethiopia, urban young people were more likely to have had a source of information than their rural peers (96% versus 83%). However, the fact that nearly all young people had a source of information about puberty does not mean that they had access to timely, accurate information. In Bangladesh and Ethiopia, fewer than half of young people learned about puberty from an adult; the remainder learned from peers and siblings. Which adult(s) taught young people about puberty varied by location. In Jordan (59%) and Bangladesh (35%), the plurality of young people learned from their parents (almost exclusively their mother, due to childrearing

norms). In Ethiopia, young people were twice as likely to learn from their teachers as their parents (33% versus 15%). In all locations other than rural Ethiopia (where the stigma surrounding menstruation is especially strong), young females were far more likely to learn about puberty from an adult than young males. The gender gap was largest (37 percentage points) in Jordan.

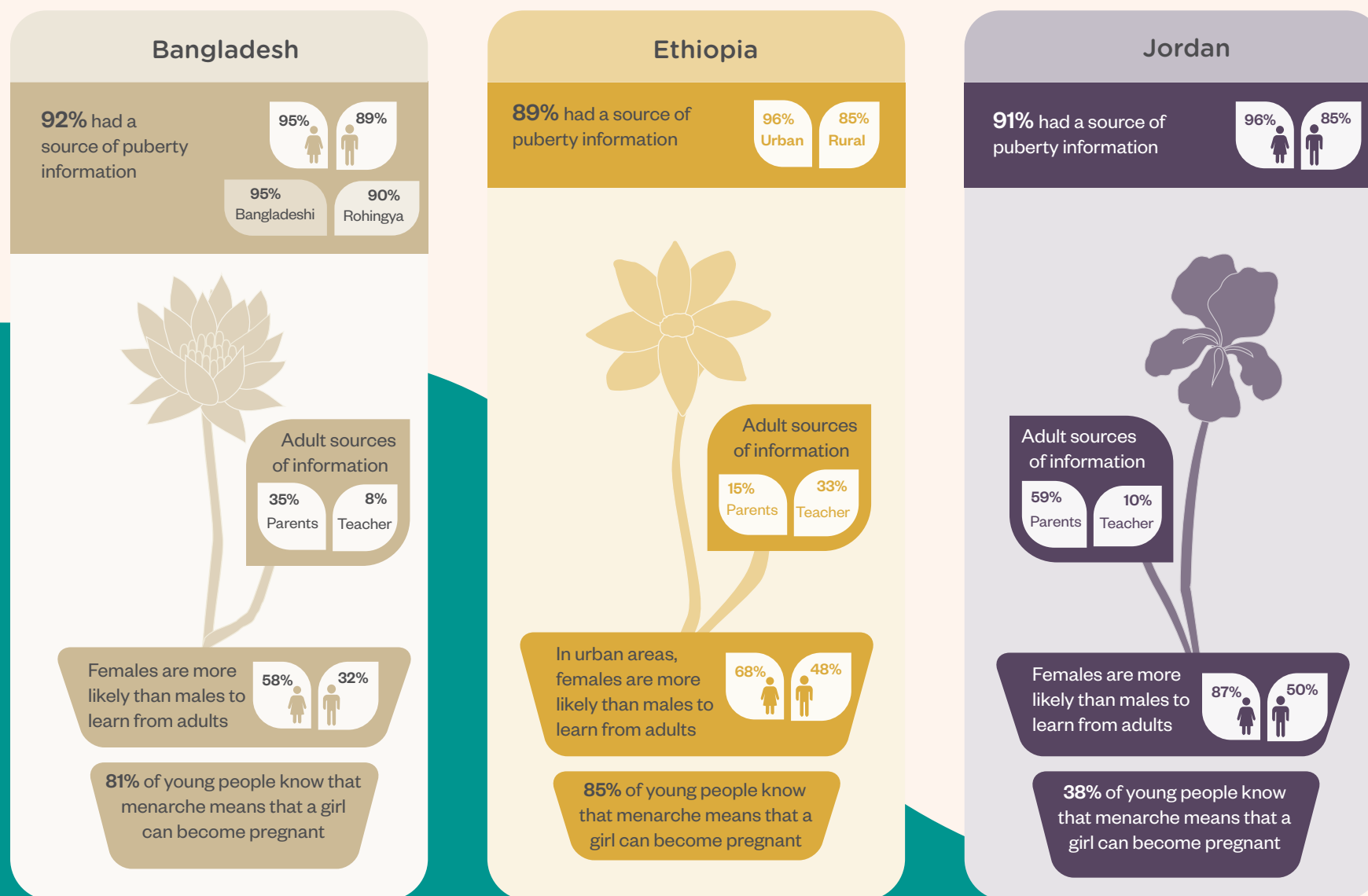
'I have never talked to my son about issues related to these things... It is not common in our community to talk to children about these types of topics.'
(Father, Afar, Ethiopia)

'When I first got my period, I was really scared... I started screaming, and my mom told me not to worry, to trust in God and not be afraid. She said that as you grow up, these things happen.'
(21-year-old Jordanian young woman)

'In our society, boys usually don't get taught these things – only girls are taught by their mothers, elder sisters, or sisters-in-law.'
(18-year-old Bangladeshi young man)

Even when young people are educated by adults about their developing bodies, information tends to come late (after girls have begun their periods, for example), be focused on hygiene (not just menstrual hygiene, but also ablutions required for prayer, for Muslim males), and to be poorly linked – if at all – to sexuality and reproductive biology. Indeed, in Jordan, and despite the fact that the average young person is approaching age 20, only 38% of young people were aware that menarche means that a girl can become pregnant.

Figure 11: Young people's knowledge about puberty



Menstrual health management is a challenge for some girls and young women

Most girls and young women in all locations use disposable or reusable sanitary pads to manage their periods, rather than old cloth or other materials. Rates were highest in Nepal (94%) (where the sample is admittedly unusual because most young females are secondary or post-secondary students), and lowest in Ethiopia (63%) (see Figure 12). In Ethiopia

and Jordan, young females' access to ready-made period products was shaped by whether products are available in local markets (which they generally are not in pastoralist Afar), and whether household budgets can be stretched to purchase them, which explains Syrians' more limited uptake compared to Jordanians and Palestinians.

'I like those 4 days of restriction. This is the only time each month when your food is served where you are and all you need to do is wash your own plate. You don't need to do any household work. It is such a relief.'

(18-year-old Nepali young woman, Gandaki)

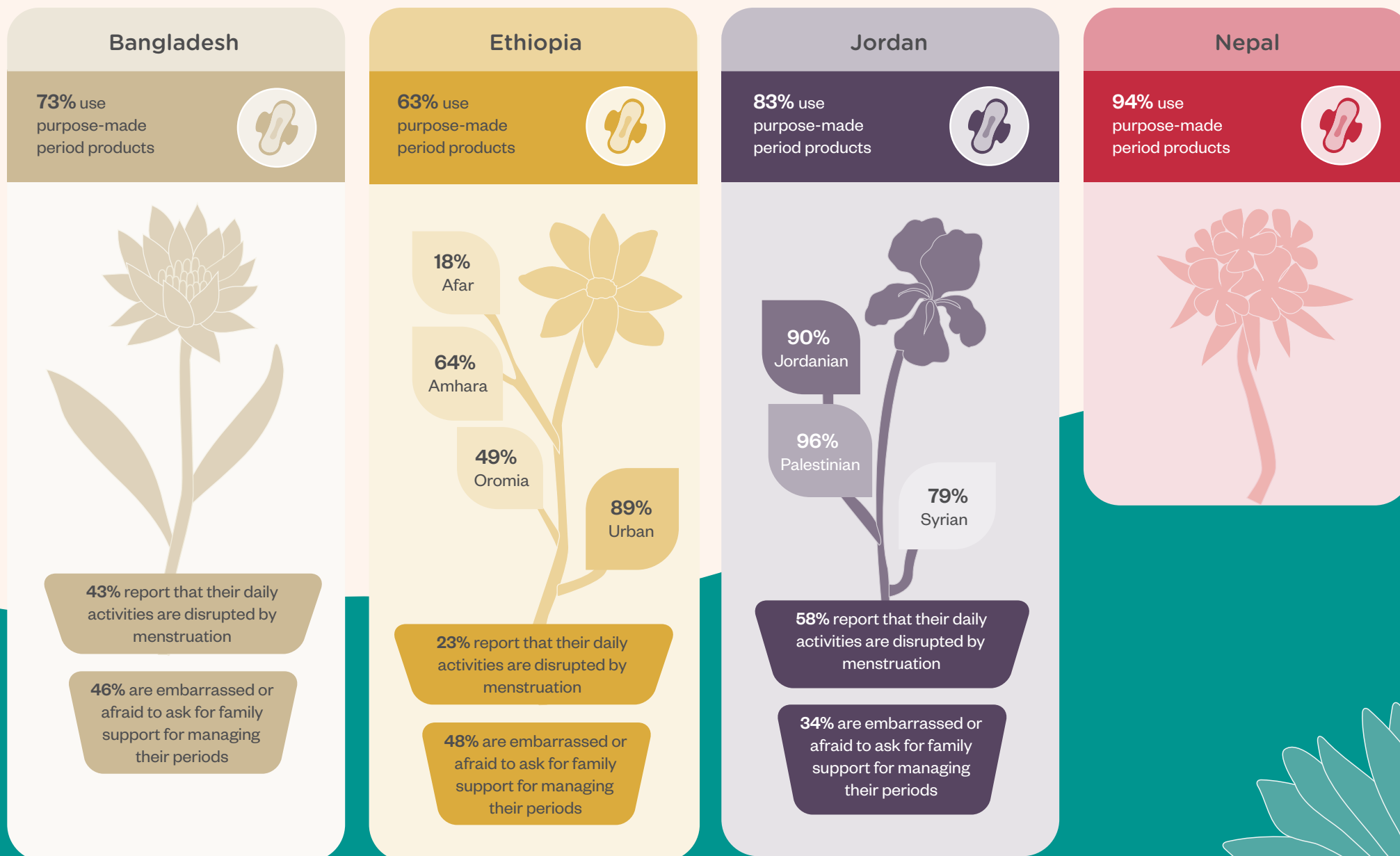
'When I got my first period, I told my mom, but she didn't say what to do... I climbed up a tree out of confusion. My elder sister was at home; she saw blood on my pants. She asked what it was, I said it's blood. Then she taught me what to do. Mom said I couldn't leave the house. It was like that for 7 to 8 days.'
(20-year-old Bangladeshi young woman)

In all locations, menarche is highly disruptive to girls' lives –whenever they are menstruating (given the shame and stigma that surround this natural process, especially in Ethiopia), and more generally, as parents tighten restrictions on girls' mobility and behaviour once they begin menstruating and can become pregnant. How these disruptions play out in girls' lives varies. In Bangladesh, Rohingya girls are strictly confined to home at menarche. In Afar (Ethiopia), many girls hide the fact that they are menstruating for as long as possible, because they know that once their parents are aware, they will be forced into marriage. In contexts where young females are heavily burdened with domestic work, some note that menstruation-related restrictions are actually a relief, as it is the only time they get to rest.

'I use torn clothes for my period because I can't afford sanitary pads.'

(17-year-old girl, Debre Tabor, Ethiopia)

Figure 12: Menstrual health management



Many young people are not aware of contraception, and even those who are often hold mistaken beliefs about its safety

Young people's knowledge about contraception is highly varied and reflects not only their access to school-based biology courses and their contact with health care workers, but also whether they are exposed, or shielded, from learning about sexual topics. Young people in Ethiopia, where exposure to such knowledge is the norm, had the best knowledge of contraception at endline – 81% were able to name a modern method (see Figure 13). Young people in Jordan, where shielding is the norm, had the least – only 46% of young people were able to name a modern method.

In all locations, young people's awareness of contraception is shaped by age and gender – and their odds of marriage. In Bangladesh and Jordan, many young people do not learn about contraception until they have already become parents. Indeed, in

Jordan, many young brides (especially those from conservative families) are so shielded from sexual knowledge that they are not told until their wedding day that marriage entails a sexual relationship, and do not learn that pregnancy results from sex until they are already pregnant.

Critically, even when they are aware that there are ways to prevent pregnancy, most young people – and especially most young males – believe that contraception is likely to cause permanent infertility.

'On my wedding day of course they [mother and older sisters] taught me about sex, because here the girl does not know things except at the right time for her.'
(18-year-old Jordanian young woman)

'Everyone knows about pills and male condoms. Even girls and boys in grades 8–9 will know about it. It is common knowledge now.'
(18-year-old Nepali young woman, Gandaki)

'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, Ethiopia)

Figure 13: Knowledge and beliefs about contraception

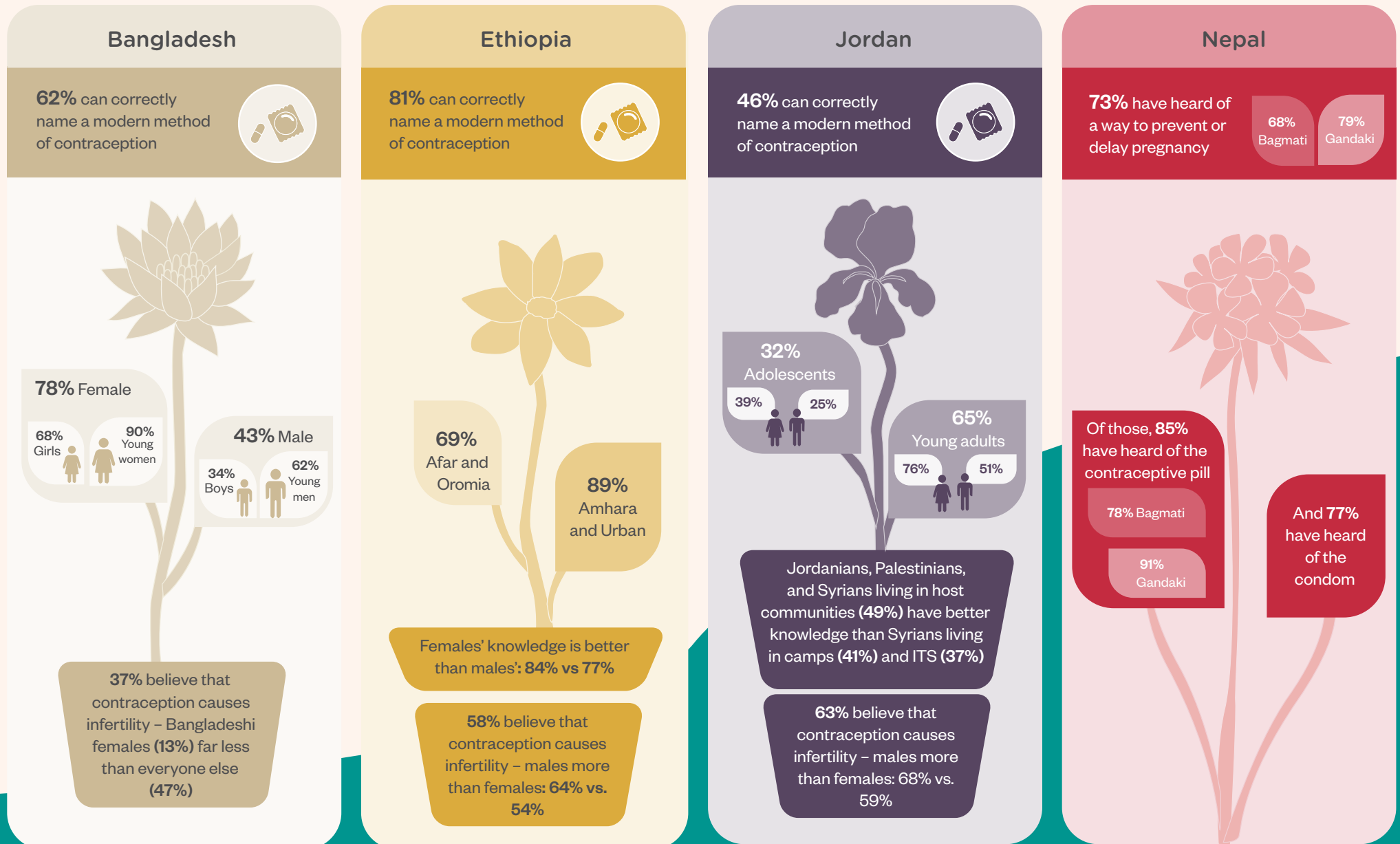
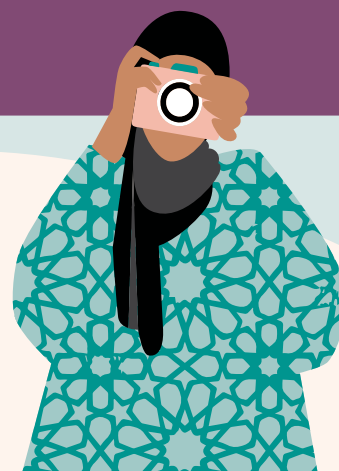


Photo story: 'The human being is the cheapest thing in Lebanon'



The human being is the cheapest thing in Lebanon, and girls are the cheapest among people. Families are marrying off their daughters more than ever to decrease the household expenses. They marry them off to anyone and do not care about the groom or his conditions anymore. People are struggling in Lebanon, we cannot eat meat, chicken or fruits anymore. We cannot buy medicine, diapers, or milk for the children. The lack of work opportunities has increased violence at home, the husband is always lashing out at the wife and hitting her because he is always stressed. Syrians will not be able to survive the crisis if the UNHCR [United Nations High Commissioner for Refugees] does not increase aid for us.

(Photo and narrative by Samiha, an 18-year-old Syrian mother)





Only a minority of married couples use contraception, and not all young brides have a say

Across contexts, a minority of young brides were using a form of contraception. Rates ranged from a high of 37% in Bangladesh, to a low of 22% in Ethiopia (see Figure 14). Within-country variation was often marked. In Bangladesh, uptake was shaped by nationality, with Bangladeshis (45%) more likely to be using contraception than their Rohingya peers (33%). Nationality also shaped uptake in Jordan, but only to a point. Location was also an important

factor. Syrians living in host communities were just as likely to use a method as their Jordanian peers (36%); Syrians in formal camps (30%) and informal tented settlements (21%) were less likely. In Ethiopia, uptake was shaped by location, which is highly correlated with religion. Young brides in (primarily) Orthodox Christian Amhara (58%) were far more likely to use contraception than their peers in (primarily) Muslim Oromia (6%) and Afar (14%). Notably, in all contexts – and especially in Ethiopia (0%), which has the highest rate of HIV of all six contexts – it was rare for young grooms to report using condoms.



'After delivering my first baby, doctors told me about contraception. I first learned about it then.'
(21-year-old Rohingya mother)

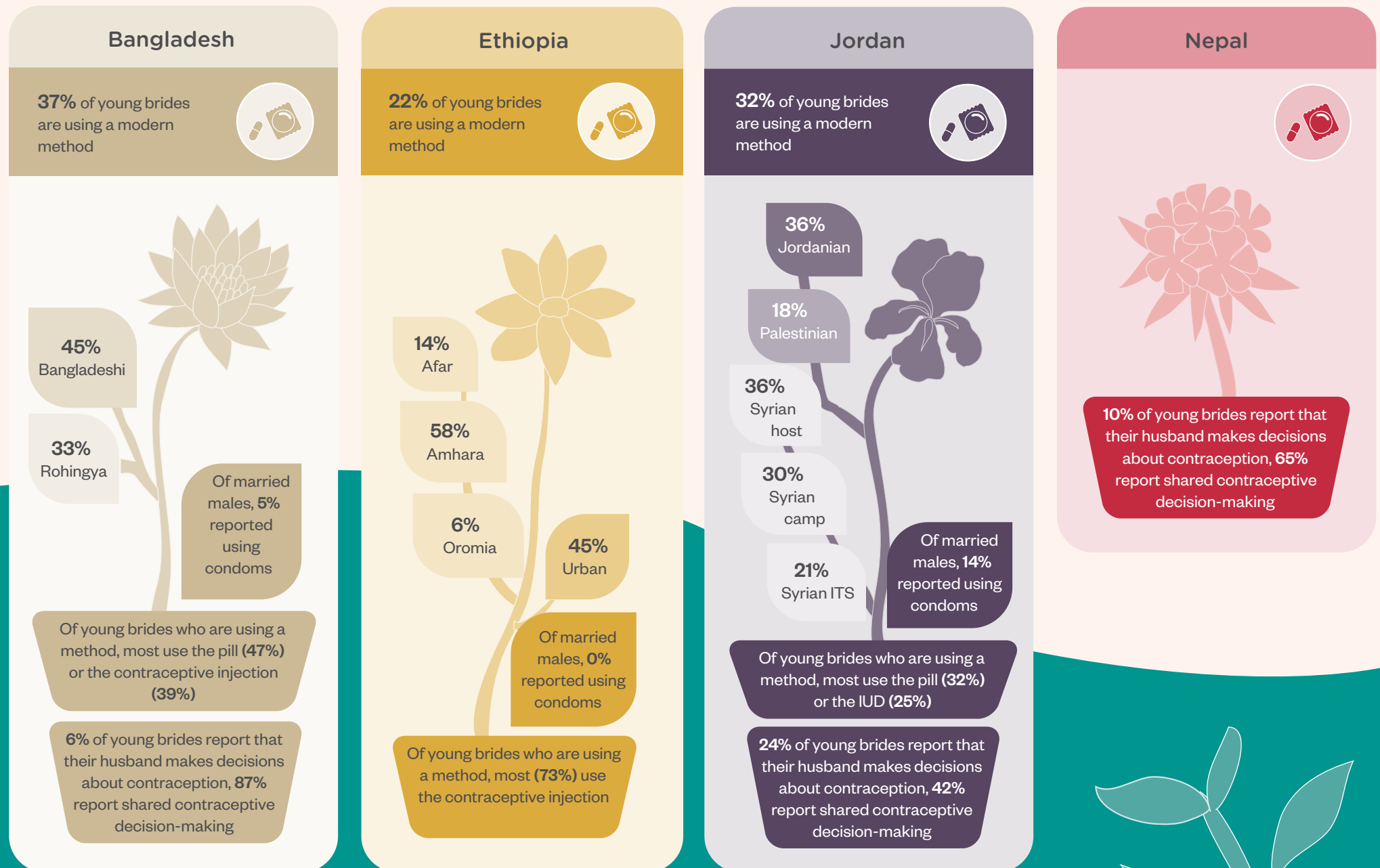
'I will use family planning service if I get more than 7 children.'
(20-year-old mother, Oromia, Ethiopia)

Low uptake is primarily shaped by two factors: beliefs that the very reason for marriage is to produce children, and concerns that contraception is prohibited by religion (more specifically, by Islam). Details matter; in Oromia and in Jordan, it is considered vital that young brides fall pregnant immediately after marriage, to demonstrate their fertility (and in Jordan, young mothers are not considered 'successful' until they have produced a son). In Amhara, on the other hand, there is widespread agreement that pregnancy should be delayed until young couples have attained some measure of financial security – and that children should be spaced to improve child health outcomes. In Bangladesh, although most families prefer to have sons rather than daughters, most couples want smaller families due to the cost of raising children.

'I... took a long time to get pregnant... They kept talking about it. They even brought me medicine for pregnancy.'
(21-year-old Jordanian mother who did not fall pregnant until a year after marriage)

Nearly all young brides report some say in family planning. Across contexts, most say that contraceptive decision-making is shared with their husband. In Jordan, however, a large minority of young brides (24%) report that their husband makes contraceptive decisions and that they have no say at all. Indeed, marital families' requirement that young brides produce children is so strong that some are forced to take fertility medication if they do not fall pregnant within six months of marriage.

Figure 14: Contraceptive use



Most young brides soon become young mothers

Unsurprisingly, given contraceptive uptake rates, most young couples soon become parents. In Bangladesh and Jordan, 84% of married girls and young women had been pregnant; in Ethiopia, the aggregate figure was 74%, with Amhara's lower rate (60%) shaped by the fact that contraception is more widely used there. In Nepal, and with the caveat that few girls and young women in the sample had been married by endline – despite the country's very high rate of child marriage¹³ – 59% had been pregnant (see Figure 15). The age at which young brides became young mothers is shaped by both the age at which they married and by whether young couples use contraception to delay parenthood. On average, young mothers were the youngest in Oromia, Ethiopia (16.1 years), where girls marry as early as age 10 and contraception is nearly unthinkable.



Young pregnant woman at a health centre in Afar, Ethiopia © Nathalie Bertrams/GAGE 2026

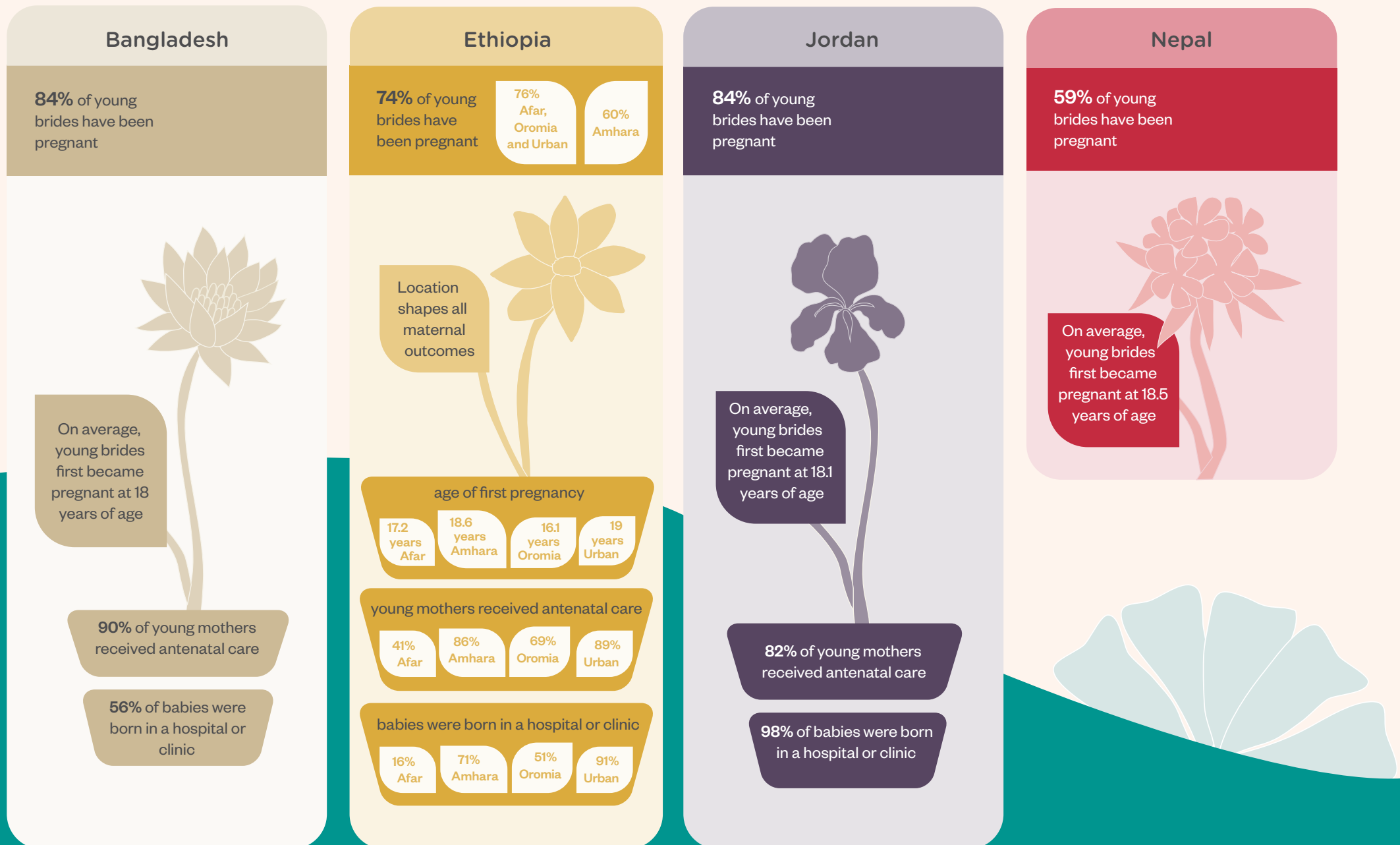
'When a woman gets severely sick with labour, a call is made for an ambulance. But getting an ambulance is very difficult in our place.'

(18-year-old mother, Afar, Ethiopia)

'When I had my first child, I could not see a doctor or any treatment. That is why the first child died. After my first child, I started coming to the hospital.'
(22-year-old Rohingya mother, Bangladesh)

Except for Afar (Ethiopia), where most young mothers live in very remote communities (and some still engage in seasonal migration), the majority of young mothers received at least some antenatal care for their first pregnancy. Care tends to be comprehensive in Jordan, which has a well-developed medical system; it is more ad hoc in Ethiopia, where in rural areas most care is delivered by community health workers. Except for Jordan, where nearly all babies are born in hospitals, facility delivery is far less common than antenatal care. This is partly because of cultural preferences for home delivery and partly because it is difficult for labouring mothers to reach facilities, especially in rural Ethiopia.

Figure 15: Young motherhood



Most young people do not believe that marital relationships should be equitable, and many believe that marital violence is acceptable and best kept private

Across all contexts, most young people agreed that a wife owes her husband total obedience. Rates were highest in Bangladesh (85%) and Ethiopia (84%), and (with the caveat that the sample is quite different because it is entirely female, most of whom are still enrolled in school) lowest in Nepal (62%) (see Figure 16). In Ethiopia (34%) and Bangladesh (30%), and with substantial intra-location variation shaped by culture, a large minority of young people also agreed that it is acceptable for a man to control his wife by beating her. Many young people, especially in Bangladesh (79%), also agreed that marital violence should be kept private.

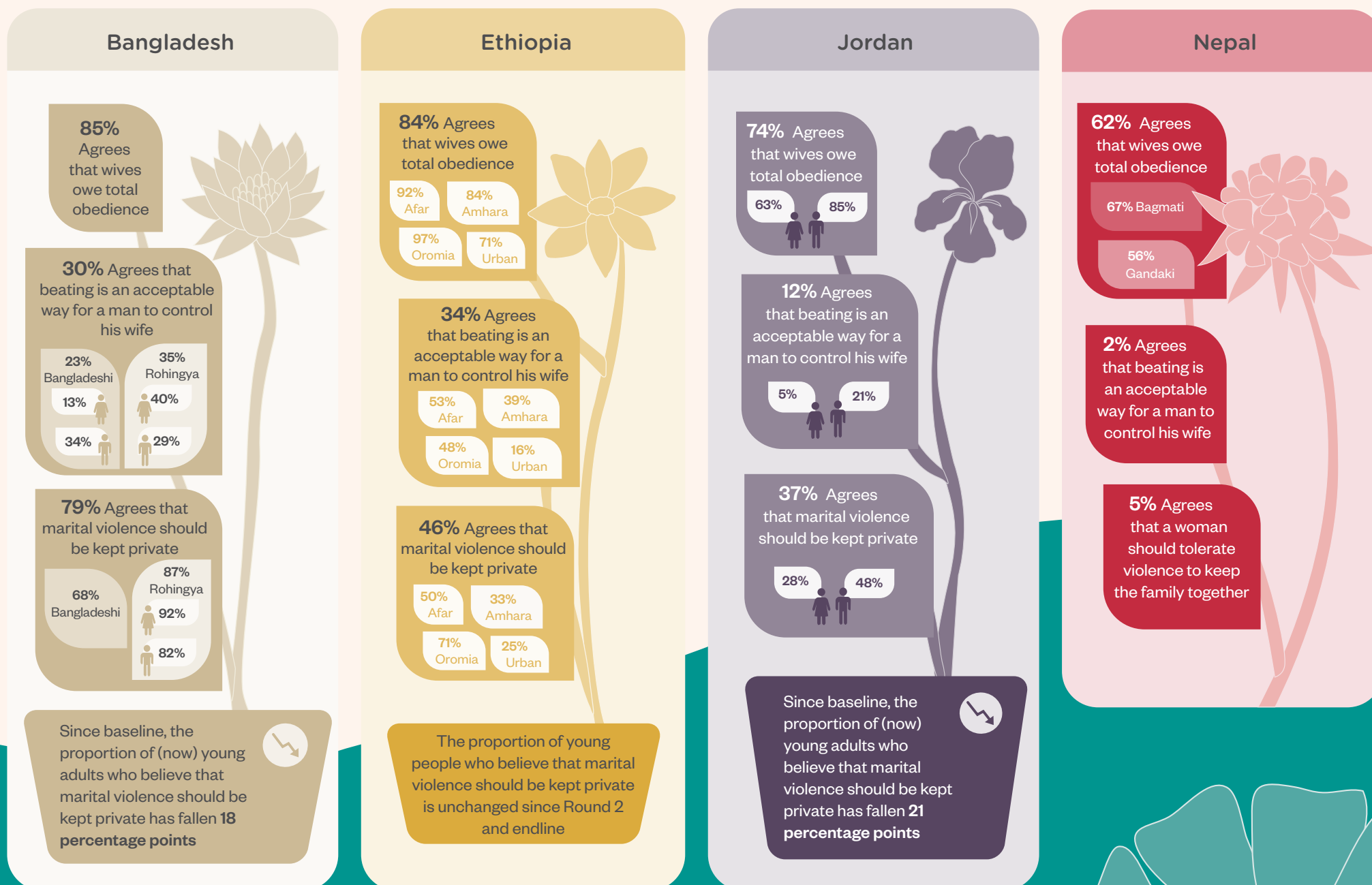
'Insulting and undermining are common in this community. However, these practices are not considered as violence by most of the community. However, wife-beating or flogging is also a common form of intimate partner violence.'
(Key informant, Amhara, Ethiopia)

'It's between husband and wife. If there's no reason, then it's abuse. But if the wife makes a mistake, then she can be beaten.'
(16-year-old Rohingya boy, Bangladesh)



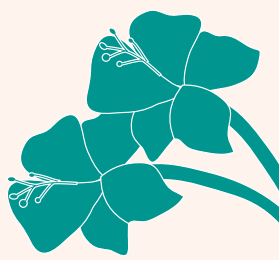
In Bangladesh and Jordan, beliefs about marital violence were significantly shaped by gender. In Jordan, the gender gap always leaned the same way: young males hold more inequitable beliefs than young females. In Bangladesh, this was not the case. Bangladeshi males were more likely than Bangladeshi females to believe that wife beating is acceptable. However, with the caveat that differences may reflect reporting rather than actual beliefs, Rohingya girls and young women were more likely than their male peers to support wife beating and non-disclosure, underscoring how normalised the practice is.

Figure 16: Young people's beliefs about marital violence





Conclusions and implications for policy and programming



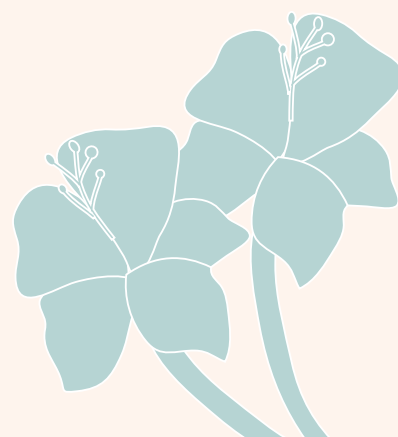
Across contexts, GAGE's endline research finds that most young people report being in good health. However, this headline obscures details that matter for protecting and promoting young people's good health – both now, and in the future. Food insecurity is common; overweight and obesity are growing concerns, particularly among girls and young women; substance use is a threat to boys and young men; marital violence is normalised; and access to health care is limited by cost and distance. In addition, young people's knowledge about sexual and reproductive health is thin. Most enter puberty without accurate information about their developing bodies, with girls severely impacted by the stigma that continues to surround menstruation and boys largely left to figure out puberty with their peers. Indeed, many young people begin their adult lives with little understanding of reproductive biology or the advantages of timing or spacing children. This means that contraceptive uptake is low and young motherhood is common. Young brides, those with disabilities and those living in conflict-affected contexts are most at risk. They are more likely to be food insecure, less likely to access care, and have worse health outcomes.



To improve the health of young people living in low- and middle-income countries, GAGE research suggests the following:

- ✱ **Expand access to social protection programmes that support nutrition;** pair this (as needed) with raising awareness about the importance of ensuring that girls are well nourished.
- ✱ **Engage communities to shift the social norms that leave girls and young women confined to home and unable to exercise,** and pair this with creating structured opportunities for young females to be physically active.
- ✱ **Develop awareness-raising campaigns aimed at reducing boys' and men's use of substances –** teaching them risks and offering them alternative ways to reduce stress.
- ✱ **Reduce barriers to accessing health care –** building more clinics, hiring more staff, and subsidising costs, depending on context. Pair this (as needed) with awareness-raising efforts aimed at increasing demand for services, especially targeting young brides' gatekeepers.

- ✱ **Provide young people with iterative school- and community-based courses on human development and sexuality**, including reducing the stigma that surrounds menstruation, contraception, and disease prevention. Pair this with programming that teaches girls and women how to make hygienic re-usable period products.
- ✱ **Develop tailored empowerment programming for young people that teaches them their health-related rights**, makes them aware of gender norms and how these impact health outcomes, and supports self-confidence and voice.
- ✱ **Provide parenting education courses that cover adolescent development**, make parents aware of gender norms and how these shape health outcomes, and reduce parents' discomfort with discussing 'taboo' topics. Use these to build support for delayed and spaced pregnancy to improve maternal and infant health outcomes.
- ✱ **Develop counselling sessions for engaged and newly married couples** that address communication skills, the rights and responsibilities of marriage, contraceptive options (and the advantages of delayed and spaced pregnancy), and the importance of consent.
- ✱ **Encourage health care workers to use all patient contact points to educate young people about sexual and reproductive health**. Pair this with expanding access to 'youth-friendly' clinics and community distribution of condoms.
- ✱ **Address the stigma that surrounds disability**, including with regard to accessing sexual and reproductive information and services, and work to ensure that primary and specialist care and assistive devices are accessible and affordable.





GAGE Programme Office
ODI Global
4 Millbank
London SW1P 3JA
United Kingdom
Email: gage@odi.org.uk
Web: www.gage.odi.org

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About GAGE

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

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