



Gender and regional inequalities in adolescent health and nutrition in Ethiopia

Policy and programming implications from the GAGE baseline findings

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Overview

Ethiopia is globally renowned for its cadre of health extension workers who provide basic health care for communities. However, evidence about Ethiopian adolescents' health and nutrition, aside from older girls' sexual and reproductive health, is very limited. This narrow focus has largely been driven by concerns about the reproductive health needs of the significant number of adolescent girls subject to child marriage, over a quarter of whom are already pregnant or mothers by age 19 (CSA and ICF, 2017).

This policy note synthesises findings from baseline mixed-methods research as part of the Gender and Adolescence: Global Evidence (GAGE) longitudinal study (2015–2024) to address these knowledge gaps. Our work included nearly 7,000 adolescent girls and boys between the ages of 10 and 19, as well as their caregivers, service providers and programme and policy actors. More details can be found in the full companion report (Jones et al. 2019). Paying careful attention to gender and regional differences, here we focus on adolescents' health, nutrition and sexual and reproductive health, which we define as being physically healthy and well nourished; and having access to age- and context-appropriate puberty education and support, and to age- and context-appropriate sexual and reproductive health information, supplies and services. We then discuss key actions to accelerate progress.


Key findings: scope and scale of the challenge

Ethiopia's current generation of adolescents are comparatively advantaged over previous generations. Food security is improving, childhood mortality and morbidity are declining, and adolescent fertility is dropping due to declines in child marriage and better access to contraception. However, our findings highlight significant scope for improvements in adolescent health and nutrition, including the need to address gender, regional and disability-related inequities in access to age-tailored information, services and support. There is also an urgent need to address adolescents' exposure to HIV (which appears to be on the rise), climate change-related health and nutritional vulnerabilities, and growing risks of substance abuse, especially in urban areas.

General health

While adolescents perceive their health to be good overall, poverty-related disease (especially related to sanitation) remains common. Just over half of our respondents reported having been ill in the month before the survey.¹ Significant accidents and illnesses, some of which result in permanent disability due to delays in care-seeking, also remain common and are increasing in some regions due to climate change. Another key theme emerging from our qualitative research is the rising incidence of substance abuse – including alcohol, tobacco, marijuana, khat and glue – especially among boys and in urban areas. We also found interesting patterns around the interaction between context and gender: for example, boys in Afar – unlike their peers in other regions – are more at risk of ill health than girls, probably due to their arduous pastoralist lifestyle.


GAGE research found that adolescents with disabilities are at especially high risk of ill health, due in part to the stigma that surrounds disability and in part due to poor health service availability (see Box 1).

 Earlier there were no malarial diseases but now it started to be seen in our village... The rainfall is becoming inadequate... The volume of water in the river is greatly reduced.

(Key informant, East Hararghe, Ethiopia)

Nutrition

The average adolescent in the GAGE sample lives in a moderately food-insecure household and is more likely to report poor diet quality than insufficient quantity. However, the poorest young people in rural communities, especially in areas prone to drought, continue to experience hungry seasons that now stretch across years, due to climate change (see Box 2). We also found evidence that traditional feeding practices impact adolescent nutrition; in some cases, adults are prioritised over children for nutritious food, particularly protein, while in others boys are prioritised over girls. In the study communities, school feeding had recently been discontinued, much to the chagrin of both adolescents and key informants, who reported that it had improved young people's attendance and attention.

 I live only on camels' milk and I don't get any other food. Since there is a shortage of pasture in the dry season, the camels don't produce sufficient milk... As a result, I get milk from the camels only in the morning and evening, while having nothing to eat during the day.

(12-year-old boy, Zone 5, Afar)

Box 1: Disability and health

Our research found that young people with disabilities are far less healthy than their peers without disabilities. Of those who completed our survey, only 44% of those with disabilities reported being in good health (compared to 89% of those without disabilities). In addition, of younger adolescents, those with disabilities were more likely to report recent health symptoms than those without (70% versus 51%) and to have had a serious illness or injury in the past year (33% versus 16%).

Adolescents with disabilities in our qualitative research reported that because transportation to health clinics can be challenging, and because specialist care is available only in urban areas and tends to be quite expensive, many adolescents do not have access to the care they need. A young adolescent girl with a physical disability in Batu (East Shewa) lamented that she wished that her parents 'could get me a medical service. I know they would do anything for me if they have any money'. Adolescent girls in Melkejebe (Zone 5, Afar), on the other hand, reported that fatalism and disability-related stigma prevents other children from receiving care, because parents simply say: 'it is Allah's will... if the child is born disabled'.

Box 2: Regional differences shaping adolescents' food security

Agro-climatic differences are fundamental to understanding food security. Parts of Amhara, for example, are surplus producing and the adolescents who live there generally have diversified, healthy diets. Other parts of Amhara, however, have recently seen steep declines in agricultural yields, due to over use. As one farmer explained: 'The land gets old like human beings. The quality of the soil deteriorates through time.' The lowlands of Oromia are in the midst of a drought that has radically reduced capacity to produce crops and also left livestock at risk. As a key informant from the district Bureau of Agriculture commented, 'In the last five years we did not get any food crops production'. In Afar, where pastoralist livelihoods mean that adolescents are often travelling for days or weeks looking after livestock, our qualitative work found that young herders often had the least diverse diets and sometimes went hungry.

¹ The GAGE Ethiopia baseline survey was undertaken in the last quarter of 2017 and first quarter of 2018.

Puberty and menstruation

Young adolescents, especially those in rural areas, have limited access to timely information about puberty. Menstruation is typically a taboo topic; out-of-school girls, and girls who are over-age for grade, often experience menarche with no prior knowledge or instruction, leading to great anxiety, given that bleeding is associated with sexual activity or severe illness. Many schools lack running water and private spaces for girls to change sanitary pads, which exacerbates girls' anxiety, as menstruation is deeply stigmatised. Where girls have access to school-based girls' clubs, and especially where those clubs can provide them with hygiene supplies and private spaces, they are better informed and feel more secure about their changing bodies.

▶ When my first menstruation came, I was screaming, holding my ears. My cousin said “what happened to you?” I said “I don't know when but they raped me”. She laughed.

(12-year-old girl, Dire Dawa city administration)

Contraception

Given regional variation in contraceptive use, we found that adolescents' access to and uptake of contraceptive information, supplies and services is highly variable. Girls in South Gondar, for instance, are significantly advantaged compared to their peers in East Hararghe and Zone 5. While misinformation about side effects is common, several fathers reported that they had taken their daughters to health clinics to get contraceptive injections to prevent pregnancy in the event of rape, and married girls reported using contraception, with their husbands' support, to delay pregnancy until their bodies were mature and their finances more stable. In East Hararghe, on the other hand, where adults reported that shifts in shegoye (traditional dancing involving young people) are leading to increased adolescent-led child marriages and early sexual debut, health workers admitted that they do not even discuss

contraception with young wives until they have given birth to at least one child (thus demonstrating their fertility). In Zone 5 (Afar) where girls and boys both pay the price for premarital pregnancy due to absuma (cousin) marriage customs, older adolescents – especially those who participated in the traditional all-night sadah dancing – admitted that despite younger teens' relatively limited awareness of contraception, it is increasingly (if secretly) used.

▶ If they give birth while being a grown-up and know many things, they will also benefit the child.

(A married 14-year-old girl, Community D, South Gondar, Ethiopia)

Preventing sexually transmitted infections

GAGE's baseline research found that there is an urgent need to step up efforts to prevent sexually transmitted infections (STIs) among adolescents, especially girls, who are at growing risk of contracting STIs. This is due to a combination of factors, including poor access to condoms, increased migration, high risk of sexual violence, greater tolerance for premarital and extramarital sex, as well as social norms that stigmatise boys' condom use and deny girls' voice to negotiate or insist on having protected sex. Health extension workers in all study sites reported that after years of decline, HIV incidence appears to be on the rise (see Box 3).

Key actions to accelerate progress

The transition between childhood and adulthood involves opportunities as well as risks. The government of Ethiopia and the broader development community could take advantage of this window of opportunity to remediate some of the health and nutrition deficits facing young people and put them on a healthier future trajectory. To improve support for adolescents' health, nutrition, and sexual and reproductive health, our research findings point to six key actions:

Box 3: Adolescent girls, including married girls, are at high risk of HIV

Tewabech is an older adolescent girl living in a remote kebele (community) in South Gondar. Having contracted HIV from her ex-husband, she lives with her mother and younger siblings, unsure what comes next in her life given the stigma directed at people with HIV.

As she explained, *'my mother is poor and there is no one that supports me to attend school'*, so she dropped out of school at age 17, in 6th grade, and was soon married off. Tewabech did not know her husband, she only knew that he worked in the lowlands sesame plantations in Metema.

Her married life was short – and tragic. *'We lived together for a short time. I become HIV positive.'* While she now knows that her ex-husband *'was aware of his health condition/HIV when he married me'*, at the time of their marriage she *'did not know that he was infected'*.

In Tewabech's community, HIV positive people are highly stigmatised. *'Here everyone hides his/her health condition... There are many people living with HIV in this area, but no one tells others about it. There is no association or way for people living with HIV to get together.'* Tewabech's mother is advising her to remarry to tackle her social isolation, but for now, Tewabech wants to live alone and have her own small shop to become financially independent.

1. Strengthen health awareness and outreach services for adolescents.

While health extension workers have helped improve access to basic health care, continued efforts are needed to raise parental awareness about common ailments in children that require timely interventions. There is also a need to improve access to basic medications, which are often out of reach, especially for communities furthest away from district towns. Services could reach adolescents in those areas through scaling up school-based health clubs and through mobile vaccination clinics at rural schools.

2. Ensure that health awareness programmes and services are informed by an understanding of the specific gendered health risks and vulnerabilities that adolescents face.

This must include a focus on married and unmarried girls' sexual and reproductive health, and on adolescent boys' susceptibility to substance abuse.

3. Expand household and school-based nutritional support as a core pillar of social protection programming.

To prevent the longer-term developmental damage that results from prolonged malnutrition, there is an urgent need to provide nutritional support to families in drought-affected areas. This should include extending Productive Safety Net Programme (PSNP) support in Afar in particular, as well as school feeding that reliably delivers free, quality food to students in all food-insecure communities. These initiatives could be usefully complemented by nutrition education programmes that address cultural beliefs about food and intergenerational food distribution that impact adolescent nutrition.

4. Invest in educating children about puberty and engage communities to accept the need for such education.

Age-tailored puberty education classes that begin with younger children need to be provided in school-based and other community settings, alongside classes for parents that help them address children's questions and concerns (while also ensuring that their own knowledge is accurate). To reduce menstruation-related harassment, girls and boys alike need accurate information about puberty and the changes it involves for both sexes. It is also critical to secure parental and community buy-in (especially among community and religious leaders) for educating children about puberty to shift underlying social norms.

5. Scale up accessible and affordable menstrual hygiene support

Adolescent girls need access to sustainable and affordable menstrual hygiene products, as well as simple ways to help them track their menstrual cycles. They also need separate latrines and access to water and dedicated private spaces in schools so that they can change their sanitary products as necessary during the course of the school day.

6. Expand access to and improve the quality of adolescent-friendly sexual and reproductive health services

To reduce adolescents' exposure to pregnancy and STIs, stakeholders should take a multi-pronged approach that includes awareness-raising to delay sexual debut (to allow for cognitive and emotional maturity), promote better access to condoms, improve education and services on HIV and other STIs, and initiatives to reduce the social barriers (e.g. stigma, shame, and restrictive gender norms) that reduce contraceptive uptake.

References

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