Ethiopia Research Report

Experiences of Young Lives During Crises in Ethiopia

Initial Evidence from the Sixth Wave of Qualitative Research (Qual 6)

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January 2026

Young Lives

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Executive summary

The 'Health and Well-being in Times of Crises in Ethiopia' qualitative longitudinal research programme ('**Qual 6**') has enabled Young Lives to complete a sixth wave of qualitative longitudinal data collection in 2025, building on over 20 years of significant research and policy engagement.

This timely, policy-relevant research provides vital insights into how young people's lives are changing as they navigate multiple intersecting crises, including the impacts of conflict, COVID-19, climate change, high inflation and living costs, and how these challenges have affected their health and well-being, and that of their children and families. Young Lives' holistic approach highlights the importance of cross-sectoral approaches for effective health and well-being policies and programmes and has enabled the research to expand into wider aspects of young people's transition to adulthood, including education, work and un(der)employment, and migration.

Collecting in-depth information about the same individuals over time and assessing the cumulative effects of life experiences provides a unique perspective and a better understanding of how early-life circumstances affect later-life outcomes, including intergenerational effects. The study has also collected **lived experience testimonials** from participants selected from the full Young Lives sample, broadening the qualitative sample to include individuals who are grappling with issues relevant to the original Qual 6 priority research areas of maternal and child health (MCH), sexual and reproductive health (SRH), disability and mental health.

This report presents key research findings from initial analysis of Qual 6 data, examining related trends identified through the Young Lives Round 7 quantitative survey conducted in 2023–24, and highlighting key changes since both Round 7 and the previous Young Lives qualitative study (Qual 5) in 2019. Comparisons with Qual 5 findings are particularly important for understanding the impacts of multiple, overlapping crises over the past six years.

Qual 6 findings are organised around eight key themes, providing a strong foundation for the in-depth, policy-relevant research planned for 2026. The study has also published a **Literature Review Of Health Services and Trends in Health Expenditure and Health Outcomes in Ethiopia** (Endale, 2026). This comprehensive report uses data from the Ethiopian Demographic and Health Surveys (EDHS), the Ethiopian Ministry of Health, the Ministry of Finance, and UNICEF to provide essential background information for the research.

Importantly, **Qual 6 data collection and research analysis focus on priority areas where the findings can directly inform key government policies and programmes**. Emerging policy recommendations from Qual 6 findings are summarised in the related policy brief [title and hyperlink to be inserted upon completion]. Ensuring that young people's voices, aspirations and lived experiences inform policies and programmes is vital to delivering lasting positive change in times of crises.

Table 1 presents an overview of initial Qual 6 findings, including analysis of related trends from the Round 7 quantitative survey, with further details under each theme in the main report.

Table 1. *Overview of initial findings from Young Lives Qual 6*

#	Research theme	Key findings 'at a glance'
1	Female genital mutilation/cutting (FGM/C) and early and child marriage	• Despite recent declining rates, FGM/C remains prevalent in some parts of Ethiopia, particularly in rural areas, with practices and ages varying by region. In rural Oromia, FGM/C remains common among girls in early adolescence, driven by stigma, expectations of purity and preparation for marriage. • Overall rates of child marriage have declined: Round 7 data comparing cohorts born seven years apart shows that only 5% of women in the Younger Cohort married before the age of 18, compared to 13% in the Older Cohort. However, among those who are married, a significant proportion (19%) in the Younger Cohort were married before 18, highlighting the importance of sustained efforts to eliminate child marriage. • Economic hardship, conflict and rising living costs are reshaping marriage practices, sometimes delaying or preventing marriage, and at other times accelerating early marriage and risking a reversal of earlier declines. In Tigray, conflict has led some families to encourage early marriage or childbearing to offset lives lost during the war and deter their daughters from migrating. • Financial barriers – including high dowry and bridewealth payments, scarcity of land and lack of parental support – and limited job opportunities for young people are making formal marriage and establishing separate households increasingly difficult. • Changing social norms mean that young people are increasingly making their own marriage decisions, with many opting for cohabitation or informal unions; however, limited resources often make these early unions fragile, increasing the risk of separation or divorce, which have significant effects on the livelihoods of single women and mothers.
2	Maternal and child health (MCH)	• Overall access to MCH services has improved over the past six years, with free provision through government institutions and some NGOs. Health Extension Workers (HEWs) play a key role through home visits, and institutional deliveries are increasingly common, especially in urban areas. • MCH services in rural and conflict-affected areas face significant barriers resulting from cultural norms, intermittent healthcare worker absences and financial constraints, while conflict has damaged health facilities and disrupted ambulance and vaccination services, leading to a reduction in institutional deliveries. • Some rural mothers still give birth at home due to traditional practices, limited awareness or lack of transportation. Traditional birth attendants continue to assist deliveries despite government policies designed to encourage institutional deliveries, while disruptions due to conflict – including to access to food and drink – reduce the motivation to use MCH services, especially for first-time mothers. • Children follow a structured vaccination schedule from birth through to age 5, while dedicated teams screen children for malnutrition and provide supplementary foods. Mothers receive tetanus toxoid vaccinations and iron supplements, though awareness remains limited, particularly in rural communities.
3	Sexual and reproductive health (SRH)	• Young people's SRH knowledge comes primarily from peers and older siblings, as well as schools, health facilities and NGOs. Peer-to-peer education programmes have improved awareness in some areas, but coverage and access often remain limited, especially in rural and conflict-affected areas. • Access to SRH services and contraceptives is generally better in urban areas and among married youth, while unmarried youth – particularly in rural areas – face significant barriers due to stigma, cultural norms and fear of judgement, compounded by inconsistent service provision in conflict-affected areas. • Young people have experienced significant disruptions to SRH services during and after periods of conflict, especially in Tigray and Amhara. These have often led to limited availability of free contraceptives, implant removals and SRH education, forcing many young people to buy services from private clinics or forgo them altogether. • Contraceptive use is limited by fears of infertility, side effects and perceived long-term health risks, as well as sociocultural barriers such as religious beliefs, male partner dominance, limited knowledge, social stigma, limited availability in conflict contexts and, for some unmarried women, the use of pregnancy to secure marriage.
4	Disabilities	• The increasing cost of healthcare places a significant economic strain on young people with disabilities and their families, sometimes forcing them to borrow money, sell critical assets such as cattle, or cut back on prescribed medications. • Limited access and low levels of trust in health services, particularly in rural areas, leads some young people with disabilities to avoid or delay seeking formal medical care and instead rely on traditional healers and remedies, such as bone-setting and *tebel* (holy water), which are more accessible, trusted and significantly less costly. • Significant obstacles lead many young people with disabilities to either remain unemployed or confined to informal, insecure or low-paid jobs. Social exclusion and discrimination contribute to emotional distress and isolation. • The war in northern Ethiopia has increased the prevalence of disabilities and intensified their effects, including through battlefield injuries, compounded by delayed medical treatment due to disrupted health services, as well as additional economic pressures and the long-term mental health impacts of psychological trauma and emotional distress.

Table 1. *Overview of initial findings from Young Lives Qual 6 continued*

#	Research theme	Key findings 'at a glance'
5	Mental health	• The current generation of young men and women has transitioned to adulthood in the exceptionally stressful context of multiple crises, including COVID-19, limited higher education, unemployment, high inflation and protracted war and conflict in northern Ethiopia, even as many young people demonstrate notable resilience. • Young people are experiencing significant mental health challenges, with six out of ten Young Lives participants in the Round 7 survey reporting at least moderate stress and around one in five reporting symptoms consistent with anxiety or depression, particularly in conflict-affected areas, where post-traumatic stress disorder is also prevalent. • Few respondents have benefited from adequate mental health services, with most respondents deterred by distant, lengthy and costly referrals and lack of insurance; instead, many place greater trust in prayer and holy water, as well as support from family and friends. • Gender differences are evident: young women's mental health is affected by additional caring responsibilities and heightened risks of sexual violence, especially during conflict, and they rely more on religion, family and peer support; while young men are more affected by un(der)employment and sometimes resort to substance abuse and other negative coping strategies, leading to alienation, depression and hopelessness.
6	Education	• Despite high childhood aspirations, most young people have not achieved higher education due to the impacts of conflict, COVID-19 disruptions, rising costs and the introduction of competitive university entrance exams. • Urban–rural inequalities are stark, with young people in rural areas typically leaving education after primary school, while access to secondary schooling is often limited by the high cost of living in towns and long travel distances, alongside additional risks of sexual violence for girls and young women. • Conflict in northern Ethiopia has severely disrupted education, causing prolonged interruptions and lasting setbacks to young people's learning trajectories, with those exposed to extended conflict less able and motivated to continue their studies. • Increasing costs of tuition, the high cost of living in towns for rural migrants and graduate unemployment also discourage many young people from investing in higher education.
7	Work and un(der) employment	• Young people face fragmented transitions to work, with limited access to stable employment leaving many unemployed, underemployed or in insecure, low-paid jobs. • Young people in rural areas are often restricted to precarious agricultural and manual work, while those in urban areas face intense competition, low wages and limited secure opportunities. • Young women face additional challenges in employment due to unpaid care responsibilities and limited workplace childcare, and are also more vulnerable to unsafe working conditions, sexual harassment and gender-based violence at work. • Conflict in northern Ethiopia destroyed livelihoods and increased youth unemployment, while those who dropped out of school and even university graduates face poor-quality jobs that fail to match their skills and expectations.
8	Migration	• Over half of the young people interviewed in Qual 6 had migrated internally or internationally, motivated by a range of factors including employment, education, marriage and conflict, with migration patterns varying by region, location, age cohort and gender. • While domestic migration is primarily driven by young men moving for seasonal labour and young women moving to towns for domestic work or marriage, international migration is increasingly viewed as a pathway to a better future, but frequently involves irregular and risky routes, exposing young people to financial loss, physical harm, potential deportation and even loss of life. • Young women are particularly vulnerable to exploitation, sexual harassment and deception during migration, while men tend to take on more hazardous but potentially lucrative work. • Despite significant challenges and risks, some international migrants have achieved economic success, transforming their lives, sending remittances home to their families and inspiring others to follow in their footsteps.

Looking forward, the Qual 6 project extension in 2026 will enable in-depth analysis of these findings, to deliver five papers and five policy briefs, accompanied by high-level policy engagement and dissemination activities. The research will focus on:

- young people's migration experiences
- work and un(der)employment
- MCH and SRH experiences and access to services
- the effects of war on access to health services
- mental health in times of crisis.

The analysis will investigate how conflict and other compounding crises affect young women and men differently, within the broader contexts of humanitarian response, social protection, community-based health insurance, education, family formation and parenting.

The Young Lives study and Qual 6 in Ethiopia

Young Lives has been following the lives of 12,000 young people in Ethiopia, India, Peru and Vietnam, from infancy into early adulthood, since 2001. This includes two age cohorts: the Younger Cohort, born in 2001–02, has been followed since age 1, and the Older Cohort, born in 1994–95, has been followed since age 8.

In Ethiopia, the study follows 3,000 young people located in 20 sites across Addis Ababa, Amhara, Oromia, Tigray and the former Southern Nations, Nationalities and Peoples' Region (SNNPR), now located within the Central Ethiopia Regional State, South Ethiopia Regional State and Sidama Region. Young Lives is one of the few longitudinal studies collecting data in the conflict-affected areas of Tigray and Amhara – through an innovative COVID-19 phone survey in 2020–21, and more recently through the in-person Round 7 survey conducted in 2023–24.

As a mixed methods study, Young Lives has also conducted in-depth longitudinal qualitative interviews since 2007 with a sub-sample of young people, their families and communities located in seven sites across Addis Ababa, Amhara, Oromia, Sidama and Tigray. **To protect the anonymity of study participants, all quotations use pseudonyms and sites are identified only as either rural or urban locations within respective regions. In addition, the photographs used do not depict Young Lives respondents but instead show individuals living in similar circumstances and communities.**

The current programme, **Health and Well-being in Times of Crises in Ethiopia** ('**Qual 6**'), co-funded by FCDO Ethiopia and Irish Aid (from October 2024 to December 2025), has enabled Young Lives to undertake a sixth wave of qualitative longitudinal data collection focusing on young people's health and well-being in times of crises. This includes a wealth of new data collected from a total of 494 respondents, including the qualitative sub-sample and additional lived experience respondents (181 from both the Younger Cohort, now aged 23–24, and the Older Cohort now aged 30–31), spouses or caregivers (136), key informants (67: including *kebele* (district) administrators, clinic and Health Extension Workers, women and children's affairs officers and community leaders) and focus group participants (110).

Full details of the survey design and fieldwork implementation are set out in the **Young Lives Ethiopia Qual 6 Fieldwork Data Gathering Report** (available upon request). This includes comprehensive information on survey modules and interview guides, sample selection, fieldwork preparation, data collection, reporting and transcription, data management and fieldwork experiences.

Young Lives is led by the University of Oxford, in partnership in Ethiopia with the Policy Studies Institute (PSI) and Pankhurst Development Research and Consulting (PDRC).

1. Female genital mutilation/cutting and early and child marriage

This section examines current experiences of female genital mutilation/cutting (FGM/C) and early marriage across the Young Lives study sites, alongside an analysis of changing trends since Qual 5 in 2019. It explores regional and community variations and the complex factors influencing these practices, including the effects of conflict and other overlapping crises.

FGM/C is driven by different cultural beliefs and practices

FGM/C is a deeply rooted cultural practice across most parts of Ethiopia, with significant regional differences in the age at which girls are affected and type of cutting. In northern Ethiopia, FGM/C is generally carried out soon after birth, while in most other parts of the country it is performed when girls are in their early teens prior to marriage. The procedure involves the cutting and partial or total removal of external female genitalia, with this being followed by infibulation (narrowing the vaginal opening) in communities in parts of eastern Ethiopia.

While Ethiopia has made significant progress in reducing FGM/C over the last two decades, it remains prevalent in many areas, due to deeply entrenched patriarchal norms, long-standing traditions, social pressures and beliefs about purity and marriageability. Although knowledge about the government ban and rationales for stopping the practice are widespread, cultural beliefs about the perceived benefits of FGM/C often outweigh the perceived health or legal risks.

FGM/C is mainly practised in rural areas and is much less common in urban areas, with very high rates in Oromia and declining prevalence in Amhara, Addis Ababa, Tigray and Sidama. In the site in rural Oromia, most girls undergo FGM/C in their early teens (usually around age 13) regardless of their level of education, their family's wealth and community knowledge about potential health risks. The practice is mainly driven by deep-rooted traditional beliefs and local practices that label a girl as *lumbutam*, a derogatory term to mean uncircumcised, which holds a defiling connotation that would stigmatise and isolate the girl and restrict her relations within the community.

Girls often choose to undergo FGM/C to avoid being stigmatised, despite knowing the legal implications. It is considered an important rite of passage to indicate a girl's readiness for marriage, and men typically expect their potential wives to have undergone the procedure, reflecting patriarchal norms to control female sexuality. Mothers are the primary enablers of FGM/C, and there are cases of girls who marry without undergoing the procedure who are later subjected to it at the insistence of their mothers-in-law. Some young mothers in the Young Lives study with daughters aged 12 or 13 also shared plans to have their daughters undergo the practice.

Government officials who are expected to implement measures to prevent FGM/C are aware that it is culturally considered normal and necessary, as explained by a gender expert in rural Oromia:

"Although early marriage and FGM/C are legally prohibited, these practices continue within the community. This … primarily stems from the lack of legal enforcement, inadequate reporting and insufficient follow-up on these practices. In the case of FGM/C, all community members support the practice for cultural reasons. Similarly, … young people are influenced by their peers to marry at a young age."
Community-based health worker (female)[1]

Ayu, who lives in the same community and is a mother of three children, has been followed by Young Lives since the age of 8 in 2001 and has been consistent in her views about FGM/C. She was circumcised when she was only 12 and married at the age of 16 through 'voluntary abduction', by eloping to avoid the costs of marriage payments. She and her husband arranged the marriage clandestinely and later informed their parents. The couple paid the *gaaddisa* (reconciliatory money) and later a reduced amount of *gabbaarraa* (bridewealth) to legalise their marriage. She has two daughters, aged 13 and 3. Ayu told the Young Lives fieldworker that she is planning to circumcise her older daughter during the main school holiday in 2026.

Current trends in early and child marriage

While Ethiopia has made significant progress in reducing child marriage over the last two decades, cultural traditions, economic pressures and deeply entrenched social norms – especially in rural areas – continue to drive the practice. Child marriage denies girls of their rights to health, education and personal development, exposing them to increased risks of early pregnancy, school dropout and lifelong limitations.

Young Lives longitudinal data collected during the Round 7 survey in 2023–24 shows that overall rates of child marriage have declined when comparing the study cohorts born seven years apart: about 5% of women in the Younger Cohort married before the age of 18, compared to 13% of women in the Older Cohort (Tanima, 2025).

Although child marriage has declined overall, married individuals in the Younger Cohort entered their first marriage at a younger average age (19 years) than those in the Older Cohort (22 years), and on average, a significant proportion (19%) of married participants in the Younger Cohort were married before the legal age of 18 (Table 2). These patterns highlight the importance of continued efforts to eliminate child marriage.

Child marriage continues to be primarily experienced by girls, with almost one in five (20%) of married women having wed before the legal age of 18, compared to only 3% of men (Table 2). Child marriage is also more common in rural areas, where the prevalence among those married is twice as high (20%) as in urban areas (10%).

Economic hardship, conflict and increased living costs are changing trends in early marriage

Qual 6 evidence reveals a nuanced pattern in recent marriage trends, showing how economic hardship, conflict and rising living costs have shaped these changes. While such pressures have led to higher rates of early marriage in some contexts, they have also created substantial barriers to marriage elsewhere, contributing to a rise in informal unions and cohabitation, particularly in urban areas. Understanding how these experiences differ across regions, and how they affect women and girls differently to men and boys, is crucial for informing effective action and support.

Table 2. *Percentage of Young Lives respondents married as at Round 7 in 2023–24 (N=2,228)*

	Total	Younger Cohort	Older Cohort	Women	Men	Rural	Urban
Married (%)	26	13	56	37	17	26	27
Among those who are married (N=587):							
Average age at first marriage (years)	21	19	22	20	23	20	21
Married before legal age of 18 (%)	14	19	12	20	3	20	10

1 To protect the anonymity of study participants, all quotations use pseudonyms and sites are identified only as either rural or urban locations within respective regions. In addition, the photographs used do not depict Young Lives respondents but instead show individuals living in similar circumstances and communities.

Shifting marriage practices

In rural Oromia, early marriage through 'voluntary abduction' (carried out with the girls' consent) is widespread, with most girls in the study sites marrying before the age of 18 (usually between ages 14 to 17). In contrast, while a significant number of boys marry between the ages of 17 and 18, some are now delaying marriage due to the high cost of living and economic instability affecting their ability to establish a family.

In Tigray, young men are delaying marriage even up to the age of 24 due to financial constraints, unless they are from better-off families. In contrast, girls in Tigray are much more likely to marry after completing Grade 10 at age 14 or 15, particularly those with low educational and employment prospects.

Household wealth also influences the timing of marriages due to the practice of marriage endowments, such as the payment of *gemzi* (dowry) by the bride's family in Tigray, or bridewealth paid by the groom's family in Oromia, which can encourage elopement as couples seek to avoid high costs.

In the rural Tigray site, many parents prefer their daughters to marry rather than migrate, as outlined by one participant during the men's focus group discussion:

> "It is better if a 14-year-old girl gets married because she will be protected from bad things that she may experience during the risky migration routes."

Parents also encourage early marriage and childbirth for their daughters as a way to compensate for lives lost during the war and to discourage their daughters from migrating. During a women's focus group discussion in the rural Tigray site, one participant said that:

> "Currently, parents fear migration so they insist on their daughters having a child. They believe that if she has a child, she wouldn't dare to migrate. Second, for the past two years, the community has been in a terrible conflict, and many young children have died in the war. As a result, at this time, most parents would like to see their children give birth, even if they are not married, to compensate for the lost children."

In urban areas, young people also often take the initiative to arrange their own marriages, sometimes with the involvement of their families. This is notably among Muslim families, who still play a role in choosing husbands for their daughters and vice versa. This can also lead to cohabitation, which tends to be higher in urban areas. As one participant in a women's focus group in the urban Sidama site explained:

> "Couples typically arrange their own marriages and may consult their parents only after making their decision. In many cases, couples simply move in together. A boy may introduce a girl as his wife, even if they don't have enough food at home. Subsequently, if the boy's family is in a good economic situation, they may attempt to formalise the marriage by sending elders and organising a small ceremony. Otherwise, the couple continues to live together without formal recognition."

Young people are still beginning sexual relationships early, with the majority in rural areas getting married through their own initiative, while those in urban areas typically start by cohabitating, with marriage formalised later through customary practices.

As more couples choose to marry on their own initiative, many face increased vulnerability

There is an increasing trend of young people deciding to start to live together without informing their parents and without planning how they will make a living.

> "Nowadays, many young people start engaging in relationships at an early age, often without telling their parents. Eventually, the parents find out. Typically, these young people lack maturity and do not think about the long-term consequences of their actions; instead, they are guided by their emotions when making decisions."
>
> (Male caregiver, rural Oromia)

Often, a lack of planning and limited resources mean that early cohabitations or marriages are fragile, leaving young people vulnerable to the pressures of married life and increasing the risk of separation or divorce. Beze, a 31-year-old woman from rural Oromia, divorced her husband after having two children and returned to live with her parents. She explained the impact of her divorce:

> "I am stressed because it is far better to live in one's own house with a spouse than to live with your parents. My mind does not feel free when I think of living with my parents. Thus, I am stressed. Sometimes I think it would have been better if I had not gone back to my parents."

In traditional marriage practices, the parents of the groom send elders and clan members to formally propose to the bride's family. This process is often lengthy and involves several formalities, including families investigating any potential blood relations extending back seven generations, as well as ties between clan members. However, these practices are becoming less common, as young people increasingly circumvent traditions by eloping or deciding to live together, though in some cases customary wedding ceremonies and parental contributions are arranged afterwards.

Drivers of early marriage are exacerbated by conflict, economic circumstances and changing social norms

In Tigray, before the conflict, the local government was perceived to have taken strong action to prevent child marriages. During and following the war, however, this issue has not been prioritised. The conflict and uncertainties in the post-war period have had mixed effects. Some parents have encouraged their daughters to marry early out of fear for their safety, while some young men and women met during this period and formed relationships. At the same time, economic uncertainties have prompted many families and young people to delay marriage.

More generally, caregivers express mixed views regarding the appropriate age for their children to get married. Many

believe that it is essential to achieve economic self-reliance before starting a household, whereas many young men and women are often eager to start living together sooner. However, other caregivers are keen to see their children married early – often wanting to have grandchildren – and sometimes feel their children are delaying marriage unnecessarily and try to persuade them. In many communities, particularly in rural areas, limited access to education and employment opportunities, especially for young women, continues to drive early marriage, as many feel they have few alternatives. For example, Etay, a 31-year-old woman in the rural Tigray site, married early because she lacked educational support:

> “At that time, I wanted to attend school, but I didn’t have a supporter, so it pushed me to get married. I wish I had continued schooling if I had had someone who could support and encourage my interest in education.”

In contrast, young women in urban areas are more likely to marry after the age of 18 and continue their education if married, rather than dropping out.

In other cases, some young people are marrying early to escape parental arrangements, as one participant explained during a men’s focus group discussion in the Addis Ababa site:

> “I got married early, around 24, because I wanted to marry that girl, as her parents were trying to arrange a marriage to a rich husband. So, we both decided to escape their arrangement.”

Economic hardships and changing social norms are also delaying marriage for many couples

Inability to afford marriage endowments

Compared to experiences reported in Qual 5 in 2019, the financial costs of marriage have significantly increased.

In Tigray, it is customary for the bride’s family to provide marriage endowments to the couple. However, many families are now struggling to make these payments because of financial constraints linked to the war and uncertainty about the post-war situation. Expected dowry payments have increased from around 150,000 birr in 2019 to 300,000 birr in 2025, leading many young people to opt for pregnancy outside of marriage and begin living together without a formal, and costly, wedding.

In Oromia, legalising the ‘voluntary abduction’ form of marriage requires two payments: *gaaddisa* (reconciliatory money), which is provided shortly after the couple comes together, and *gabbaarraa* (bride wealth), which can be paid at any time the husband’s family is financially able. Bride wealth has quadrupled with inflation, from approximately 10,000 birr in 2019 to 40,000 birr in 2025.

Lack of essential resources

In the past, parents typically supported their children by providing essential resources such as land, cash, livestock and household items. However, this practice has also declined due to economic uncertainties and the effects of conflict. The situation is particularly challenging in rural areas where land is becoming scarce and families are no longer able to provide plots for young couples to establish a family or engage in agricultural work. In urban areas, it is increasingly difficult to find accommodation separate from families, and rental costs are often prohibitively expensive.

> “Newlyweds often establish their households independently as parents lack resources. Friends and relatives may contribute items as gifts.”

(Male caregiver, Addis Ababa)

> “The couple agree in secret and inform their parents, prepare for a small ceremony, and start life. If they planned a huge festivity, they couldn’t afford the cost of an ox, … sheep, red pepper, butter, and so on. You cannot cover the cost of goods, arrange simple ceremonies with neighbours, and start life. … [while the] marriage has been concluded between couples, they don’t invest too much money in preparing a marriage ceremony.”

(Women’s focus group, rural Tigray)

Increased cost of living

Young people are experiencing a period of significant economic uncertainty, where finding work and earning enough to set up their own household is very difficult:

> “I completed Grade 10 and work in the private sector, but my low salary means that I want to find a new job. Because of the effects of war and inflation, I struggle to save money, which worries me constantly. I have a boyfriend, but we don’t have any plans for marriage yet. I hope to save to pay for wedding expenses, as my parents cannot help me financially.”

(Tsehaytu, 24-year-old woman, rural Tigray)

Political instability in some parts of Ethiopia also continues to be a major concern for young people, reducing their motivation and ability to work and earn a living.

> “I have two oxen, which I took to the market. I had 1,000 birr while my friend had 5,000 birr. We were stopped by some individuals [from a rebel group] who demanded to know what we were looking for and physically assaulted me with their gun … and demanded a payment of 5,000 birr, which we managed to pay within 30 minutes. They warned us that if we took too long, the amount would increase. As time passed, they raised the demand to 10,000 birr. The situation kept changing, and we ultimately made the payment using mobile banking.”

(Zena, 31-year-old man, rural Amhara)

Shifts in social expectations and marriage norms

Parents are increasingly more likely to invest in their children’s education rather than arranging early marriages or providing endowments for setting up a household. However, limited job opportunities for graduates, increasing costs of tertiary education and uncertain returns on educational investment are becoming discouraging factors. At the same time, young people are prioritising finding work and saving money before considering early marriage.

Key findings on FGM/C and early and child marriage

- FGM/C remains common in some parts of Ethiopia, despite declining rates over time – especially in rural areas – though prevalence varies greatly by region and the age at which it is performed.
- In the rural Oromia site, FGM/C remains common among girls in early adolescence, driven by stigma, expectations of purity and preparation for marriage.
- Despite legal prohibitions and awareness of health risks, patriarchal cultural norms, beliefs about marriageability and social pressure perpetuate FGM/C, with mothers typically playing a central role.
- Child marriage has also reduced over the last two decades but remains prevalent in some communities, disproportionately affecting girls – especially in rural areas – due to persistent cultural norms and economic pressures. Among the full Young Lives sample, almost one in five (20%) of married women were wed before the legal age of 18, compared to only 3% of men.
- Overall rates of child marriage have declined: Round 7 data comparing cohorts born seven years apart shows that about 5% of women in the Younger Cohort married before the age of 18, compared to 13% in the Older Cohort.
- However, on average, married individuals in the Younger Cohort entered their first marriage at a younger average age (19 years) than those in the Older Cohort (22 years), and a significant proportion (19%) of the Younger Cohort married participants were married before the legal age of 18. These patterns highlight the importance of sustained efforts to eliminate child marriage.
- Economic hardship, conflict and rising living costs are reshaping marriage practices, delaying or preventing marriage in some contexts, while accelerating early marriage in others. In some areas, these pressures risk reversing previous declines in early and child marriage, with women in the Younger Cohort marrying earlier and at higher rates than those in the Older Cohort.
- Financial barriers – including high dowry and bridewealth payments, scarcity of land and lack of parental support – and limited job opportunities for young people, are making formal marriage and establishing separate households increasingly difficult, often leading to delays. In the rural Oromia site, young couples frequently decide to elope to avoid the high costs of marriage, a practice locally referred to as ‘voluntary abductions’.
- Changing social norms mean that young people are increasingly making their marriage decisions, with many opting for cohabitation or informal unions, often in response to unplanned pregnancies – particularly in urban areas where traditional practices are increasingly less common.
- Parents and caregivers hold mixed views on when their children should marry, with some pushing early marriage for security or economic reasons, while others advocate waiting until financial independence is achieved.
- In Tigray, conflict has led some families to encourage early marriage or childbearing to offset lives lost during the war and deter migration.
- Limited planning and scarce resources often mean that early cohabitations or marriages are fragile, leaving many young people – particularly young women – vulnerable to the pressures of married life and increasing the risk of separation or divorce, often affecting the livelihoods of young mothers.

2. Maternal and child health

This section presents findings on four key aspects of maternal and child health (MCH): antenatal care, childbirth deliveries, postnatal care and overall child health, including nutrition and immunisation. It examines factors influencing access to MCH services, including regional and community variations, as well as the impact of conflict and other overlapping crises, highlighting existing MCH service gaps.

Current trends in early parenting

Young Lives longitudinal data collected during the Round 7 survey in 2023–24 shows that overall rates of early parenting have declined when comparing the study cohorts born seven years apart: only 7% of women in the Younger Cohort had a child by age 19, compared to 18% of women in the Older Cohort (Tanima, 2025).

Although early parenting has declined overall, parents in the Younger Cohort became parents at a younger average age (19 years) than those in the Older Cohort (22 years), and on average, almost half of Younger Cohort parents (46%) had their first child before age 19 (Table 3). These patterns – mirroring those observed for child marriage – highlight the continued need for efforts to both eliminate child marriage and reduce early parenthood.

Overall, just over one in five (21%) young people had become parents by Round 7 in 2023–24 among the full Young Lives sample, with clear gender differences: nearly one-third of young women (32%) had had a child, compared to only 11% of young men (Table 3). Young people in rural areas were also less informed about sexual disease transmission than those in urban areas (59% versus 70%).

Table 3. *Fertility and parenthood trends across the Young Lives sample (N=2,043)*

	Overall	Younger Cohort	Older Cohort	Women	Men	Rural	Urban
Has a son/daughter (%)	21	9	47	32	11	21	21
Knows condoms prevent disease (%)	81	80	82	74	87	76	84
Knows healthy-looking person can pass on disease (%)	66	62	74	66	66	59	70
Among those who are parents (N=423):							
Age at first child (years)	21	19	22	21	23	21	21
Had a child before age 19 (%)	32	46	26	36	23	32	32

MCH services include antenatal and postnatal care, alongside nutrition and immunisation

Across Young Lives study sites, MCH services consist of integrated sets of interventions delivered from pre-pregnancy to early childhood. These include antenatal care for pregnant women, childbirth care, and postnatal care for both mothers and their newborns. Additional support services include pre-pregnancy awareness, child healthcare, skilled birth attendance and broader maternal and child health initiatives, which focus on addressing malnutrition, preventing disease and promoting sexual and reproductive health.

Overall access to MCH services has improved

Overall access to MCH services appears to have improved over the past six years when comparing the Qual 6 findings to those from Qual 5 in 2019. Young people now receive services from multiple providers and are generally better informed about the support available. However, access remains inadequate, particularly in rural and hard-to-reach areas, and especially in conflict-affected areas.

Most MCH services are offered free of charge through government health institutions, including hospitals, health centres, health posts and the Family Guidance Association of Ethiopia, with a few women accessing them through non-governmental organisations (NGOs). For example, in Addis Ababa, Marie Stopes – an international NGO – provides antenatal and postnatal care, along with other maternal health services, while a local NGO, Yenegew Tesfa, supports children from low-income households with balanced nutrition. However, some local NGOs, such as Mary Joy and Eyerusalem, which previously provided similar services, have left the community in Sidama over the past six years for reasons that remain unclear.

While service delivery is relatively effective in urban areas, rural communities continue to face significant barriers, including cultural norms, the impacts of conflict, shortages of healthcare personnel and financial constraints. In the Oromia rural site, health institutions often remain closed even on designated working days due to a lack of health professionals. Similarly, in Tigray and Amhara sites, ongoing conflicts have severely interrupted the availability of MCH services.

Antenatal and postnatal care

Qual 6 findings show that pregnant women access a range of services during antenatal care, including blood and urine tests, foetal position monitoring, HIV testing, deworming and other laboratory services, alongside diet assessment and tracking the baby's weight. According to a young mother in the urban Sidama site:

> “The Health Extension Workers gave me pregnancy counselling, vaccination information and information on where to give birth. They also gave me the phone numbers of ambulances.”

Counselling may be offered if a mother is underweight or she may be referred for additional support depending on her needs, as outlined by Hibiste, a 31-year-old mother of three children in the site in rural Oromia:

> “During my last pregnancy, I accessed ultrasound services for the first time. I felt like something heavy was pressing on my stomach, and it had become quite large, making it difficult for me to move and walk. As a result, I visited the healthcare centre frequently. Thankfully, the foetus was healthy. I received proper antenatal care at Mission Hospital, where I also gave birth.”

Health reforms have increased the recommended number of antenatal visits from four to eight across all study sites, a change welcomed by many participants.

Most young women are now aware of the importance of antenatal and postnatal care, and after delivery, health professionals provide guidance on family planning, immunisation and necessary follow-up appointments. Health professionals emphasised that postnatal care is crucial for both mothers and infants.

Services include breastfeeding counselling, vaccinations and monitoring for any potential complications. Mothers are assessed for bleeding, headaches, shivering and fever, while infants are checked for weight gain and signs of jaundice. Follow-up care lasts for up to seven days after birth, with check-ups at 24, 48 and 72 hours. The initial 24-hour follow-up takes place at a health facility, while subsequent check-ups – introduced three years ago – occur at home to monitor the mother's health and the baby's weight, breastfeeding and overall activity level.

Fathers have limited involvement in antenatal and postnatal care

Fathers have limited involvement in antenatal and postnatal care, often due to a lack of awareness and especially the belief that these matters are purely women's issues. As a result, many young mothers report feeling isolated and unsupported, while young fathers show varying levels of engagement in MCH decisions. For example, in the site in rural Tigray, Halefay's husband knew that his children were vaccinated but had not been involved:

> “I don't have enough information about vaccinations, but I know that both of my children have been vaccinated, including the nine-month vaccination.”

In contrast, in the urban Sidama site, Lili's husband accompanied his wife for check-ups:

> “I supported my wife during her first pregnancy by attending her medical check-ups at the health centre.”

Fathers in urban areas tend to be more engaged in childcare than those in rural areas. For example, in the Addis Ababa site, some young fathers are now participating in childcare from the early stages of pregnancy:

> “Young fathers help in every way they can, from accompanying their wives during antenatal and postnatal care to feeding the infants. Nevertheless, the majority of childcare responsibilities still rest with women.”
>
> (Men's focus group, Addis Ababa).

Institutional deliveries are increasingly common, but some rural mothers still prefer home births

Increasing the number of births attended by skilled health professionals is vital for reducing health risks for both mothers and children. Ensuring appropriate medical care and hygienic conditions during delivery can significantly reduce the risk of complications and infections that could threaten the health or well-being of the mother, the baby, or both.

Institutional delivery has become increasingly common in urban sites in Addis Ababa and Sidama, with many women giving birth at the same medical facilities where they received antenatal care. Institutional delivery is considered preferable for several reasons:

> “Institutional delivery is good because mothers and children get medical treatment, vaccination and medicines as well. There are treatments to prevent postnatal illnesses and infectious diseases.”
>
> (Men’s focus group, Addis Ababa).

Institutional delivery is highly encouraged and most young mothers in both urban and rural areas now give birth at government health facilities. Home births are now rare and typically occur in rural areas when labour is very short and the baby is delivered before reaching a health facility. However, a small number of rural mothers still give birth at home, often due to a lack of information – particularly for first-time births – preference for traditional birth practices, or lack of transportation, such as ambulances in conflict-affected areas.

In rural Oromia, many women still prefer home births with the help of traditional birth attendants, even though officially they are not allowed to practise due to government policies that promote institutional delivery:

> “The traditional birth attendant assists home delivery secretly … Women go to healthcare centres for delivery if and only if they face labour pain or when the labour takes a long time.”
>
> (Women’s focus group, rural Oromia).

Ayu, a 31-year-old mother in the site in rural Oromia, gave birth at home because she lacked knowledge and experience about childbirth:

> “When I gave birth for the first time, I was not aware of childbirth because I was very young. Since I did not have prior experience, I was unaware of the labour pains and hence gave birth at home. During my third pregnancy, my labour did not last long, and I easily gave birth at home.”

In Tigray, traditional birth attendants continue to support mothers primarily because of health service disruptions due to the war, and the previous penalties for home births have not been reinstated:

> “When the public health facilities fail to provide the necessary delivery services, mothers will give birth at home with the support of traditional birth attendants. Previously [before the conflict], … Health Extension Workers supervised each home delivery and penalised [household heads] who violated the regulation. However, recently [during and after the conflict], no one has been penalised, and the delivery service is also not sufficiently available in the public health facilities.”
>
> (Men’s focus group, rural Tigray)

In contrast to the rural communities, and small towns in Tigray and Amhara where services were disrupted due to war, services in other sites were only temporarily disrupted by the COVID-19 pandemic.

Health Extension Workers are important in raising awareness of MCH services

Health Extension Workers (HEWs) play a vital role in raising awareness and promoting MCH services across Ethiopia. Through regular home visits, community meetings and health education sessions in rural areas, they provide information on the importance of antenatal and postnatal care, skilled birth attendance, immunisation, nutrition, family planning and hygiene.

Community education and outreach

In both rural and urban areas, monthly forums are held where women can share their experiences and engage with health professionals to discuss the quality of MCH services and how to access them. A HEW in the urban Sidama site outlined how:

> “Pregnant women have monthly forums where the HEWs provide comprehensive information regarding their services. There is a leaflet containing the ambulance number, which helps them call for assistance if needed.”

Home visits

HEWs conduct home follow-up visits with pregnant women and new mothers, reminding them of appointments, monitoring their health and reinforcing information on danger signs and healthy practices.

Since Qual 5 in 2019, many women in both urban and rural areas have gained a better understanding of the importance of visiting healthcare facilities during pregnancy, and have consistently attended antenatal care appointments, usually at public health facilities where services are provided free of charge.

There has been a noticeable improvement in MCH awareness and service delivery in urban areas, particularly when compared to rural areas. Young women living in urban areas generally report satisfaction with the services they receive, whereas those in rural areas have voiced concerns and complaints.

Overall, there has been a clear shift in the health-seeking behaviour of young mothers compared to their mothers’ generation. Young mothers now recognise the importance of antenatal and postnatal care and are more likely to access these services at healthcare facilities:

> Our generation did not utilise antenatal care services as much as young women of this generation. At that time, we were giving birth at home with the support of traditional birth attendants, while nowadays some young women give birth at healthcare centres.

(Female caregivers' focus group, rural Oromia)

While there is limited engagement of fathers in antenatal and postnatal care, some fathers from both cohorts have started supporting their pregnant wives and taking an active role in childcare, particularly in urban areas, which was not common in the previous generation.

Postnatal care includes promoting child health through immunisation and nutritional support

Immunisation

Following institutional delivery, health workers submit reports to the respective HEWs, who then follow up with mothers on their children's vaccinations. Children typically follow a structured vaccination schedule that begins at birth with the BCG (Bacillus Calmette–Guérin) and OPV (oral polio vaccine). After 45 days, they receive a series of six vaccines, including rota, polio and PCV (pneumococcal conjugate vaccine). This is followed by three doses of the pentavalent vaccine, each administered at 28-day intervals. After completing these, children receive additional vaccines: the measles vaccine at nine months and ten days, and a second measles dose at one year and three months.

In addition, children receive routine growth and development check-ups and are given vitamin A with a second dose six months later. At age 2, they receive deworming treatment and another dose of vitamin A, which is repeated every six months until age 5. At age 5, children receive the human papillomavirus (HPV) and polio vaccines during health campaigns, and girls aged 9 and older are eligible for the cervical cancer vaccine. All such services are currently provided free of charge.

> Both of my children started receiving vaccinations at 45 days old. After that, they received additional vaccinations at three-month intervals. Later, they were vaccinated again at six months, nine months and then at one and a half years old. Finally, they received their vaccinations when they turned 2 years old. I ensured that both of my children completed all rounds of their vaccinations.

(Bire, 24-year-old mother of two, rural Oromia)

Typically, children receive eight routine vaccinations, in addition to vitamins and the polio vaccine. Mothers are expected to receive five TT (tetanus toxoid) vaccinations, as well as iron supplements. Three rounds of TT vaccination are required before delivery, with the remaining two within two years of childbirth. However, awareness about vaccinations for mothers remains limited.

Unlike six years ago, mothers consistently ensure that their children receive vaccinations as scheduled. Previously, children had to be taken to health facilities for immunisation, but now door-to-door visits are conducted to vaccinate children under the age of 5, especially for those who missed their immunisations during postnatal care. However, these services have been partially disrupted due to the conflict in some parts of Amhara and Tigray.

While vaccinations are considered essential for babies, challenges remain across all sites in delivering effective postnatal care. These include a perceived lack of commitment among some healthcare workers and limited transportation for conducting home visits.

Child nutrition

Another notable improvement compared to six years ago is more emphasis by dedicated teams of health professionals who screen children for malnutrition and provide supplementary foods, such as Plumpy'Nuts, across all study areas. HEWs also emphasise the importance of exclusive breastfeeding in the first six months and advise mothers to introduce nutritious porridge thereafter to ensure their babies remain healthy.

In the study site in rural Oromia, prior to 2023 the *woreda* administration provided supplementary food, including flour and Plumpy'Nuts, to malnourished children and pregnant women. However, after the area was incorporated into a nearby town for administrative reasons, this support was discontinued, limiting access to these essential resources.

Similarly, these services have also been disrupted in conflict-affected areas, even during the post-conflict period:

> Currently, HEWs measure the mid-upper arm circumference of mothers to assess their nutritional status. If a mother is found to be malnourished, she receives Plumpy'Nuts to support both her health and that of her baby. The same assistance is provided to malnourished children, who receive baby Plumpy'Nuts to aid their recovery. However, this support programme has been suspended for over a month, and the reason for the interruption is currently unknown.

(Women's focus group, rural Tigray)

In both the rural and urban Tigray sites, supplementary food is typically provided to children with the support of the Irish NGO Concern. The food is supplied to health centres, where HEWs distribute it to vulnerable children who are identified through nutritional screening.

Factors affecting maternal and child health services

Impacts of war and conflict

In the rural Oromia study site, the curfew imposed three years ago due to political unrest had a negative impact on service delivery for the whole community, with a profound impact on pregnant women. Expectant mothers were unable to access healthcare during curfew hours. Additionally, the study site health post was reportedly damaged, with essential medications stolen:

"Following the death of renowned Oromo singer Hachalu Hundessa, a group of young people vandalised a local health post. They stole medical equipment, including blood measuring devices, delivery kits, scales for adults and children and supplementary food items like Plumpy'Nuts. As a result, the health post was left without vital supplies and services until a new facility was built in 2022."

(Health Extension Worker, rural Oromia)

In the rural Tigray site, child immunisation services were also disrupted during the war:

"There were no healthcare providers during the conflict who offered vaccination services. We went through a very difficult time; it felt like imprisonment. Public health facilities were completely closed, and services were available only in private clinics and drug stores."

(Male caregivers' focus group, rural Tigray)

As noted above, assisted births conducted by traditional birth attendants before the conflict were considered illegal in both rural and urban Tigray sites, and those attending such births were fined. However, these checks and penalties have not resumed since the end of the war.

Lack of incentives to support institutional deliveries

Qual 5 findings in 2019 reported the practice of providing food at health centres to incentivise women to give birth in health institutions – a national initiative introduced in 2013 to make them feel at home. However, the current lack of funding and essential healthcare infrastructure and supportive services, including access to food such as porridge and soup, and coffee and other drinks, reduces the incentive for expectant mothers to utilise MCH services.

"In the past, grain was collected from the community through the women's association. World Vision used to provide wheat flour and coffee, but they no longer do. This change has posed a challenge for the health facility in promoting institutional deliveries."

(Health Extension Worker, rural Tigray)

Currently, food and drinks are not provided at the health facilities in urban and rural areas, and mothers, relatives and neighbours support the new mother in preparing and providing these during the weeks around childbirth.

"The health facility organises infant feeding demonstration sessions every two months … These aim to educate mothers on proper feeding and a balanced diet for their infants. Other than that, there are no ceremonies done in the facility for delivering mothers."

(Health officer, Addis Ababa)

Similarly, in the rural Oromia site, government initiatives to encourage institutional deliveries by collecting food grains from the local community to support HEWs to prepare porridge and gruel for women giving birth at health facilities has also been discontinued. Rising living costs and inflation have made it difficult for the community to provide extra food.

In contrast, in the urban Tigray site, food for pregnant women is still sometimes provided, allowing families to prepare meals in health facilities while they wait for delivery. These provisions – typically flour, macaroni, cooking oil and pasta – are currently provided by UNICEF and Irish international NGO Concern, although they are not always consistently available.

While institutional deliveries are increasingly common, it is still common practice – particularly in rural areas – for first-time mothers to give birth at their mother's house, or at their in-laws' home if their mother is not available. This practice, however, varies depending on the new mother's preferences, her mother's availability and ability to provide care, and the family's economic situation.

"The support available to young women in the community during childbirth, including first birth, is typically from family members. After a woman gives birth to her first child, her mother usually cares for her and the infant, either in her own home or in the woman's home. If the mother is not available, the woman's mother-in-law will take on the responsibility of caring for both the mother and the newborn."

(Female caregivers' focus group, rural Oromia)

Lack of comprehensive antenatal resources

In some rural areas, pregnant women stop attending health facilities after two or three visits due to the lack of laboratories, medication, required tests and health professionals.

"There is no laboratory available for conducting HIV tests. Women typically visit the health facility for their first antenatal care appointment, but the number of visits decreases for the second and subsequent follow-ups. Only a small number of women manage to complete all eight antenatal visits."

(MCH expert, rural Tigray)

"The health post generally lacks adequate tools, including delivery kits. As a result, Health Extension Workers are unable to assist women in labour."

(Health Extension Worker, rural Oromia)

Lack of ambulance services

A lack of ambulance services – due to irregular fuel supplies and insecurity – continues to be a serious concern for young people living in war- and conflict-affected regions. This has contributed to a significant drop in institutional deliveries in both rural and urban areas.

"Though there was an ambulance service in the past, recently we have not been getting such services. It has been almost four years since the ambulance has been available."

(Bezach, 32-year-old woman, rural Amhara)

"The drivers switch off their cell phones [as they do not want to provide a service]. However, [if it was] to save life, ambulances were not prohibited from traveling during the conflict."

(Lemlem, 31-year-old woman, urban Amhara)

“Before the conflict, a person could call the health facility to get an ambulance and have pregnant mothers deliver safely at the health facility. During and after the conflict, however, this stopped and pregnant mothers delivered at home. There is no other option at all. If the individual has the capacity, they can take their spouse to the nearby village with better facilities or Mekele for medical treatment. Otherwise, mothers will deliver at home.”

(Male caregivers' focus group, rural Tigray)

Disruptions to ambulance services have had devastating consequences for some people:

“During the siege, … there were no ambulance services and most mothers delivered at home. Two years ago, I remember a pregnant mother who couldn't get an ambulance and delivered at home, and she died from excessive bleeding.”

(Women's focus group, rural Tigray).

In contrast, ambulance services have not been disrupted in the sites in Addis Ababa and urban Sidama. The situation has also improved in the site in rural Oromia, after the *kebele* was incorporated into the nearby urban town in 2023, enabling pregnant women to call for an ambulance when needed.

Key findings on maternal and child health

- Overall rates of early parenting have declined: Round 7 data comparing cohorts born seven years apart shows that about 7% of women in the Younger Cohort married before the age of 18, compared to 18% in the Older Cohort.
- However, parents in the Younger Cohort became parents at a younger average age (19 years) than those in the Older Cohort (22 years), and on average, almost half of Younger Cohort parents (46%) had their first child before age 19 (46%). These patterns – mirroring those observed for child marriage – highlight the continued need for efforts to both eliminate child marriage and reduce early parenthood.
- Overall access to MCH services has improved over the past six years, with free provision through government institutions and some NGOs. However, rural and conflict-affected areas face significant barriers due to cultural norms, intermittent healthcare worker absences and financial constraints.
- Antenatal visits have increased from four to eight, and postnatal follow-ups last up to seven days, with the initial check-up at a health facility and subsequent visits at home.
- Fathers' knowledge and engagement in antenatal and postnatal care remains limited, primarily due to cultural norms, though urban fathers tend to be more involved than rural fathers.
- Institutional deliveries are increasingly common, especially in urban areas, but some rural mothers still give birth at home due to traditional practices, limited awareness or lack of transportation.
- Traditional birth attendants continue to assist deliveries in conflict-affected regions despite government policies to encourage institutional deliveries, and disrupted services – including access to food such as porridge and soup, coffee and other drinks – reduces motivation to use MCH services, especially for first-time mothers.
- HEWs play a key role in raising MCH awareness through home visits, community meetings and monthly forums. Urban women report greater satisfaction with MCH services than rural women.
- Children follow a structured vaccination schedule from birth through to age 5 and dedicated teams screen children for malnutrition and provide supplementary foods. Mothers receive TT vaccinations and iron supplements, though awareness of these remains limited.
- War and conflict have damaged health facilities, disrupted ambulance and vaccination services and reduced institutional deliveries in Oromia, Tigray and Amhara sites. The urban sites in Addis Ababa and Sidama, and a rural community in Oromia recently incorporated into a town, have better access to services, including ambulance support.

3. Sexual and reproductive health

This section presents Qual 6 findings on young people's awareness and knowledge of sexual and reproductive health (SRH) as they transition into adulthood, their access to services, and the factors influencing their SRH experiences in the context of multiple crises.

Young people's knowledge and awareness of SRH comes from a variety of formal and informal sources

Schools and school clubs

Although SRH education at school is not comprehensive, young people – both married and unmarried – report receiving general SRH information, including about puberty and reproduction, from their teachers or school friends. Biology classes and gender clubs were mentioned as key sources of SRH information and learning and forums for related discussions. In addition, health workers collaborate with school clubs to organise campaigns on youth health, including SRH, HIV/AIDS and sexually transmitted infections.

> “In school, there were days when health workers came to provide information about sexual and reproductive health during an annual campaign that lasted a week. They met with us during lunchtime. Additionally, there were gender clubs where we got SRH-related information at the school.”

(Men's focus group, Addis Ababa)

Kidu, a 24-year-old man from the urban Tigray site, recalled when he heard about sex and pregnancy for the first time:

> “I learnt about it quite well in Grade 4 when I was still a little boy. I understood that pregnancy occurs as a result of having sex.”

Media (radio, TV and social media)

Radio and television programmes dedicated to young people and health issues are widely available, especially in urban areas. Social media platforms such as Facebook and TikTok have also become popular sources of SRH information for young people in the study sites, an increasing trend since Qual 5 in 2019. While access to media varies across regions, it has notably improved young people's ability to obtain SRH information, especially in the urban sites in Addis Ababa and Sidama:

> “Yegna Media's TV programme has provided important information to youth about SRH. It has encouraged many young people to discuss SRH openly.”

(Tamiru, 24-year-old man, Addis Ababa).

Health facilities

Clinics, health centres and health posts all offer youth-friendly SRH services where young people can access counselling, information and resources about contraception, HIV/AIDS and other related SRH topics with support from HEWs. In addition, some health centres provide bespoke SRH education to adolescents aged 14 to 19, either in person or through video sessions.

“In the last six years, there has been an increasing flow of people to the health facilities to seek professional advice. Similarly, there is a separate room for adolescents' counselling and SRH services. The health centre organises various campaigns targeting young people, mainly in schools and youth centres.”
(Health officer, Addis Ababa)

Across the study sites, HEWs also provide family planning information, most commonly during vaccination visits or while distributing supplementary food.

Older siblings and peers

Across the sites, informal sources – such as peers, older siblings and other relatives – remain the primary means through which young people learn about puberty and menstruation for both girls and boys:

“When I was in Grade 6, an older female relative explained it to me. Until that moment, I knew nothing about menstruation because my mother hadn't taught me about it – she assumed I was still too young. As a result, when I told her about my first period, she got upset because she hadn't prepared me for it.”
(Helen, 31-year-old woman, urban Sidama)

“I learnt about [menstruation] in detail from my older sister. I first heard about it in Grade 7. At that time, I could define what menstruation was but I didn't fully understand it. My sister asked me to buy her sanitary pads from the shop. Not knowing what they were, I asked her, as I liked to inquire about things I didn't understand. My family laughed at me. After that, I went to the shop and asked, and they told me it is something women use during their menstruation. I felt shy returning home. That was the first time I learnt about it in detail.”
(Kidu, 24-year-old man, urban Tigray)

Peer-to-peer education programmes – led by health professionals – aim to raise awareness and train young people (typically between the ages of 15 and 24) to educate their peers on various SRH topics, although these initiatives have not been consistently delivered across the study sites. In rural and urban Tigray sites, peer-to-peer initiatives previously took place in designated spaces before the war, while in Addis Ababa site, a previously run programme by an NGO called Society is no longer operational. Recently, peer educators in the communities in Tigray and Sidama have also begun raising awareness about cervical cancer screening, which is part of a broader national initiative to 'screen and treat'.

Non-governmental organisations

National and international NGOs and youth centres implement community- and school-based programmes and campaigns aimed at improving SRH awareness among young people:

“During the school break, students received education about contraceptives. Enrolling in such an educational programme can provide valuable information about SRH. Additionally, an NGO called Christian Child Fund visited and taught us about various types of contraceptives, menstruation and related topics.”
(Nunu, 24-year-old woman, Addis Ababa)

In the site in urban Sidama, the local youth centre provides SRH education to both young people and adults. The Family Guidance Association of Ethiopia office also provides dedicated SRH services for young people. Similarly, in the community in rural Oromia, a youth-focused SRH service provides targeted information and education. However, young people do not always value or utilise the services provided at these centres.

Family and community

Although cultural norms and taboos can sometimes constrain open conversations, family members and community leaders can also serve as important sources of information, guidance and support on SRH and puberty. In particular, educated parents tend to be more supportive of their children as they transition into adulthood.

“I began menstruating at the age of 13. My father was aware of this before I started, as he kept sanitary pads at home. Once I began my period, I started using sanitary pads. My father is knowledgeable about these matters because he is somewhat educated.”
(Medhin, 31-year-old woman, Addis Ababa)

In the urban Sidama site, a recent family health team initiative has been launched to provide SRH education and advice in schools and youth centres. However, the programme targets only those aged 14 and above, even though health professionals report that some younger girls are beginning sexual activity.

Menstruation awareness varies among young girls and across locations

Some girls are well-informed before their first period, while others have only limited knowledge, which can lead to shock and confusion when it first occurs. As Melkamnesh, a 24-year-old woman from the urban Sidama site, recounted:

“I was shocked. I was playing outside, went to buy pads, and sat on a rock. When I stood up, my clothes were stained with blood. I ran home, and my aunt explained everything.”

In some urban and rural schools, emergency sanitary pads are provided to girls who begin their periods, whether it is their first time or they are unprepared. In schools where sanitary pads are not available, girls are often forced to stay home, missing lessons.

Girls and boys both appear to have similar levels of understanding about SRH and puberty. Most students learn through informal sources, while some also receive information from school programmes.

Young people access SRH services through a variety of channels

Young people access SRH services through various channels. Most services are provided by public health facilities, including health centres and hospitals in urban areas, and health posts staffed by HEWs in rural areas. Private health providers – such as pharmacies, drug stores, NGOs and 'youth corners' within community centres – also play a significant role, often using youth-friendly approaches to ensure accessible, confidential and acceptable services.

Access to menstrual hygiene management varies across communities

In the Addis Ababa site, the Christian Child Fund provides sanitary pads to schoolgirls and educates adolescents on family planning and SRH. According to a health worker, the local health centre also occasionally provides pads for married women who are unable to purchase them:

> “A woman volunteers at this health centre, collecting menstruation pads from local shops and distributing them to underprivileged women through health workers who make home visits.”

In the rural Oromia site, schools previously provided sanitary pads, though this support is no longer available. However, the NGO Food for the Hungry International provides menstrual hygiene education and distributes sanitary pads in collaboration with girls' clubs. They also train girls to make reusable pads and provide bars of soap to students once or twice a year.

Previously, the site in rural Tigray benefited from initiatives aimed at improving menstrual hygiene management, carried out in collaboration with teachers and other partners. During that time, health centres had a sufficient supply of sanitary pads. However, in the current post-war context, such activities have largely disappeared, leaving most young women to obtain menstrual pads on their own.

HEWs also no longer regularly visit schools to teach about menstrual hygiene. Although they do provide some instruction, it is not consistent and educational materials are limited. Additionally, coordination with teachers is limited, and regular evaluations are lacking.

Access to general SRH care and contraceptives

Many young people begin using contraceptives after marriage and having their first child, though some start earlier in their teens before getting married. Access varies across communities, depending on availability and user preference. In the rural Oromia site, a private clinic offers young people a range of contraceptive options that are not currently available at the government health post due to limited resources and sometimes an absence of HEWs. These options include condoms, contraceptive pills, Depo-Provera injections and three-year implants, as well as pregnancy tests. However, many unmarried young people are afraid to visit these facilities because of cultural taboos and a fear of being seen.

Patterns of contraceptive use vary. In some sites, unmarried women in relationships use post-pills (taken after sexual intercourse). In the rural Oromia site, married women typically use injectable contraceptives from the health post, while some unmarried girls and women access them from the nearby town health centre. Unmarried men primarily use condoms.

> “Unmarried women and adolescents who are living with their parents are afraid to utilise contraceptives from the health posts. They worry about gossip. They are concerned about whether someone saw them. So, they access contraceptives secretly from the nearby town.”

(Health Extension Worker, rural Oromia)

Some married couples use the calendar method to prevent unplanned pregnancies.

> “She [his girlfriend] would tell me the dates of her last period. If it had occurred about a week ago or around that time, I would avoid having sex on those days. Aside from that, I did not use condoms, nor did I ask her to take contraceptives.”

(Mitiku, 24-year-old man, rural Oromia)

The health centre in the Addis Ababa site offers a variety of contraceptives, though most users prefer contraceptive pills or three-monthly injections. Similarly, in the urban Sidama site, young people use a range of methods, including pills, intrauterine devices (IUDs) and injections, all available free of charge. Destaw, a 31-year-old mother of two boys (aged 3 and 9), explained what type of contraceptive she uses and why:

> “I managed my family in a planned manner and was effective in child delivery. I am using Choice [an oral contraceptive pill] … I have the information that each birth control methods has its side effects. Currently, I am using this method … and it is much better compared to other options. Additionally, it can help you conceive quickly [by stopping using it] if you wish to have children in the future.”

In both the rural and urban sites in Tigray, SRH services are typically provided at hospitals and other public health centres. In the rural site, health posts provide various short- and long-term contraceptive options. However, IUDs must be inserted at a health centre under professional supervision. Permanent methods such as tubal ligation and vasectomy are also available; tubal ligation is provided by appointment at the Family Guidance Association of Ethiopia office or other service providers. Young women tend to prefer long-acting contraceptives, specifically those that last for three years, as they are seen as having fewer health risks. Most other contraceptives are available at health centres free of charge.

Over the past six years, there has been low usage of SRH services in some study sites, mainly due to services being disrupted because of war and conflict.

In the rural Oromia site, some women were previously hesitant to space births and did not accept the information or advice provided by HEWs, resulting in low contraceptive use and frequent pregnancies. More recently, however, door-to-door visits have improved awareness, and many women have started using family planning services.

Cervical cancer screening campaigns have also recently started in the urban site in Sidama and both the rural and urban sites in Tigray but were not mentioned in other sites. Health professionals report rising cases of cervical cancer, particularly among young women aged 15 and above. However, many women avoid screening as they are ashamed to expose their reproductive organs to health professionals.

Several barriers limit young people's access to SRH services

War and conflict

Before the war, public health facilities in Tigray, specifically the *woreda* health centres, offered a variety of free contraceptives. However, these services have been disrupted during the war, forcing young people to buy contraceptives from private pharmacies.

> Women used to pay 150 birr for three-month injectable contraceptive, forcing them to access paid contraception services. At this time, however, the services for contraceptive provision have been restored … It is difficult to abstain from sex and pregnancy if you are married and live with your spouse. I think they [married women] have purchased [the injectable contraceptive] from private drug vendors, and all types of drugs and contraceptives were available in private clinics and drug stores. However, it was purchased at a higher price.

(Women's focus group, rural Tigray)

After the conflict, health facilities in Tigray have struggled to meet the demand for contraceptive implant removals due to a lack of required anaesthesia services. Services providing SRH information and awareness have also been disrupted.

> [Youth-friendly services] have disappeared completely since the war due to destruction, looting and lack of equipment. They made a great contribution to awareness creation among young people on gender-based violence, HIV and family planning issues. Many young people participated in the services and helped create awareness in an organised manner.

(Healthcare leader, urban community, Tigray)

Currently, the Tigray sites lack youth-friendly services or sufficient personnel to address young people's SRH needs. Similar challenges also exist in the conflict-affected sites in urban and rural Amhara.

In addition, in post-war Tigray, there is a community-level perception that women should not use contraception to help compensate for lives lost during the war. As an MCH expert in the rural Tigray site outlined:

> There is a tendency in the community to avoid using contraceptives due to the many lives lost during the conflict. This outlook is evident among both community members and their leaders.

Fear of sterility

There is also an assumption among some young women that some contraceptives can cause infertility.

> Most women believe that the three-month injectable contraceptive exposes them to infertility, and they don't like to use it. For example, when I gave birth to my first daughter, I was injected with a three-month contraceptive. My daughter is now 11 years of age, and I haven't conceived since then. I have menstruated regularly, but I can't conceive.

(Women's focus group, rural Tigray)

Fear of health impacts

Some forms of contraception, particularly injections, are believed to have negative repercussions, such as hair loss or continuous bleeding, leading some women to avoid using them. An MCH expert in the rural Tigray site explained that:

> Some women experience bleeding after placing an IUCD and they will get it removed within three months if the bleeding continues.

Husband's dominance and limited knowledge

Most young women are aware of the benefits of contraception; however, some find it difficult to convince their husbands. Husbands often want to have more children and hence do not allow their wives to use contraception. According to Tayachew, a 31-year-old man from the site in rural Oromia who recently became a father:

> After we got married, we both wanted to have a baby [so] we did not use contraceptives. Currently, my wife is thinking of using an effective contraceptive, but I am refusing her request as I want to have another baby. She thinks that we can't raise two children as living costs have become expensive. Therefore, she suggested that we try another child after the first child grows up.

In addition, some husbands have limited knowledge about SRH, with many leaving the subject completely to their wives.

> I don't know about them [contraceptives] specifically. However, I know that there are pills, injectables and the one that is inserted into the upper arm.

(Mitiku, 24-year-old man, rural Oromia)

> My wife is strong and has good knowledge on this issue. We have discussed … family planning and birth control methods. I was a member of a health club during elementary and high school.

(Mamaru, 31-year-old man, rural Oromia)

Pregnancy as a pathway for marriage

Some unmarried women who are in a relationship prefer not to use contraception, hoping that pregnancy will pave the way to marriage.

“Unmarried young women do not use contraceptives while having sex with their boyfriends. This is because if they become pregnant, they think their boyfriends will marry them. If they use contraceptives and prevent pregnancy, they worry that after a certain period, their relationship may end.”

(Health Extension Worker, rural Oromia)

Religious beliefs

Some young people also report that religious beliefs can discourage or prevent the use of contraception, and have a significant influence on young married couples' views. In some communities, the young people think that contraceptive use is prohibited by God.

Key findings on sexual and reproductive health

- Young people's knowledge and awareness of SRH comes primarily from informal sources such as peers and older siblings, alongside more formal channels through schools (biology classes and girls' clubs), media, health facilities and NGOs.
- Peer-to-peer education programmes and outreach initiatives have improved awareness and uptake of SRH in some settings. Challenges remain in coverage and access, especially in rural and conflict-affected areas where services have been significantly disrupted, and in Tigray where they have not yet been fully established.
- **Menstruation awareness varies across communities: some girls are well-informed** before their first period, while others are shocked and unprepared, with schools and NGOs sometimes providing emergency sanitary pads, although provisions have been disrupted in conflict-afflicted areas.
- **Access to SRH services** and contraceptives is generally better in urban areas and among married youth, while unmarried youth – particularly in rural areas – face significant barriers due to stigma, cultural norms and fear of judgement, compounded by inconsistent service provision in conflict-affected areas.
- Most young people start using contraceptives after marriage or first childbirth, but some use them earlier. Preferences vary by site, gender, marital status and cultural norms (e.g. post-pills for some unmarried women, condoms for young men, long-acting methods for married women, such as three-year injections).
- **Young people have experienced significant** disruptions to SRH services during and after conflict, especially in Tigray and Amhara, often leading to limited availability of free contraceptives, implant removals and SRH education, forcing many young people to buy services from private clinics or forgo them altogether.
- Some young women avoid certain contraceptives due to fear of infertility, perceived side effects such as hair loss or prolonged bleeding, or misconceptions about long-term health risks.
- **Sociocultural barriers also reduce contraception use.** Religious beliefs, male partner dominance, limited knowledge among men and social stigma discourage some young people, especially unmarried women, from using contraceptives. Some unmarried women avoid contraception to increase the chance of pregnancy, seeing it as a pathway to marriage.
- **War and conflict continue to have significant impact on SRH services, especially in Tigray and Amhara.** Youth-friendly services are largely absent, healthcare personnel and resources are insufficient, and societal pressures encourage women to avoid contraception to compensate for lives lost during conflict.

4. Disabilities

The diversity of types and causes of disability highlights the wide range of challenges faced by young people in Ethiopia

Young people in the study report a diverse range of disabilities, shaped by various contexts and experiences such as childhood illness, agricultural work, exposure to harsh weather, migration and armed conflict. This section examines the types and causes of these disabilities, access to healthcare services, and the broader impacts on young people's daily lives and opportunities, including their education, employment, family and social relationships and mental health.

Qual 6 findings draw on in-depth accounts of the lived experiences of 14 young people identified through Young Lives Round 7 survey data. They include nine young men and five young women from four study sites – in rural Oromia, urban Sidama, rural Tigray and a small town in Tigray – with the Younger and Older Cohorts equally represented. These 14 people experience a range of disabilities, including mobility impairments (seven people), hearing difficulties (two), vision impairment (two) and long-term epilepsy (one), reflecting the varied health challenges faced by young people across different contexts (Table 4).

Table 4. *Types and causes of disability and access to treatment among lived experience respondents*

Study site	Respondent pseudonym	Cohort / gender	Disability	Identified causes	Access to treatment
Oromia (rural)	Kora	Younger Cohort man	Hearing loss; teeth loss	Maize weevils; accident	Formal (hospital) and traditional (holy water)
Oromia (rural)	Ayana	Younger Cohort man	Mobility impairment	Polio	Traditional bone-setting
Oromia (rural)	Dasse	Older Cohort man	Hearing loss	Unknown	Traditional (python fat)
Oromia (rural)	Yitayew	Older Cohort man	Broken leg	Fall from tree	Medical care
Oromia (rural)	Hassen	Older Cohort man	Chest ribs broken	Hit by metal motor pump	Medical care
Sidama (urban)	Yeab	Younger Cohort woman	Vision impairment	Diagnosed by a doctor	Medical (eyeglasses) and traditional
Sidama (urban)	Gelila	Younger Cohort woman	Vision impairment	Hereditary	Not treated
Sidama (urban)	Zoma	Older Cohort woman	Hearing loss	Infection	Surgery

Table 4. *Types and causes of disability and access to treatment among lived experience respondents continued*

Study site	Respondent pseudonym	Cohort / gender	Disability	Identified causes	Access to treatment
Tigray (rural)	Natom	Younger Cohort man	Leg and arm	Bullet injury	Medical care
Tigray (rural)	Hadera	Younger Cohort man	Dislocated arm and broken leg	Accident; War injury	Bone setting; medical care
Tigray (rural)	Fanus	Older Cohort woman	Epilepsy and injury	Childhood (unknown)	Medical and traditional (holy water)
Tigray (urban – small town)	Melese	Older Cohort man	Hand and arm broken	Drone attack injury	Medical care
Tigray (urban – small town)	Shitaye	Older Cohort woman	Swelling leg	Workload	Just taking rest

Mobility impairments

Young people report a range of mobility-related impairments, including weakened or broken limbs, fractured ribs and swelling in the legs. These disabilities stem from various causes, such as accidents and injuries, war injuries sustained during conflict, and childhood polio.

Accidents and injuries

Accidents linked to demanding workloads have had a significant impact on the physical mobility and capacity to work of several young people in the study. In many cases, minor injuries, left untreated due to limited access to healthcare, have developed into long-term mobility impairments.

Two young men from rural Oromia, where people often start working in irrigation and farming at an early age, shared their experiences of work-related accidents that led to enduring physical disabilities:

“In 2010, I fell from a big tree while I was herding cattle. The injury was very severe. My face was full of blood. I fell onto a big branch, not in the ground. Even now, the way I walk is not good; my leg is not straight, but it is not visible to others. I know it though.”
(Yitayew, 31-year-old man, rural Oromia)

Yitayew reported that the accident was so serious that he temporarily lost consciousness. Although he was hospitalised and received costly treatment, his leg was not properly corrected, resulting in a permanent abnormal gait.

The second young man explained how working in an irrigation scheme had led to a physical disability.

“In 2021, I was injured while working with a motor pump. The metal body of the pump hit my chest while I was turning it on. Blood clotting occurred in my chest. I had been working hard at that time.”
(Hassen, 31-year-old man, rural Oromia)

Hassen received treatment at a private clinic and was advised to avoid heavy physical labour. However, he continues to work hard fishing and selling fish, even during cold weather, which has worsened the severity of his disability.

Heavy work can increase and prolong physical pain. Shitaye, a 31-year-old woman who had migrated to work in the Middle East for several years, returned to Ethiopia with lasting physical pain. Now living in a small town in Tigray, when she works in her café for long hours the swelling in her leg gets worse. Shitaye has never sought any healthcare, but instead relieves her pain by sitting down for several hours to rest her leg:

“My leg swells. It hurts when I stand for long periods, but the pain goes away when I sit down.”

Battlefield injuries

The war in northern Ethiopia led to widespread destruction of infrastructure, disruption of essential services and significant human suffering, including loss of life and a range of disabilities.

All three of the young men from Tigray with physical disabilities attribute their conditions to battlefield injuries sustained during the conflict. Their experiences illustrate the profound physical effects of war and its long-term impact on health, mobility and mental well-being. Melese's story highlights the serious physical injuries caused by the war:

“I was injured during battle. While I was waiting for my friend from another army division, a drone attacked us. I was wounded by shrapnel and my hand and leg were hit.”

The other two young men also suffered from shrapnel wounds after being hit by mortar fire. Hadera, 24 years old, recalled the circumstances of his injuries:

“I was injured while we were marching towards Addis Ababa. My left leg was hit by a mortar. I felt the pain immediately because [it] hit my bone. I couldn't walk … My friends carried me on their backs and took me to the first aid station.”

Delayed medical treatment during the war contributed to lasting disabilities. All three young men reported that, although their wounds were severe, they did not have access to immediate medical care, leading to permanent

physical impairments. One of the men never received proper healthcare following his injury. Although 24-year-old Natom reported that he recovered at home, he still suffers from long-term mobility challenges and ongoing pain:

> “It happened while I was on the battlefield. [Shrapnel hit] my right leg and left arm. … I have not received any [formal] medical treatment. After I was injured, I came home and wrapped it with bandages and it healed after some time.”

Lack of polio vaccine

There were also some young people whose disability was a result of not having vaccines in early childhood, particularly for polio, which has been a major health risk in Ethiopia.

> “My disability started when I was about 3 or 4 years old because I missed my polio vaccine. I was also malnourished. My mother told me I was breastfed for three years but never ate solid food because I had no appetite and vomited everything she fed me. My walking problem worsened gradually.”

(Ayana, 24-year-old man, Oromia)

Hearing difficulties

Four young people from the sites in Oromia and Sidama reported experiencing partial hearing impairments, which they attribute to either untreated childhood infections or accidents. They described how the resulting communication barriers were especially pronounced in school environments and social settings, limiting their ability to participate fully and progress with their education.

Zoma, a 31-year-old woman from the urban Sidama site, described how her hearing loss, caused by childhood ear infections that were left untreated for years, ultimately required medical intervention and surgery:

> “As a child, I had frequent ear infections. Later, I developed serious hearing loss; unless someone shouted, I couldn’t hear. In 2013, I started treatment and was referred to a specialist. I was told I needed surgery to prevent permanent damage. I had the first surgery in 2014 and the second eight months later. Now, I’m completely fine, Alhamdulillah!”

Zoma’s partial hearing loss was resolved after two surgeries. However, she also suffers from chronic diabetes.

The experiences recalled by three young men from the same rural community in Oromia highlight the challenges caused by delayed or inadequate medical care for hearing impairments, as well as the problems stemming from ineffective traditional remedies.

Borona, a 24-year-old university student, reported that he had experienced difficulty hearing since the age of 13, although the cause remains unknown. He received minimal treatment at a university campus clinic but has never been seen by a specialist. Borona suffers from multiple other health conditions, including asthma, kidney infection and mental health issues.

Kora experienced partial hearing loss after maize weevils entered his right ear during childhood. Although he was initially treated at a hospital, he later pursued traditional remedies, which proved ineffective and delayed further formal care. Kora’s hearing has deteriorated over time and, after also losing teeth in an accident, he now faces significant challenges in hearing, eating and speaking.

Dasse reported experiencing partial hearing loss in his right ear over a two-year period. The cause was unknown as no injury or infection was identified. After two or three months of difficulty, he opted for a traditional remedy, applying python fat, which he believes fully cured the condition. Dasse’s decision to avoid formal medical care was rooted in his low trust in health services and a strong preference for community-based healing practices. This reflects broader patterns of health-seeking behaviour in underserved areas.

Vision impairments

Two young women from urban Sidama reported vision problems, mainly associated with unfavourable weather conditions in the region. Gelila, who experiences occasional blurry distant vision in bright sunlight, believes that her vision problems are hereditary, explaining that:

> “It is just a slight blur, not too difficult. It is natural, it runs in our family.”

As she has never had a medical consultation or received a formal diagnosis, Gelila does not know the cause of her vision problem.

Similarly, Yeab reported a long-sighted deficiency. She also experienced eye redness and frequently needs to blink and wipe her face to alleviate discomfort. After unsuccessful attempts to cure her sight problem using the traditional method of applying *tebel* (holy water), Yeab sought formal healthcare. Although the cause of her sight impairment remains unclear, she was diagnosed by a doctor and prescribed eyeglasses.

Epilepsy and other physical injuries

Fanus, a 31-year-old woman from a small town in Tigray, has lived with epilepsy since childhood. Her condition has been documented since the first round of the qualitative study in 2007, revealing a pattern of worsening symptoms over time.

Fanus’ epilepsy episodes involve the sudden loss of consciousness and frequent falls, resulting in her sustaining physical injuries such as facial wounds, knee damage and burns. These episodes intensify during periods of emotional distress and financial insecurity, highlighting the compound impact of chronic illness, poverty and limited access to consistent care. Due to her financial problems, Fanus sometimes resorted to traditional remedies, which had a negative impact on her health. She explained how informal health services put her life at risk:

“While I was working, I [used] holy water. Medication was not allowed; I was told to “drink holy water and stop it”. I got washed with the holy water for two weeks. I was fine when I was there. I did not take medication. After a month and two weeks, I fell into a fire and my knees were burnt … there was no one at home.”

The recent war has also aggravated Fanus’ health condition, with the disruption of healthcare services leading to frequent epilepsy relapses.

Disabilities can have significant economic consequences, disrupt education, limit employment and have an impact on mental health

The experiences of young people with disabilities are diverse, but they share common challenges. Many face the depletion of family resources due to medical expenses and experience disruptions to their education, limited access to stable employment, discrimination and – over time – significant impacts on their mental health.

Financial barriers to accessing formal healthcare

In the absence of free or affordable healthcare for people with disabilities, young people and their families face significant and extended economic pressures. In some cases, high medical expenses force families to borrow money or even reduce prescribed doses, which worsens health outcomes, as recounted by Fanus, the young woman in Tigray who suffers from epilepsy:

“I need about 1,200 birr per month for my medication. I borrow money [or] sometimes reduce the medication dose … then I became sick.”

Young people with disabilities and their families often have to make huge sacrifices, including the liquidation of their assets. To afford essential treatment, families sometimes have no choice but to sell critical assets, such as their cattle or, in one study site near a lake, their fishing boats. Yitayew, the 31-year-old man from the site in rural Oromia, shared his family’s experience:

“My father sold his cattle and boat … my parents’ economic status did not improve ... My parents have many children … inflation made things worse … they are overburdened economically.”

Family members share the economic burdens of healthcare. For example, Melese, the 31-year-old veteran of the Tigray war from the urban Tigray site, recalled that, when the army could not help with his injuries, his siblings stepped in to cover medical costs and facilitate access to urban health services:

“My sister arranged for me to go to a hospital… she covered all the costs.”

Recent inflation and conflicts have further exacerbated this situation, leading many disabled people facing additional economic challenges and unable to access required healthcare and prescribed medicine at affordable prices.

Impacts on education

Most of the 14 young people interviewed had already left school when they acquired their disabilities. Some had completed their education or had been unable to access tertiary education, while others had dropped out due to economic hardship, the COVID-19 pandemic and ongoing conflict. However, a few participants experienced educational limitations as a direct result of their disabilities. Some recalled early childhood hearing problem affecting their lessons. For Kora, a 24-year-old man from the site in rural Oromia:

“I faced a serious hearing issue after I dropped out of school. But when I was a child I also had a small problem. Until Grade 3, I did not hear in class properly.”

Borona, a university student from Oromia, has also been affected by a hearing impairment since childhood, which continues to have an impact on his academic performance. He had the following conversation with the researcher:

“**What about your hearing?**

I am not good at hearing. I like education so much. I will not forget something I heard even after a year. If I miss hearing something, I will lose a lot.

Do you need to sit at the front when a teacher lectures?

I should sit at the front. In university courses, exam questions are prepared more from oral lectures than from reading materials. The major points are spoken and I often miss these points. I rely on my reading. I miss the oral lectures because I am poor at hearing.

Are you not able to pay attention?

I never miss it if I have heard it. But I do not hear all the lectures’ contents.

Do you miss points even when you sit at the front?

I can hear if I sit at the front. But there are times when I have to sit in the back if I am late to class. When I sit at the back, I cannot hear the teacher. Thus, I read my modules like I do in the library. It is better to read than to waste my time.”

Impacts on work and employment

Most young people with disabilities face substantial obstacles to securing stable employment. Many remain unemployed, while others are engaged in informal or unstable sectors, such as driving, mobile phone repair, hairdressing, day labouring or fishing, occupations that are typically low-paid and lack job security.

Many of the physical limitations associated with their disabilities restrict the young people’s mobility and reduce their capacity to perform manual tasks. Some conditions, such as leg swelling, intensify during cold weather, further hindering their ability to maintain consistent work and income. Hassen, a 31-year-old man from the site in rural Oromia who broke his ribs in an accident at work, said:

“I feel it slightly and occasionally. I feel it during cold weather and during intensive physical work. I am still working, but I take gaps. I work for only two days a week.”

Another young man, 24-year-old Hadera from the rural Tigray site, who had battlefield injuries, reported:

“Currently, I cannot work in laborious jobs such as agriculture (tilling, harvesting), loading, unloading and so on.”

Ayana, a 24-year-old man who suffered from polio, was in a similar situation. He had to switch from being a farmer to serving the church, because he could no longer perform physically demanding tasks such as carrying water and herding livestock.

Social exclusion and mental health consequences

Young people with disabilities reported experiencing long-term social effects and discrimination, such as stigma, social exclusion and isolation. These forms of marginalisation have contributed to emotional distress and, in many cases, mental health issues.

Some of the young people reported experiencing teasing and being labelled with nicknames linked to their impairments, particularly missing teeth and hearing loss. These experiences contributed to emotional distress and feelings of exclusion. For example, Kora, the 24-year-old man from the site in rural Oromia who lost his teeth due to an accident, said:

“Some young men call me by a derogatory pseudonym, *sherifo* [toothless]. Others call me by my name. I just told everyone to refer to me by name … It is an insult when they call me *sherifo*. I like it when they refer to me by name. If I naturally lack teeth, that is okay. However, I faced that accidentally.”

Kora also suffers from hearing loss and reported experiencing emotional challenges when unable to hear his friends clearly. Likewise, Dasse, a 31-year-old man from rural Oromia who has a hearing impairment, recalled:

“My friends used to tease me, calling me *duda* [deaf] because I couldn’t hear things sharply. I felt somewhat bad when they called me this.”

These accounts highlight the social stigma surrounding disability and the need to encourage greater awareness and more inclusive attitudes.

The lack of social acceptance and inclusive environments continues to deepen the vulnerability of young people with disabilities and limits their ability to fully participate in community life. This has been the experience of Ayana, a 24-year-old man from the site in rural Oromia who has difficulty walking due to childhood polio. He explained that he has been excluded from major leadership roles at his church, despite being capable of fulfilling the duties:

“Since 2020, I have attended church school, became a deacon, and have been serving in the church. I sometimes face discrimination because of my disability at church services. Sometimes [the church leaders] say, “let somebody else do this activity because you are not able to do it.” For example, during religious teachings, they do not allow me to teach the younger children [at Sunday school]. Instead, they assign these tasks to my colleagues. They also do not give me certain leadership responsibilities in the church.”

Some of the young people perceive that their disabilities have a major effect on their lives and report low self-esteem. For example, despite achieving the highest level of education and having respectful interactions with his peers, university student Borona feels socially isolated at times and perceives himself as inferior to others:

“I feel that a person who doesn’t have vision or hearing abilities, or has a loss of hand or mind, is handicapped. In any market, information is shared verbally. Thus, I feel much inferiority in facing this partial hearing impairment. If a friend of mine surpasses me in anything, maybe in education, I feel that it is because of my hearing. I associate it with my hearing issue and get angry.”

In conflict-affected areas, memories of war have lasting mental health impacts on those who sustained injuries. The young men affected by battlefield wounds all described how their experiences, including the trauma of injury, painful treatment, prolonged recovery and ongoing political instability, have led to emotional distress, loss of hope and symptoms of psychological trauma.

Key findings on disabilities

- Young people's disabilities vary by location and gender and are shaped by a range of contexts and experiences. These include work-related exposures and harsh weather contributing to hearing and vision loss, childhood polio and workplace accidents leading to mobility impairments, and a higher likelihood of war-related physical injuries, particularly among young men in conflict-affected areas.
- Participants use a range of healthcare services, including both formal services in hospitals and clinics, which are often expensive, and informal traditional healers and remedies, such as bone-setting and holy water, which are more accessible and significantly cheaper.
- Some young people, particularly in rural areas, have low levels of trust in health services, which leads them to avoid or delay seeking formal medical care and instead rely on traditional and community-based practices. As a result, minor injuries and treatable conditions can worsen over time, developing into long-term or permanent disabilities.
- The increasing cost of medication and formal healthcare places a significant economic strain on young people with disabilities and their families, sometimes forcing them to borrow money, sell critical assets such as cattle or cut back on prescribed medications, leading to adverse health outcomes.
- Young people with hearing impairments report that difficulties hearing in classrooms and university lectures have negatively affected their education.
- Young people with disabilities face significant barriers to securing stable employment due to reduced mobility and limited capacity to carry out manual work, leaving many unemployed or confined to informal, insecure or low-paid jobs.
- Even when advised to avoid hard physical labour, some young people with disabilities report having no alternative but to continue farming, or fishing in one community, resulting in ongoing pain and a worsening of their symptoms.
- Social exclusion, stigma, discrimination, teasing and other forms of marginalisation contribute to emotional distress, often isolating young people with disabilities from their peers and, in some cases, leading to serious mental health challenges.
- The war in northern Ethiopia has caused considerable suffering, including ongoing disabilities and chronic pain from battlefield injuries, compounded by delayed treatment due to disrupted medical services, additional economic challenges and the long-term mental health impacts of psychological trauma and emotional distress.

5. Mental health

Young people's mental health is being affected by a series of crises

Young men and women in Ethiopia are facing multiple challenges as they transition to adulthood because of successive crises, starting with the COVID-19 pandemic and followed by high inflation and un(der)employment, and armed conflict in some parts of the country.

This section examines the impact of these crises on young people's mental health, drawing on in-depth accounts of the lived experiences of 25 participants who had reported symptoms of anxiety, depression, stress or post-traumatic stress disorder (PTSD) during the Young Lives Round 7 survey.

Young people are experiencing high levels of mental health issues

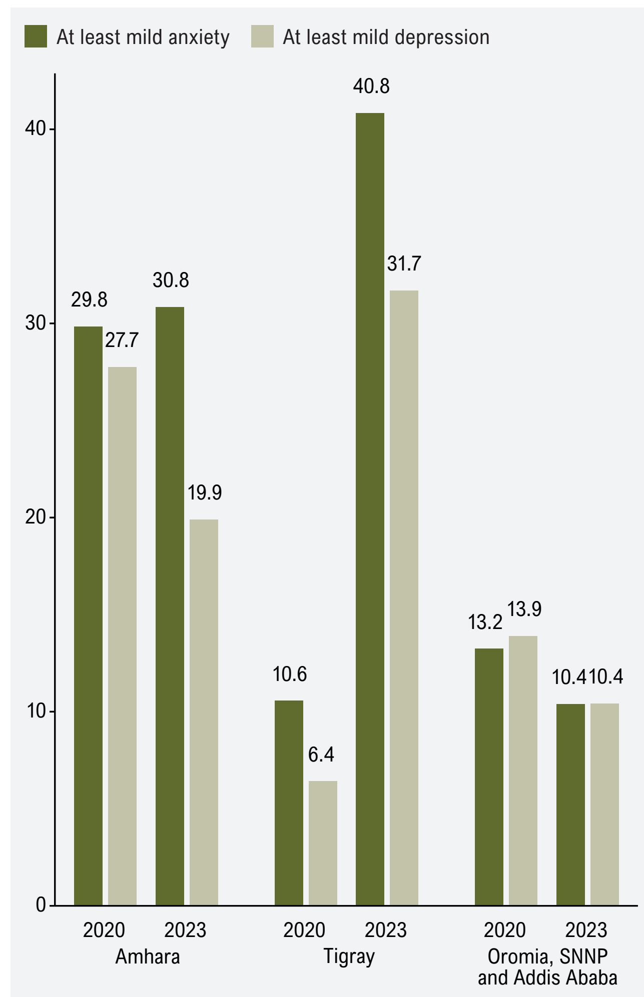
The Round 7 data collected in 2023–24 shows that stress is widespread, with six out of ten participants reporting symptoms compatible with at least moderate stress, while around one in five reported symptoms compatible with anxiety or depression, with levels of anxiety increasing since the pandemic (Quigua, 2025; Quigua, Favara and Sánchez, 2025).

The prevalence of at least mild anxiety was 20% among the Younger Cohort and 23% among the Older Cohort. The percentage of participants with symptoms of at least mild depression was slightly lower (16% of the Younger Cohort and 19% of the Older Cohort), which were similar during the pandemic. In contrast, a high proportion of participants reported symptoms associated with at least moderate stress (61% of the Younger Cohort and 63% of the Older Cohort).

Among the Younger Cohort, those from areas affected by armed conflict (Amhara and Tigray) have the highest prevalence of stress, anxiety and depression and PTSD. While no more than 3% of participants from Addis Ababa, Oromia and the Southern Nations, Nationalities, and Peoples' Region (SNNPR) reported one or more symptoms of PTSD, this increased to 19% and 7% for participants from Tigray and Amhara, respectively.

Using data from August to October 2020 (Call 2 from Round 6) to compare mental health indicators before and after the start of the conflict in Amhara and Tigray reveals that participants have consistently experienced a high prevalence of mental health conditions since the conflict began in Amhara, while those in Tigray have shown even higher prevalence (Figure 1). In contrast, participants from areas not directly exposed to the armed conflict reported better indicators of mental health in 2020 and 2023.

Figure 1. *Anxiety and depression among the Younger Cohort over time and by region (%)*



Source: Quigua (2025).

Qual 6 lived experience interviews

A total of 25 respondents were selected from the Round 7 survey results and interviewed in March 2025, using the mental health module developed for the Qual 6 research. This sample includes more women (18) than men (seven) and more respondents from the Younger Cohort (15) than the Older Cohort (ten) (Table 5).

Multiple crises are making the transition to adulthood more challenging for young people

Young men and women have faced a series of successive and cumulative crises during their transitions to adulthood, including the COVID-19 pandemic, un(der)employment, increased inflation and living costs, and conflict in Tigray and Amhara.

COVID-19 and mental health

The mental health impacts of the COVID-19 pandemic have received limited attention in Ethiopia. Young Lives' research found that girls whose education was interrupted by COVID-19 restrictions – due to a lack of access to online classes or inability to complete homework – were more than twice as likely to experience symptoms of anxiety and depression than those who were able to continue their studies (Favara *et al.*, 2022; Quigua, Favara and Sánchez, 2025).

While most respondents who have continued to face mental health issues over the last six years since Qual 5 in 2019 do not consider that COVID-19 was a serious factor affecting their well-being, some remember being initially worried. Mekdela, a 31-year-old woman from the Addis Ababa site, recalled:

> “When I first heard about it, I became stressed, but after being screened for COVID-19, I was relieved.”

Several respondents from urban areas consider that the effects of COVID-19 were more related to the indirect economic impacts on small-scale businesses due to the sharp downturn in economic activity caused by travel and other restrictions. A young woman trader from the urban Sidama site explained:

> “COVID-19 changed a lot of things in my life. These changes are mostly in negative ways, like minimising the capacity of the business, and I may also lose my job for that matter. If you had good income generation before COVID-19, then during and after it you perhaps had to sell all your materials at hand at a very low price. I praise God. There was no mobility of people and business activities were low. Therefore, I sold [my stock] at a low price.”
>
> (Tarik, 24-year-old woman, urban Sidama)

Table 5. *Overview of respondents interviewed for Qual 6 mental health module*

Study site	Younger Cohort women	Younger Cohort men	Total Younger Cohort	Older Cohort women	Older Cohort men	Total Older Cohort	Women	Men	Total
Addis Ababa	0	2	2	1	0	1	1	2	3
Oromia (rural)	2	1	3	0	1	1	2	2	4
Sidama (urban)	1	1	2	1	0	1	2	1	3
Tigray (rural)	2	1	3	4	0	4	6	1	7
Tigray (urban – small town)	4	1	5	3	0	3	7	1	8
Total	**9**	**6**	**15**	**9**	**1**	**10**	**18**	**7**	**25**

For most respondents, other issues presented more significant challenges than COVID-19. As Tesfaw, a 24-year-old man from the Addis Ababa site, explained:

“I didn’t stay at home during COVID-19, but there were restrictions on movement. God kept us safe. That period didn’t bother me much compared to other problems.”

In the site in Addis Ababa, the removal of the vegetable market on which many depended for their livelihoods was a much more serious problem. For those living in Tigray, the COVID-19 period pales into insignificance compared to the crisis of the war; young people who were asked about COVID-19 shifted the conversation to talking about the impact of the war instead.

Job losses and un(der)employment

Many young people have faced challenges transitioning from learning to earning, with reality not matching expectations that they would be able to find employment after completing secondary school (Tanima, 2025). In the study site in Addis Ababa, many had been relying on work in the informal sector and the removal of the vegetable market from the city centre took away their primary source of livelihood, resulting in a lot of stress. Tesfaw recalled:

“I was stressed out by the loss of work in the vegetable market. When I lost my work, I had to take a loan from friends.”

Qual 6 interviews in the Tigray sites were carried out after the war had ended. However, economic conditions remain extremely challenging, as war-related destruction continues to affect the economy and livelihoods, and reconstruction has been very slow. The shortage of work and very limited opportunities were given as major causes of depression, As Goytom, a 24-year-old man from the urban Tigray site, outlined:

“Before the war, young people worked and opened businesses. Almost all young people had jobs … now everything is destroyed. The current situation is very bad, leading to depression.”

Limited work opportunities are also a major driver of migration, as discussed below. Some respondents planning to migrate also described the stress of raising funds and worries about the risks involved in migration.

Inflation and rising living costs

A recurrent theme among the young people interviewed was how the rising prices of goods and services are eroding the purchasing power of salaries and affecting their ability to run businesses. This has been a major source of stress for young people and is affecting their mental health. As Mekdela, a 31-year-old woman in the Addis Ababa site, explained:

“Inflation is the primary source of my stress. Previously, I was not stressed because the prices of the things were reasonable. I only feel stressed when I don’t have enough money to meet their [her family’s] needs. When I encounter a cash shortage, I immediately feel stressed. I have so many worries which is why I am so stressed.”

Inflation was also a serious problem for people in rural areas, with price increases depleting assets and driving a loss of purchasing power, as noted by Tufa, a 31-year-old man living in the site in rural Oromia, during a discussion with a Young Lives fieldworker:

“**How do you compare the life you had six years ago with your current life?**

Life has become too difficult today. And it worsened in 2024 and 2025. You need to have big money if you intend to buy something. It costs 400 birr to buy even underwear. People are surviving by depleting their assets.

How are the work conditions today compared to six years ago?

The work conditions are good. The bad thing is the heightened living costs. You may work and make money but the money doesn’t go as far.”

The rising cost of services, particularly healthcare, is creating additional stress for families who need to cover medical expenses. University students also struggle to cover living expenses, especially when they need to move to a different town and cannot live with their families. Borona, a 24-year-old man from the site in rural Oromia, experienced mental health challenges linked to worries about burdening his family with his university costs and being unable to afford clothes and good food while attending university.

“**How do you compare your current life with that of six years ago?**

There is a significant difference … We used to experience no difficulty six years ago. I used to buy clothes when I liked. The market inflation hadn’t soared. Now, I lack clothes though I am a university student. There is a big difference in buying clothes and other goods.

Why is that?

It is because of the market inflation.

Do you feel difficulty to ask your parents to buy you things?

My father works as a guard for the Orthodox Church. He earns a salary of 3,500 birr. He sends me 1,000 birr every month. I buy soap. There are [costs at university] for laminating assignments and much more. [The money my father sends] isn’t sufficient to even drink tea or coffee … On campus, I feel depressed if I don’t have money to eat food from outside when our cafeteria food isn’t good.”

In the rural Tigray site, despite the end of the war, economic conditions remained very constrained. Price increases, which had been extremely high during the war, continued to be very high. Letish, a 31-year-old woman, suggested it had become almost as bad as during the blockade:

“The cost of living now … is almost equivalent to the siege period. The costs of all goods have increased and recently reached the level of the period of the siege.”

Mental health issues related to the war in Tigray

Different of aspects of the war in Tigray resulted in high levels of mental stress for young people during its two-year duration and in the years that followed. First, there were the food shortages and scarcity of basic goods, as Aynom, a 24-year-old woman from the site in rural Tigray, recalled:

“There was a shortage of food that was making us worried and life was worrying because there was [overall] scarcity.”

The uncertainty and fear of what might happen during the war and the risks of violence were a major source of anxiety, particularly for young women who remained in their villages:

“At that time there was a general fear that ‘they may come, they may kill us’, even before we had the enemy with us. … even toddlers were getting shocked and scared every time they heard noises. At that time, … there was no one from the people of Tigray who was not scared. There was stress.”

(Zebenay, 31-year-old woman, rural Tigray)

Experiencing or witnessing violence caused the onset of mental health challenges for some young people. A young woman from the small town in Tigray was asked by the fieldworker if there was any incident during the war that triggered her mental health issues. She responded that it started when soldiers entered her home.

Azeb, a 31-year-old woman from the same community, had a sister who was raped by soldiers. After the war, Azeb’s stress increased and she stopped working; though she reported that she had recovered, she sometimes still had relapses:

“[I get relapses] especially when I see things that remind me of my past. Additionally, when people ask me why I stopped working, it triggers my stress.”

Separation from relatives, especially lack of news about men fighting in the war, the cutting of phone lines and inability to travel were all cited as major stressors, particularly for women. Azeb also recalled:

“During the war and the blockade my sisters and I were separated from our family. We couldn’t go anywhere and had nothing. The telephone lines were also down.”

Uncertainty over whether relatives who were involved in the fighting had survived or not was a significant factor leading to mental health conditions. A young woman in a small town in Tigray who was suffering from mental health issues recalled how not knowing whether her brother had died was the main source of her stress. When she found out that he had died she felt relief but now feels an enduring grief and sense of sadness:

“I was sick only because of lacking information about my brother. I haven’t had any other causes that intensified my mental health issues … However, when I heard of his death … I stopped to think about him and felt relief. The grief will never get out of my mind, when I see his friends who he went to school with ... Particularly, when I go to do irrigation work there are times when I leave it. I say ‘this is not better than my brother’ … We are bearing children, we are rearing our children. We are eating, we are drinking. Our brothers did not bear children, they died in the desert in order to save us. We are not facing bad things because of our brothers.”

(Miritsiti, 24-year-old woman, urban Tigray)

For the young men who survived the war, there can be a sense of ‘survivor’s guilt’, as expressed by one young man:

“The crises of the conflict really affected our life and sometimes, you hate yourself. I used to ask myself, why did I come into this world? Why did God create me? I am condemning my fate. I hate myself when I think about my friends who died in the mountains and in the rivers of the battlefield.”

(Gere, 24-year-old man, rural Tigray)

Violence against women is a cause of serious mental health issues

Young women in Tigray who experienced violence and lost relatives in the war are very vulnerable to mental health issues. However, violence against women, and in particular rape, was also mentioned in other study sites as being related to mental health issues.

Limu, a 24-year-old woman from the site in rural Oromia whose mental health issues were relatively severe, often remained silent or laughed during her interview. As the fieldworkers were unable to complete the interview with Limu, they relied on talking to her mother for details of what had happened to her. During a visit to church, Limu had been approached by a man from a monastery, who took her to a toilet and raped her. The man later travelled abroad and Limu was too ashamed to tell even her mother what had happened. It was only when she became pregnant that she spoke about it. She now stays at home and avoids people because she fears stigma and insults.

Cultural beliefs about mental health lead some young people to seek traditional remedies

Mental health issues in Ethiopia are often explained as the person being attacked by the ‘evil eye’, sometimes as a manifestation of other people’s ill intensions towards them. Borona, the 24-year-old university student from the site in rural Oromia, believes his mental health issues started when his classmates invited him to a one-day event:

“Some classmates had a programme one day. They invited me to attend … by pressuring me when I refused their invitation. I suspect that something evil was done to me on that day.”

In another case, a young woman from rural Oromia moved to a town because she was advised to distance herself from a female neighbour who is believed among the community to be the one who ‘ate’ the young woman. This is referred to as *nyatto* and such women are called *gojje* (a person with an evil eye) and are believed to transform themselves into hyenas and attack people by night. The young woman recalled what happened, which sounds like an epileptic fit:

“It [was] during my childhood when I was first affected by a woman in my neighbourhood. She is called a *gojje*. She behaves like a human during the day, but at night she transforms into a hyena. One day, while I was returning from the beauty salon, I was singing a song on a horse cart. That woman with the evil eye saw me and said, “wow, she looks like a *maleka*” [queen]. Immediately after I got home, I fainted. My upper and lower jaws clenched together and my eyes rolled upward and turned white. It was on Eid al-Fitr day. When the Muslim community went to the mosque for the celebration, my parents were crying, thinking I would die because I had been inflicted by the evil eye. Then a sheik … came and gave me traditional medicine. I washed my body with mosque water, applied it to my head, and also sniffed a drug given to me by the sheik. Gradually, I recovered. The sheik advised that I should leave the area because the woman lived near us. I was taken to my uncle in a nearby town and then later to my sister, who was also living there.”

(Berhan, 24-year-old woman, rural Oromia)

Berhan also experienced *nyatto* attacks at school. She would fall asleep in class as if in a coma or would hurt herself by pulling out her hair and need to be taken home. Her father eventually allowed her to stop school and move to live with her uncle. Berhan is now married and noted that her attacks come back when she feels stressed and cannot achieve what she wants. As examples, she described times when she was unable to provide for her children, and when her husband does not give her money. She mentioned having had attacks twice in the past five years, during which times people held her tightly to prevent her from hurting herself; she also experienced headaches and dizziness for several days. Her husband called the sheikh, who prayed over water which she then used to wash herself. Berhan hopes her family can move to a rural area on the outskirts of the town where her mother-in-law has land and is also hoping to go to work abroad once she has raised enough money.

Limited access to mental health services is compounded by costs, delays, lack of confidence in services and fear of stigma

Most of the young people interviewed for the Qual 6 study have not had access to any mental health services. In most of the study sites, such services either do not exist or the young people did not know about them.

Access to mental health services

Some respondents had access to mental health services, but they expressed dissatisfaction as the services offer little support. In the few cases where they went to health services, young people tended to be given tablets, probably painkillers, without receiving any specialist diagnosis, treatment or psychosocial counselling.

Miritsiti, the young woman in Tigray whose brother in the army had died, heard that her other brother had gone to look for him and began experiencing mental health issues. She heard sounds in her ears and was unable to sleep and communicate properly. She went to the hospital in the nearest town and was given drugs for a week, which cost around 300 birr:

“There is no mental health treatment centre in my village. So I went to the town … I took drugs for some time. However, I was completely cured when I heard of his death and was relieved’

(Miritsiti, 24-year-old woman, rural Tigray).

Fears about costs, and the likelihood of a referral requiring time and money for transport and accommodation away from where they live, are major deterrents to seeking medical treatment. Borona, the young man who faced mental health challenges while at university, tried to receive treatment at a hospital but it involved transport fees. He was also worried about the time required for referrals. He pointed out that the mental health services are private and community-based health insurance does not cover mental health issues. He explained to the fieldworker:

“**Is there a counselling service at your university?**

Yes, there is ... I have heard about it, but I haven’t visited it.

Why haven’t you visited it?

I didn’t have time. We sat the final examination two weeks after the midterm exam. I also felt that they would give me appointments based on my health insurance as a student. I visited a university hospital in the main town and I was given a referral to go to Addis Ababa for service, but I didn’t go. They didn’t treat me adequately in the university hospital because I have student health insurance. There is no proper treatment without direct payment at the point of care.

What kind of health service do you believe will address your case?

There are private health service providers that are popular countrywide. If I am not cured there, I should go and use holy water, which is a popular treatment. I will be cured with these actions.

Do you have information on which service provider is like the one you said?

It is Amanuel Hospital in Addis Ababa. I should visit that one. It is there that the best counselling is provided for mental health cases.

Are there no services in the university compound?

No, the hospital, which belongs to the university, is located in the town. The one in the compound doesn’t provide good service. It is a small clinic.

So, paying the 50 birr for transportation is difficult?

Yes, 50 birr is a lot of money when you are at university.

Do you think that the mental health service that you can access is adequate?

It isn’t adequate. In the town hospital, they serve students and patients all together. The free service obtained by the students is not as good as the service provided to those who make direct payments. The service provided to the students is not adequate.”

There is a lack of mental health services in rural areas. A young woman from rural Tigray noted that there were no mental health services in her village, so she went to a town and was prescribed tablets for a week. However, she suggested that the medical services were not sufficiently developed and that people might be cured by holy water instead:

" There is no mental health treatment centre here in our village, so I went to the hospital in town. If a person has a severe mental health problem, I don't think the current medical service will cure him. The service is not yet improved. Maybe he could be cured by holy water. My problem was relatively mild; however, there are so many people who are severely affected by mental health issues and I don't think they will be cured easily. (Weyni, 31-year-old woman, rural Tigray)

Religion and holy water

Most respondents lack confidence in medical services and have more faith in prayer and reliance on religion. Mekdela, a 31-year-old woman from the Addis Ababa site, explained:

" If you go there [to hospital], you will be given medication, but I do not prefer medical treatment. I'd rather talk to St. Mary than a health expert. I prefer going to church. I do not believe that medical treatment will alleviate my tension. Going to church provides me more serenity than attending a health centre. "

There is a strong belief in the efficacy of holy water (*tebel*) treatment. A young woman from the Tigray rural site described how she feels holy water and going to church has helped her:

" Holy water is what helps. I know there are mental health services, but at church I hear preaching and songs that help treat my depression. When I go to the holy water, I also learn many words of God from the Bible that help me deal with depression and anxiety. "
(Zebenay, 31-year-old woman, rural Tigray)

For many respondents, family support was also crucial in coming to terms with their mental health issues. Zebenay acknowledged the way in which her mother helped her to cope:

" I can't explain enough how much my mother helps me! She controlled her own sadness and problems, treated me and encouraged me to never give up when I felt hopeless. She always told me, "tomorrow is another day". "

Gender and coping with mental health issues

While mental health issues affected both men and women in the context of war, young women faced additional burdens of caring responsibilities, suffered more from sexual abuse, and faced the trauma of loss of loved ones. In terms of coping, there appeared to be a stronger reliance among women on religion and family, peer and neighbourhood support, for instance in coffee ceremony gatherings. As one health worker in a small town in Tigray said:

" Women are the most affected but also the first to show progress after support. "

In contrast, some young men were involved in negative coping strategies, especially in the context of post-war unemployment and adjusting to demobilisation. Many young men spent time drinking with their peers and some turned to substance abuse, especially the narcotic *chat*, alcohol, cigarettes and drugs. There were also cases of young men gambling and becoming involved in criminal behaviour. In some cases, families resented the behaviour of young men facing mental health issues and they were perceived as being undisciplined and unruly. In turn, young men facing mental health issues felt misunderstood and hopeless, leading them to want to migrate abroad.

While family and peer support were very important for young people suffering from mental health issues, community views about mental health were often stigmatising and not supportive. Families often sought to hide members facing mental health issues for fear of discrimination, and seeking treatment was sometimes considered shameful. One caregiver in a small town in Tigray explained:

" My daughter was affected by a bad spirit, so we did not expose her condition to neighbours. "

Key findings on mental health

- The current generation of young men and women have transitioned to early adulthood in the exceptionally stressful context of multiple successive, overlapping and cumulative crises, including COVID-19, limited employment, job losses, high inflation and protracted war and conflict in northern Ethiopia.
- These crises put additional burdens on young people transitioning from school to work and establishing households, but most of the young people interviewed by Young Lives demonstrated remarkable resilience.
- The COVID-19 pandemic initially led to some anxiety, but it was the economic consequences of restrictions that became a more significant mental health stressor, especially for young people engaged in businesses.
- Inflation has eroded livelihoods increasing anxiety, while scarce jobs and uncertain futures hinder young people's independence, household formation and mental well-being, leading many to consider migrating abroad.
- The challenges of accessing higher education, stress over exams and failure, costs of education and living away from home, and concerns that degrees would not lead to jobs, induced mental distress for some students.
- The war in Tigray resulted in many stressors, including severe hunger, fear about potential and actual violence, separation from relatives, loss of mobility, worry about mobilised siblings, grief over deaths and survivor's guilt.
- A small number of young people with very serious mental health issues – sometimes since childhood, linked to other illnesses or running in families – were in some instances attributed to the 'evil eye', or caused by traumatic events, including rape.
- A few respondents had access to mental health services but often received insufficient or inappropriate medication without psychosocial care, with access to mental health care restricted by costs, worry about referrals and delays, limited health insurance, lack of confidence in the services, and fear of stigma.
- Most respondents felt that prayer and/or holy water treatment, while not always a cure, was more effective, and some young people facing mental health issues preferred to isolate themselves from family and friends and spend time at church or join monasteries.
- Young women face additional burdens of caring responsibilities and suffer more from sexual abuse and violence, especially but not exclusively in the context of war, but many women also find ways to cope through stronger reliance on religion and family, peer and neighbourhood support.
- In contrast, some young men, particularly in the context of post-war unemployment, found solace in drinking with peers and in some cases turned to negative coping strategies, including substance abuse, gambling and criminal behaviour, which can lead to alienation from their families, depression and feelings of hopelessness.

6. Education

Multiple crises have disrupted young people's educational pathways, creating a gap between their aspirations and actual attainment

Young Lives' longitudinal data shows that although participants had high aspirations in childhood to progress to higher education, most have not been able to achieve that goal (Woodman Deza, 2025). This section explores the reasons for this gap between educational aspirations and outcomes by examining young people's current and past educational status, experiences of school delays and interruptions, and the key factors shaping their decisions to either continue or drop out of education.

Although the young people in the study – now aged 24 in the Younger Cohort and 31 in the Older Cohort – were expected to have completed tertiary education and transitioned into work and independent adulthood, Qual 6 data reveals a different reality. Young people's educational trajectories were often disrupted, reflecting patterns of late school entry, grade repetition, interruptions due to work or illness, COVID-19 and conflict, and frequent changes in schools or colleges.

Current educational status reflects wide variation in educational attainment

The 181 young people[2] who participated in the Qual 6 data collection (Table 6) represent a wide spectrum of educational attainment, ranging from university graduates (26 people) to those who dropped out of primary school. Overall, the data reflects low levels of achievement: more than half of young people (95) dropped out of school before completing secondary (51) or even primary education (44), highlighting significant barriers to educational progression.

2 A total of 181 young people were interviewed during Qual 6, including both the Young Lives qualitative index sample and the lived experiences sample. Additional interviews were conducted with spouses, caregivers, key informants and focus group participants, bringing the overall number of Qual 6 respondents to 494.

Table 6. *The educational status of 181 young people interviewed in Qual 6*

Study site	Graduate	University	Diploma / TVET	Secondary education complete	Secondary school dropout	Primary school dropout	Total
Addis Ababa (urban)	8	7	5	4	8	1	33
Amhara (urban – small town)	6	3	3	4	2	0	18
Amhara (rural)	2	2	4	1	3	0	12
Oromia (rural)	0	1	1	1	7	19	29
Sidama (urban)	7	8	9	0	6	3	33
Tigray (rural)	1	0	2	0	14	20	37
Tigray (urban – small town)	2	2	3	0	11	1	19
Total	**26**	**23**	**27**	**10**	**51**	**44**	**181**

Educational trajectories reveal stark differences between rural and urban students

There are stark disparities in educational outcomes between urban and rural participants. As expected, young people from urban areas generally achieve higher levels of education. Notably, each of the two urban sites (in Addis Ababa and Sidama) include 15 people who have either graduated from or reached university level. Young people living in the small towns reported more moderate attainment, with nine from the small town in Amhara and four from the small town in Tigray having accessed higher education.

In contrast, young people from rural communities show much lower levels of educational attainment and are more likely to drop out of school earlier. Progressing to university has proved exceptionally difficult in the rural sites in Oromia and Tigray, with only one participant from each community managing to do so. These sites also have the highest dropout rates at both primary school (19 in Oromia and 20 in Tigray) and secondary school (eight in Oromia and 14 in Tigray) levels. Very few young people from these rural sites have progressed beyond secondary education – only two in Oromia and three in Tigray – with the war in Tigray a major compounding factor.

Young people from rural areas have faced increasing challenges in accessing higher education since 2019

To further understand the key barriers to educational success, Qual 6 analysed how the educational trajectories of the young people in the sample have unfolded since the Qual 5 round in 2019.

Between Qual 5 and Qual 6, 23 young people out of the sample of 181 reported completing higher education (Table 7), including diplomas at various technical and vocational education and training (TVET) levels, as well as university degrees. TVET graduates had specialised in areas such as metalwork, information technology, agriculture and human and animal health. University graduates had completed degrees in diverse fields, including accounting, business, management and water resources.

While most of these graduates had obtained their first degrees, one woman from the Older Cohort in Addis Ababa achieved a significant milestone by earning her second degree – an MBA – in 2024.

Since Qual 5 in 2019, young people from rural communities have faced significant challenges in accessing higher education. None of the young people from the rural site in Oromia had completed their studies during this period, while only one student from the rural Tigray site and two from the rural Amhara site had succeeded. Overall, across the three rural communities, only three new graduates emerged from the sample, in sharp contrast to 20 graduates from urban communities.

In Qual 6 in 2025, 24 out of the 181 young people in the sample reported that they were currently attending secondary school, technical college or university (Table 8).

Table 7. *Young people who have graduated since 2019 by study site*

Study site	Younger Cohort	Older Cohort	Men	Women	Total
Addis Ababa (urban)	5	2	1	6	7
Amhara (urban – small town)	3	5	3	5	8
Amhara (rural)	1	1	1	1	2
Oromia (rural)	0	0	0	0	0
Sidama (urban)	3	0	2	1	3
Tigray (rural)	0	1	1	0	1
Tigray (urban – small town)	0	2	2	0	2
Total	**12**	**11**	**10**	**13**	**23**

Table 8. *Young people still in secondary or higher education in 2025*

Study site	Younger Cohort	Older Cohort	Men	Women	Total
Addis Ababa (urban)	4	1	0	5	5
Amhara (urban – small town)	3	1	3	1	4
Amhara (rural)	3	1	4	0	4
Oromia (rural)	3	0	2	1	3
Sidama (urban)	6	0	3	3	6
Tigray (urban – small town)	2	0	1	1	2
Total	**21**	**3**	**13**	**11**	**24**

The variation among those still studying closely mirrors that of higher education graduates. The vast majority (18 young people) are from urban communities, while relatively few (seven) are from rural sites. Notably, none of the young people from the rural community in Tigray were enrolled in any education at the time of the Qual 6 data collection. This is largely due to conflict and ongoing insecurity.

There is also considerable variation between the cohorts, as might be expected given the seven-year age difference, with 21 Younger Cohort participants (aged 24) still studying, compared to only three in the Older Cohort (aged 31). The ages of the younger participants also appear more aligned with typical schooling timelines compared to their older counterparts. The gender gap is minimal, with slightly more men than women enrolled, possibly reflecting the greater challenges faced by some young women in continuing their education at this stage of life, especially those who have married early and had children.

Young people have experienced significant delays and interruptions to their schooling, first by COVID-19 and then, more severely, by conflict

Given their ages and childhood aspirations, the Qual 6 data indicates that many participants have experienced delays in completing their schooling and achieving their educational goals. Their educational trajectories reflect uneven pathways, marked by late entry, grade repetition, interruptions due to work or illness, disruptions caused first by COVID-19 and then more profoundly by conflict, and frequent changes in schools or colleges. Semanesh, a 24-year-old woman from one of the urban communities in Addis Ababa, recalled:

“Now, I am in Grade 12 because I joined school late. I entered Grade 2 when I was 9 years old.”

The COVID-19 pandemic affected all students, causing at least a one-year delay in young people’s education. Many also reported having to interrupt their education to earn an income, later resuming their studies either as regular students or through distance learning. One young man recalled how enlisting in the army and three years of military service had significantly delayed his schooling, but that he was now attending evening classes while working in irrigation fields during the day:

“I quit high school in 2021, when I was in Grade 10. Then I joined the military. I was shot [during the war] and hospitalised; I didn’t get the chance to undergo surgery immediately. So, I left the hospital to seek treatment elsewhere … then I returned home and resumed my education in Grade 11 in evening programmes.”

(Negassa, 24-year-old man, rural Oromia)

The educational trajectories of young people living in the conflict-affected areas of northern Ethiopia were severely disrupted by the war, compounding existing challenges. Participants reported being forced to interrupt their schooling for at least three years. Reflecting on the combined effects of armed conflict and the COVID-19 pandemic, a young woman from Tigray recalled how these crises had delayed her education:

“I was in Grade 12 and preparing to take the national exam. But due to the crises, my education was delayed for three years. I finally took the exam in 2023. My aspiration was to study medicine. I believe I would have achieved my dream if the crises had not happened. I would be in my fourth or fifth year of study. Now, I am studying accounting through distance learning. My childhood dream has changed because of the crises.”

(Beriha, 24-year-old woman, urban Tigray)

Kidanu, a 31-year-old man from the same war-affected community, also spoke about how both his education and graduation were disrupted:

“I started my degree in management in 2019, but due to the COVID-19 pandemic and the conflict, our graduation was delayed until 2023.”

Multiple crises have altered the educational trajectories of young people in Ethiopia, leading to irregular schooling pathways and requiring them to reassess their childhood aspirations. Delayed access to education often means young people have to resume their schooling after long periods of absence, often requiring them to combine their studies with work responsibilities.

Multiple barriers contribute to high education dropout rates

Many young people reported that they were unable to complete, continue or resume their studies and were ultimately forced to drop out of education. Qual 6 data shows that the number of young people who left school or higher education was nearly equal to the combined total of those who either graduated or were still enrolled. Nearly one-quarter of those interviewed in 2025 (41 out of the 181 sample) who had been at various educational stages had dropped out since Qual 5 in 2019 (Table 9).

Table 9. *Young people who dropped out of education between 2019 (Qual 5) and 2025 (Qual 6)*

Study site	Younger Cohort	Older Cohort	Men	Women	Total
Addis Ababa (urban)	10	3	6	7	13
Amhara (rural)	0	0	0	0	0
Amhara (urban – small town)	4	2	2	4	6
Oromia (rural)	5	0	4	1	5
Sidama (urban)	6	0	3	3	6
Tigray (rural)	5	0	3	2	5
Tigray (urban – small town)	6	0	3	3	6
Total	**36**	**5**	**21**	**20**	**41**

Overall, more young people from urban areas (31) have dropped out of education compared to their rural peers (ten). However, this does not necessarily suggest that students from rural communities are faring better; rather, it reflects the fact that many rural students had already dropped out much earlier. Urban students often make great efforts to remain in education, but many are eventually forced to leave when no viable options remain. No significant gender difference was found, with slightly more young men than women leaving school.

To better understand the high education dropout rate, Qual 6 examined the barriers identified by young people themselves. The obstacles that limit young people's educational opportunities operate at global, national, community and individual levels. Major factors include the COVID-19 pandemic, armed conflict, academic challenges (such as failing exams) and personal circumstances including economic hardship, illness, migration, work obligations and early family formation.

The COVID-19 pandemic

The global COVID-19 pandemic had an impact on nearly every aspect of life, with education one of the most severely affected sectors. Following the Qual 5 data collection in 2019, the pandemic led to widespread restrictions on people's movement and the closure of schools and universities. When Young Lives returned for Qual 6 in 2025, it was clear that many young people had been deeply affected. Their education had either been significantly disrupted or, in many cases, abandoned altogether.

Some young people who stayed at home during the pandemic began exploring alternatives to formal education. Many redirected their focus toward work, family formation and parenthood, reshaping their futures in response to prolonged school closures and uncertainty.

One young woman from the Addis Ababa site described how COVID-19 had turned her life away from education, resulting in her dropping out of school, starting work and becoming a mother:

> “I stopped at Grade 8 because of COVID-19. When the schools were closed because of COVID-19, I started doing garment work. People sit at home only if they had enough savings or if they had someone to provide basic necessities. We didn't have enough to stay at home, so we had to face the risk of COVID-19 … In the meantime, my boyfriend asked me to live together. I got pregnant and didn't go back to school.”
>
> (Shiwaye, 24-year-old woman, Addis Ababa)

All the young people who dropped out of school since 2019 highlighted the pivotal role of COVID-19 in their decision to leave education.

Conflict

Political and security disruptions have created widespread unrest, severely affecting both mobility and young people's education. Young people in northern Ethiopia, particularly in Tigray and Amhara, have been deeply affected by the armed conflict that began in 2020. Many participants in these regions experienced significant setbacks in their educational trajectories, with prolonged interruptions and limited access to schooling.

The armed conflict that followed the COVID-19 pandemic exposed students to multiple overlapping crises that many could not endure. The experience of Hadera, a 24-year-old man from the rural Tigray site, illustrates the challenges faced by young people living in conflict-affected areas. Hadera was enrolled in a TVET automotive technology course but was forced to leave due to the pandemic. When he attempted to resume his studies, the outbreak of armed conflict further disrupted his education, making it impossible to return.

“I quit my college education in 2020 because of the COVID-19 pandemic. Then the conflict began and I did not return to school. Although I remain eager to join, the automotive department which was closed during the war has not yet reopened.”

During data collection in 2025, it was observed that educational institutions in conflict-affected regions had not yet fully resumed in the post-conflict period. Moreover, many young people who had left school during the war were no longer motivated to continue their education.

Economic challenges and personal crises

Multiple economic challenges and personal crises have also compelled some young people to abandon their education. Many participants reported that financial constraints were the main reason for dropping out and being unable to return to school or university. Rising education costs, combined with high inflation, have increasingly strained families' ability to pay for their children's schooling. When families cannot cover school fees and living costs, young people often have to leave school to participate in income-generating activities, either by working for their family or finding paid work.

In many communities, particularly in rural areas, continuing education beyond primary school often requires relocating to towns, which incurs additional costs for families. As a result, most rural students leave school after completing primary education. Ayana, a 24-year-old man from the site in rural Oromia, explained that he had repeatedly interrupted his education for economic reasons and ultimately had to quit school because his family could not afford the costs of studying in town:

“I dropped out of school in 2022 after finishing my primary education. I had to go to high school, which is located in town. My mother couldn't afford to pay the rent for me to stay there. It was also difficult to cover food expenses.”

Severe illness also prevents some students from completing their education. Young people without access to proper medical treatment, often due to financial constraints, were typically forced to drop out. Kihisen, a 24-year-old former student from a small town in Tigray, shared how she struggled to stay in school despite battling a prolonged illness and now wishes she could resume her studies:

“I reached Grade 11. When I was in Grade 10 the illness started, and I fainted in class during exam times. My friends took me to the holy water and brought me back to school many times. I entered Grade 11 but I was sick all three days in school. I then quit school. I would be happy if I could go to school even now.”

Recent changes in education policy, combined with limited job opportunities, have demoralised and discouraged some young people

The recently introduced national education policy established new exams for Grades 6, 8 and 12, as well as entrance exams for university graduates, which only a very small proportion of students pass. Some young people have criticised these reforms, especially the post-COVID-19 curriculum changes that have resulted in automatic grade promotions and poorly aligned national exams, which many felt undermined their academic performance and future opportunities. Increasingly competitive university entrance exams and a lack of post-graduation employment opportunities are also discouraging many students, contributing to rising dropout rates. In some cases, university graduates are perceived to be at a disadvantage compared to those who dropped out of high school when it comes to securing jobs, as they are often regarded as overqualified for the low-quality jobs that are often the only jobs available.

Young people in a focus group discussion in Addis Ababa described the current education system as 'demoralising the youth'. One young man, who had failed the new national university entrance exam, later enrolled in a private college by paying tuition fees but eventually dropped out altogether. He recalled how this had a negative impact on both his own aspirations and those of his generation:

“The new policy was introduced during our batch. We were the first batch to take the national [Grade 12] examination to enter university organised in university campuses … There are challenges during implementing a new policy. For example, there are model exams for the purpose of preparing students ahead of time. When new policies are reinforced, there is a need to test their applicability before they are actually implemented. We were used as a laboratory where the new policy was tested. But it killed our aspiration as we couldn't withstand the new challenges.”

(Ferede, 24-year-old man, Addis Ababa)

Ferede shared his expectations that educated people should be rewarded with good job opportunities and fair compensation, and that there needs to be better prospects for those who complete higher education.

Key findings on educational trajectories

- Despite high childhood aspirations, most young people have not achieved higher education due to the impacts of conflict, COVID-19 disruptions, rising costs of higher education, inflation and the introduction of competitive university entrance exams.
- Educational attainment varies widely across study sites, with stark differences between rural and urban participants. In rural areas, young people typically leave education after primary school, as continuing to secondary school often requires travelling or relocating to towns, which entails long travel distances and high living costs, alongside additional risks of sexual violence for girls and young women.
- Conflict in northern Ethiopia, particularly in Tigray and Amhara, has severely disrupted education, causing prolonged interruptions and lasting setbacks to young people's learning trajectories, with those exposed to extended conflict less able and motivated to continue their studies.
- By 2025, many educational institutions in conflict-affected regions had still not fully resumed operations.
- Increasing tuition costs and graduate unemployment are also discouraging many young people – and their families – from investing in higher education.
- Recent changes in the national education policy introduced exams for Grades 6, 8 and 12, alongside competitive new university entrance exams, which only a small number of students pass. Many young people have found such changes demoralising, which, alongside limited job opportunities, have discouraged students and increased dropout rates and migration aspirations.

7. Work and un(der)employment

Young people are experiencing a fragmented and challenging transition from education to employment

At their current ages – 24 for the Younger Cohort and 31 for the Older Cohort – participants in the study would typically be expected to have completed their education and entered the workforce. However, Young Lives data reveals a different reality: only a small proportion have secured stable employment. Since Qual 5 in 2019, young people have faced successive and cumulative crises that have disrupted their education and existing jobs, and curtailed new employment opportunities. These include the COVID-19 pandemic, rising inflation, conflict and insecurity, development-induced relocations, and family or personal challenges (Tanima, 2025).

This section provides insights into young people's employment status, types of work, income levels and job satisfaction, and explores the reasons behind deepening youth unemployment and its impact on the well-being and future aspirations of those affected.

Young women are less likely to be working than young men

Young Lives Round 7 quantitative data collected in 2023–24 (Table 10) shows that young women are significantly less likely to be working (61%) than young men (30%), with higher rates in urban areas (47%) compared to rural areas (42%). Schooling is reported as the most common reason for not working overall, but there are significant gender differences, with 42% of young women reporting unpaid domestic work and childcare responsibilities as the reason for not working, while no young men cited this as a barrier to employment.

Table 10. *Percentage of Round 7 respondents not working (N=2,231)*

	Total	Younger Cohort	Older Cohort	Women	Men	Rural	Urban
Did not work for at least an hour in the last seven days (%)	45	48	39	61	30	42	47
Reasons for not working							
Domestic work/childcare (%)	30	18	64	42	0	30	29
Schooling (%)	48	61	8	43	60	50	46
Limited job opportunity (%)	3	3	6	3	5	2	4
Illness/disability (%)	5	5	5	5	6	5	5
Other reasons (%)	14	14	16	9	29	13	16

Young people are engaged in a wide range of paid and unpaid work, but there is high unemployment

In Qual 6, one-quarter of the 157 young people interviewed were unemployed, with the remainder engaged in a variety of paid and unpaid work activities (Table 11). These included those who were self-employed (38 people) or engaged in salaried or wage-based jobs (32), agricultural work (27), casual labour (ten) and household responsibilities (ten) such as childcare and domestic work. The nature of these activities varied according to community context, urban–rural setting, age cohort and gender.

Table 11. *Work situation of young people interviewed during Qual 6*

Study site	Unemployed	Self-employed	Salaried / wage	Agriculture	Casual work	Housework /childcare	Studying (see Table 8)	Total
Addis Ababa (urban)	8	9	8	0	2	1	5	33
Amhara (urban – small town)	6	4	3	0	1	0	4	18
Amhara (rural)	4	3	1	0	0	0	4	12
Oromia (rural)	4	3	3	14	1	1	3	29
Sidama (urban)	8	9	9	0	1	0	6	33
Tigray (rural)	5	5	4	13	3	7	0	37
Tigray (urban – small town)	5	5	4	0	2	1	2	19
Total	**40**	**38**	**32**	**27**	**10**	**10**	**24**	**181**

Rural versus urban employment opportunities

Young people in rural communities were predominantly engaged in agricultural and related livelihood activities, with some variation depending on the region. In the site in rural Oromia, the principal forms of work include rain-fed and irrigated farming, fishing, wage labour and cart transport. In the rural Tigray site, young people typically reported irrigated farming, poultry production and casual labour, such as stone loading and cobblestone work. In the rural Amhara site, alongside farming, young people also participate in cattle fattening and small-scale trading.

Self-employment is evident across all rural sites, including occupations such as driving *bajaj* (three-wheeled taxis), construction work, operating pool houses and repairing mobile phones. Overall, however, rural livelihoods are concentrated around farming, fishing, cobblestone work, cart transport and daily wage labour. These forms of employment are seasonal, low-paid and physically demanding, underscoring the precarious nature of rural youth economic engagement.

In urban and small-town communities, young people have greater access to job opportunities in formal employment and wage labour, alongside self-employment. Reported occupations include civil service positions, accounting, sales, commission-based work and working in the cosmetics trade. Other common occupations include hairdressing, security services, cleaning, driving and embroidery. These activities illustrate the broad and diverse livelihood opportunities available to young people in urban areas and small towns, covering both formal professional roles and informal sector work.

Differences between genders and cohorts

Young women's access to employment is significantly more limited than young men's (Table 12). Of the 40 young people who reported being unemployed, 32 were women. Household responsibilities, including domestic work and childcare, are predominantly assigned to women, reflecting the persistence of traditional gender-based divisions of labour. Some young women remain at home, doing household work or childcare, either because they have lost their jobs or were unable to find employment. Some unmarried young women, despite having fewer domestic responsibilities, have also struggled to secure paid employment.

Table 12. *Young people's work situation by age cohort and gender during Qual 6*

Cohort/gender	No job	Self-employed	Salaried/wage	Agriculture	Casual work	Housework/care	Total
Older Cohort	18	23	21	13	2	4	81
Younger Cohort	22	15	11	14	8	6	76
Total	40	38	32	27	10	10	157
Men	8	20	10	17	8	0	63
Women	32	18	22	10	2	10	94
Total	**40**	**38**	**32**	**27**	**10**	**10**	**157**

Young women are involved in all types of work activities, though they are mostly confined to low- or unpaid roles such as household (domestic work, childcare) or agricultural activities (harvesting), self-employment and low-wage labour. Urban women have greater access to jobs in salons, restaurants, petty trade and sanitation, while rural women often face more difficult and sometimes unsafe working conditions, for example on farms and in wineries. One young woman working on a private flower farm in rural Oromia recalled her experience of exposure to chemicals at work:

"The job I am doing darkens the colour of my face. I went to the pharmacy for medication but I did not find a cure. I work in the packing room. They sprinkle chemicals on the flowers' external part. So, while packing the flowers, my face was exposed to the chemical. The chemical is very dangerous … I went for medical treatment at the farm hospital. Employees of the farm get free medication. They prescribed medicine, a cream to buy from a private pharmacy. However, the medicine was not available here … Sometimes the hospital provides medicine; mostly, workers buy medicine from private pharmacies. If you submit a receipt, they reimburse you. They told me to give it to a driver who goes Addis, but I do not know a driver who goes there … When I went to another private clinic, they suggested I go to a skin specialist. Over time, my condition has become severe. I am afraid that it may affect my eyes."

(Shegitu, 24-year-old woman, rural Oromia)

Overall, Qual 6 data reveals little disparity between the Younger and Older Cohort in terms of access to employment and work opportunities. However, the Older Cohort were more likely to have secured formal employment or be engaged in self-employment, while the Younger Cohort were more likely to be involved in casual labour. This pattern suggests that, unlike the Younger Cohort, Older Cohort participants had largely transitioned into work and were relatively more established before the crises. They therefore benefited from better access to a wider variety of work opportunities before the economy was affected by conflict.

Successive and cumulative crises have created new barriers to youth employment

Since Qual 5 in 2019, young people have faced successive and cumulative crises that have disrupted work and curtailed new job opportunities. The COVID-19 pandemic and rising inflation affected all communities, while conflict in Tigray and Amhara deepened unemployment in those regions. In the Addis Ababa site, development-induced relocation has added further disruption at the community level.

Recent 'corridor development' projects and community relocations in Addis Ababa have dismantled long-established workplaces for many young people and their families. For example, the displacement of the fruit and vegetable market in the Young Lives study site has erased a vital source of livelihood, depriving young people of job opportunities that the community had relied on for generations:

"I had been employed in our community, but I left when my workplace was moved … I used to work at the vegetable market. [I] used to make more money working [there] than people with higher levels of education … The market's relocation by the government had a detrimental economic effect on everyone in the community. For this reason, I lost my job. There is no work right now."

(Tesfaw, 24-year-old man, Addis Ababa)

Conflict and war in northern Ethiopia have severely disrupted economic activities, forcing the closure of government offices, private institutions and factories, while many small businesses were dismantled. In the study communities in Tigray, young people who had been engaged in farming, irrigation, stone loading, cobblestone crafting, petty trade and various forms of daily labour saw their livelihoods destroyed. Youth unemployment became widespread and has continued to worsen in the post-conflict period. In addition, access to credit and small business support that existed before the conflict has vanished. One typical experience, shared by a young man from rural Tigray, illustrates how the war and preceding COVID-19 pandemic has affected employment:

"In 2019 and 2020, I was employed in a textile factory and earned a salary of 1,500 birr. It was relatively better than the existing situation. I could cover the rent for my sister. It was a better time. When the COVID-19 pandemic erupted, the costs of goods started to increase. Inflation was increasing and my earnings couldn't cover the costs of food and other services. Following the pandemic, the conflict began at the end of 2020, and things became tense and strange. The company [I was working for] closed down when the conflict began."

(Kisanet, 31-year-old man, rural Tigray)

There is a mismatch between young people's education and skills and the job opportunities available, especially for young women

The relationship between education and work is creating a paradox. While those who drop out of education are locked into casual or unsafe work, university graduates struggle to find suitable jobs in their fields of expertise. Some graduates reported that they could not find work at all, while others were forced to take jobs far below their level of education. In some cases, even those who wanted to engage in income-generating activities, despite a mismatch with their skills and university qualifications, faced additional barriers that made this impossible. A young woman from a small town in Tigray shared her experience:

"I graduated in 2019 in water engineering from a university. As there were no job opportunities, I started a small café preparing and selling coffee/tea and breakfast. But later it was closed because I didn't have enough money to pay the rent. There was no work and no income during the conflict. Currently, I have moved to another city and still do not have work."

(Azeb, 31-year-old woman, urban Tigray)

Some university graduates reported working as security guards or gardeners. Although initially reluctant to take low-paid or manual jobs due to concerns about family dignity and social status, prolonged unemployed and worsening economic challenges eventually compelled many young people to take any jobs that were available. University and college graduates have frequently found themselves working as guards, *bajaj* drivers, receptionists, or in small self-employment ventures requiring little formal preparation. As a result, they often view themselves as underemployed**.**

One young university graduate explained how she accepted a job in a lower-level profession but remains dissatisfied and finds the work demoralising:

“I graduated in 2019 with a BSc in civil engineering from a university. In 2023, I was employed in a government office as a guard and gardener. Currently, I earn 4,000 birr per month … I am doing this lower-status job because there are no alternatives here. I am affected psychologically and I feel demoralised. I am doing this because I need to work in order to live.”

(Mulu, 31-year-old woman, rural Amhara)

For some young people, higher education has offered more options. When they are unable to get the job of their choice, their skills offer broader opportunities to explore their own income-generating activities or find work in the private sector. For example, Ehite, a 24-year-old woman from a small town in Amhara, whose university studies were disrupted by the conflict, eventually took a job in Addis Ababa:

“I studied IT at Mekelle University, but due to the war, I was moved to Haromaya University. One year was lost due to the war, and I then attended Haromaya University for two years. I graduated in 2024 … I was searching for a job for almost a year. When I got a job, either the salary was too low or it was far from where I lived. I was employed only two months ago in a supermarket in Addis Ababa on a monthly net salary of 6,400 birr. I live with my sister so that rent is not an issue.”

Securing available jobs is considerably more difficult for young women, often due to domestic responsibilities, lack of flexible working arrangements and childcare facilities, and their heightened vulnerability to gender-based violence. Young women in the Addis Ababa site reported some company owners or hiring officers demanded sexual relationships when they applied for jobs. One young woman was left with no opportunities other than hotel work, but found it impossible to continue because of persistent gender-based violence and harassment:

“I worked for several hotels as a receptionist or a manager, but I did not stay at any hotel for more than three months. The hotel owners wanted to use having beautiful young girls to attract customers, so that customers visit repeatedly just to see us. The hotel owners employed me only as temporary worker. The nature of the job was not interesting. I also felt uncomfortable if I stayed at a hotel for several months. That was stressful. The customers thought that I was standing there for another purpose and have dirty minds. They wanted to use me. That was something unacceptable for me.”

(Shiwaye, 24-year-old woman, Addis Ababa)

After trying to work in several hotels, Shiwaye finally quit and decided to get married.

Structural barriers and weak institutional capacity undermine efforts to create sustainable youth employment

In some communities, mainly in urban areas, there are dedicated offices responsible for youth employment**.** These offices primarily play a facilitative role, including the registration of jobseekers, organising skills training and connecting young people with private employers, land authorities and microfinance institutions. In some cases, they also support the establishment of cooperatives or overseas placements.

However, Qual 6 data shows that youth employment offices in all the study sites face serious challenges. In Addis Ababa, low wages and identification requirements discourage jobseekers; in urban Sidama, rising graduate unemployment, land scarcity and the disruption of loan schemes constrain opportunities; and in conflict-affected areas, job opportunities have collapsed, alongside limited access to microfinance loans in both Addis Ababa and the small town in Tigray. These structural barriers and weak institutional capacity, exacerbated by conflict, undermine efforts to create sustainable youth employment, as described by a job creation officer in a small town in Tigray:

“[In total,] 2,026 youth registered as jobseekers (1,311 men and 715 women). Of these, 40 held university degrees and 101 diplomas**,** while the majority had only primary or secondary education. Just 358 youth secured jobs in local construction, cobblestone or quarry work, and related activities.”

The officer emphasised that registered jobseekers account for only about one-third of the actual number of young people looking for work**,** as many do not register because they doubt the office’s ability to help them find jobs.

Young people who aspire to start their own businesses also encounter significant obstacles, including struggling to secure work spaces and initial start-up capital, due to weak institutional support and cumbersome bureaucratic processes. Those displaced by conflict, particularly young people from Tigray and Amhara, face additional barriers, as host communities often require residence identification cards, making it difficult to access employment or start businesses.

Key findings on youth unemployment

- Unlike the smooth transition from school to work they anticipated, young people have experienced mixed and irregular pathways and found their entry into employment fragmented and challenging, with limited opportunities to secure stable jobs.
- A significant proportion of young people remain unemployed, underemployed or trapped in unstable and underpaid occupations.
- Successive and cumulative crises, including war and conflict, the COVID-19 pandemic and inflation, and the shrinking and disruption of local employment opportunities, have further intensified the challenges of youth unemployment and underemployment.
- Disparities in youth employment are largely shaped by location, with many rural young people locked into precarious agricultural and manual work, while urban young people can access more diverse opportunities but face intense competition and low wages.
- Young women face additional challenges due to unpaid domestic and care responsibilities and limited workplace childcare, and are also more vulnerable to unsafe working conditions, sexual harassment and gender-based violence at work.
- Young people in the Older Cohort are relatively better positioned, as they are more likely to have found established jobs before the recent crises, while their younger counterparts struggle with casual, unstable work and rising youth unemployment.
- Conflict and war in northern Ethiopia have severely disrupted economic activities and destroyed the livelihoods of many young people; youth unemployment became widespread and has continued in the post-conflict period.
- Many young people in the study dropped out of school, leaving them poorly prepared for the labour market and more likely to be locked into casual, unsafe or unpaid work.
- University graduates also report being dissatisfied, mainly due to underemployment and a mismatch between their skills and expectations and the availability of jobs, leaving them demoralised and questioning the value of their investment in higher education.
- Institutional support for youth employment is inconsistent and undermined by structural barriers, with youth employment offices functioning more as facilitators than providers, and their limited resources, bureaucratic requirements and inability to respond to crises leaving young people without meaningful pathways to secure work.
- Young entrepreneurs looking to start their own small businesses are also hindered by a lack of capital and limited access to loans, and struggle to secure work spaces.

8. Migration

This section explores young people's patterns of domestic mobility and international migration, examining the forms these movements take, the factors that drive them, and how they vary across communities, regions, age cohorts and gender. It also documents migrants' lived experiences, highlighting both the positive and negative outcomes of migration.

Current trends suggest high rates of migration, particularly among young men and those from urban areas

Young Lives longitudinal quantitative data from the 2021 COVID-19 phone survey (Call 5) and the 2023–24 Round 7 survey show high levels of mobility over the last few years, with over one-third (35%) of young people reporting they had moved away from their home during this period (Table 13). Migration is notably higher among young men (39%) compared to young women (30%), and among those from urban areas (40%) compared to rural areas (28%).

The primary drivers of migration were reported as relating to employment (36%), education or training (14%), escaping war and violence (10%) and joining the military or armed groups (10%). While young men are more likely than young women to migrate for work, young women are more likely than men to migrate for social reasons, such as visiting family or to care for ill relatives.

Table 13. *Migration experiences across the Young Lives sample between 2021 and 2023–24 (N=2,231)*

	Total %	Younger Cohort	Older Cohort	Women	Men	Rural	Urban
Ever migrated or moved between 2021–23 (%)	35	37	30	30	39	28	40
Reasons for migration/movement							
To join family (%)	6	6	7	6	6	8	5
To visit family (%)	7	8	5	11	4	8	7
To escape war and violence (%)	10	9	14	12	9	3	14
Job/work related (%)	36	32	48	30	41	43	33
Education/training related (%)	14	17	5	16	13	8	17
To join military/armed groups (%)	10	11	7	3	15	12	9
Own illness or to support ill relatives (%)	3	3	3	6	0.4	3	3
Health-related migration (%)	3	3	3	4	2	5	2
Other reasons (%)	10	11	8	12	9	11	10

Employment, education and family formation are key drivers of migration, alongside the impacts of war and conflict

Similarly, the Qual 6 data (Table 14) also reveals diverse migration trajectories among young people, involving both internal and international movements. Internal mobility is primarily driven by the pursuit of employment, education, marriage and family formation. However, a considerable number of migrants also reported that their decision to leave was driven by the effects of conflict in their communities. In addition, 15 young people were involved in international migration, with outcomes ranging from successful return to deportation or forced repatriation. During the fieldwork, ten additional young people were identified as actively preparing to migrate internationally.

In total, over half (105, or 58%) of the 181 young people interviewed in Qual 6 had migrated or planned to do so.

Patterns of migration vary across the study sites

Patterns of migration and local mobility differed across the study sites. Around one-third (35 out of 105) of young people moved out of their communities in search of employment, while one in five (19 out of 105) moved to other regions to pursue tertiary education.

Among the 20 young people who migrated from the urban Sidama site, more than half moved in search of work. In contrast, domestic migration among young women in the site in rural Oromia, as well as in the Tigray communities, was primarily driven by marriage.

Young people from the Addis Ababa site have relatively lower domestic mobility, reflecting their better access to higher education and employment opportunities compared to other regions. In contrast, conflict and war led to the displacement of many young people from areas of Tigray and Amhara. When opportunities are limited in their communities or elsewhere in the country, young people often seek migration abroad. In particular, young people from Addis Ababa expressed strong interest in pursuing overseas opportunities in search of a better life. Of the 15 young people in Addis Ababa, 11 had either already migrated abroad or were planning to, while four had relocated within Ethiopia for education or marriage. Similar experiences were reported among young people from the Tigray communities.

Drivers of migration also differ by gender and age cohort

The drivers of migration and domestic mobility, as well as related experiences, vary across gender and cohort (Table 15). While seeking work was the dominant motivation across all groups, clear gender differences highlight the diversity of reasons for moving. Older Cohort men (aged 31) are primarily motivated by employment opportunities, while Younger Cohort men (aged 24) are more strongly influenced by conflict and have high aspirations for international migration.

Table 14. *Drivers of migration for 105 young people by study site (Qual 6 data)*

Study site	Education	Work	Flee conflict	Marriage / family	Deported / failed	Returnees	Plan to migrate	Total
Addis Ababa (urban)	3	0	0	1	5	1	5	15
Amhara (urban – small town)	4	3	5	0	0	0	0	12
Amhara (rural)	0	4	6	0	1	0	0	11
Oromia (rural)	1	7	0	4	0	0	1	13
Sidama (urban)	5	11	1	0	0	1	2	20
Tigray (rural)	4	4	2	2	2	2	1	17
Tigray (urban –small town)	2	6	4	1	1	2	1	17
Total	**19**	**35**	**18**	**8**	**9**	**6**	**10**	**105**

Table 15. *Drivers of migration for 105 young people by gender and cohort (Qual 6 data)*

Cohort/ gender	Education	Work	Conflict	Marriage/ family	Deported/ failed	Returnees	Plan to migrate	Total
Older Cohort men	3	11	3	0	5	1	1	24
Younger Cohort men	3	9	6	0	2	0	4	24
Total men	6	20	9	0	7	1	5	48
Older Cohort women	6	8	5	3	1	5	1	29
Younger Cohort women	7	7	4	5	1	0	4	28
Total women	13	15	9	8	2	5	5	57
Overall total	**19**	**35**	**18**	**8**	**9**	**6**	**10**	**105**

Migration patterns among young women are more diverse. Women in the Older Cohort reported work and education as key drivers of domestic mobility, while those in the Younger Cohort were more strongly influenced by education, marriage or family-related reasons. Some women in the Older Cohort have already experienced international migration, and women from both cohorts expressed intentions to move abroad in pursuit of a better life.

8.5 Domestic migration offers both new opportunities and significant challenges

While domestic migration is primarily driven by the pursuit of employment, education, marriage and family formation, alongside escaping the negative impacts of conflict, young people face significant challenges in achieving their goals, especially during periods of instability.

Employment

Driven by economic hardship, land scarcity and limited local prospects, young people primarily migrate to other areas in search of job opportunities. Young men often move regions to engage in seasonal labour (e.g. moving from Sidama to Afar and Western Oromia), while young women typically move from rural communities to urban centres in search of domestic work.

In the urban Sidama site, young people have been particularly affected by the relocation of the former SNNPR capital from Hawassa, following the 2020 referendum that granted Sidama regional status. Unlike previously, an increasing number of young people reported a decline in job and business opportunities. One young woman described how she was compelled to operate her business across multiple locations. She became a trader after leaving school in Grade 8, and thereafter transformed both her life and her family's through five years of hard work in cross-border trading:

“For the past five years, I have been engaged in business activities, mainly trading goods such as clothes, shoes and cosmetics. My work often involves moving goods across borders, including Djibouti, Kenya, Moyale, Jigjiga and Dangila, and selling them in Hawassa. This business has ups and downs, and sometimes I face losses or risk losing my business altogether. Despite the challenges, my business has brought positive changes to my family's life. I was able to repair our house and improve our living conditions. Economically, I am in a better position now. Contraband trading carries risks, and traveling frequently exposes me to insecurity. At times, I have faced harassment while moving from place to place. Still, I continue working hard to achieve more for myself and my family.”

(Tarik, 24-year-old woman, urban Sidama)

Despite facing risks and challenges, such as financial instability, harassment and the uncertainties of cross-border trade, Tarik has achieved economic stability and improved her family's living conditions – reflecting her resilience and determination in building a better future.

Education

Apart from those who moved to Addis Ababa for tertiary education, students who have relocated to other regions often struggle to attend classes regularly and complete their studies. The situation has been far worse for those who moved to war-affected areas of Amhara or Tigray. For example, Ehite, the 24-year-old woman from the urban Amhara site, had to pursue risky routes to complete her university education:

“First, I was assigned to Mekele University but due to the war I was moved to Haromaya University. I studied for two years at Mekele University and two further years at Haromaya University. One year was lost due to the war, so it took me five years to complete my studies. I graduated in 2024.”

Despite the challenges of relocating, Ehite successfully completed her education, again illustrating the resilience among many young people during times of crisis.

Marriage and family formation

Many young women from the site in rural Oromia have migrated away from their communities primarily for marriage. This pattern reflects local traditions where marriage typically occurs outside one's clan, often necessitating the woman relocating to another community. One such young woman interrupted her schooling to marry and move elsewhere; like many young people, she is now considering migrating abroad to improve her job prospects:

“I dropped out of Grade 9 in 2000 to marry a man who lived in another area, a place I did not know before, and I found it hard to adapt due to its bad weather. But I had to move there because it is customary for women to move and live in the husband's community … Now, I am considering migrating abroad to work and earn a good income that would help me to improve my life, for example, by building a house. Although my husband does not support my plan to migrate, I have told him that I intend to do so in order to secure a better income.”

(Mulualem, 24-year-old woman, rural Oromia)

Despite her husband's disapproval, Mulualem remained determined to migrate and improve her family's life.

Escaping war and conflict

The war that began in 2020 in northern Ethiopia profoundly affected young people in Tigray and Amhara. Many were forced to flee their homes during periods of active conflict, often traveling on foot either with their families or alone. Displacement was frequently short term, with many seeking refuge in nearby urban areas for days, weeks or months, or relocating to towns and cities perceived as safer. Young people from conflict-affected Amhara sites, for example, moved to other towns in Amhara, Oromia and Addis Ababa. The persistence of conflict in the Amhara region compelled many to undergo multiple displacements:

“During the Junta war [between the Ethiopian government and the Tigrayan People’s Liberation Front (TPLF)], I went to Bahir Dar with my father until the peace was restored … We walked half of the distance on foot and used a vehicle for the other half. We stayed in Bahir Dar for six months and my father paid for the rent and living costs. I interrupted my education for a year because of the conflict. I continued my Grade 11 schooling when I returned, before joining university.”
(Yirgu, 24-year-old man, urban Amhara)

A young woman from the same community, which has endured recurrent conflict and multiple shifts in control by different forces over several years, described her experiences:

“To save my life, I migrated to Bahir Dar during the Junta war. We travelled on foot for almost the entire part. There was no transport service. It was very difficult and tiresome. I returned a week later because the TPLF left our town. Then, due to the continued war [between the federal army] with Fano [rebel group] in our area, I migrated to Addis Ababa. I live and work here on a contract basis whenever a job is available … If I get a chance, I want to migrate abroad, although it is difficult.”
(Genu, 24-year-old woman, urban Amhara)

Her aspiration to migrate abroad reflects a broader trend among young people who envision opportunities beyond national borders. In particular, those who have already experienced internal migration often express a strong inclination toward pursuing international migration.

Conflict-driven migration from Tigray communities ranges from short-term local displacement to permanent relocation to Mekelle. While migration often saved lives, it deepened economic hardship, disrupted education and health services, and created new forms of stress and discrimination. A young woman who fled war and lived in an internally displaced persons (IDP) camp shared her experiences:

“My children, husband and I came to Mekelle when the war started in 2021 and the city was under federal army control. My relatives encouraged us to come here to escape the fighting. Older relatives said, “if we die in the conflict, it is okay because we are old, but you are young and need to escape and stay alive.” … Although it was expensive, we borrowed money from neighbours to cover the cost. It was 200 birr from my community to Mekelle … Before the crisis, transportation costs were lower, ranging from 100 to 130 birr.

I stayed with my aunt until my husband rented a house. We faced starvation and thirst on our way here. I did not have money to pay the rent, so I joined the IDP [internally displaced persons] centre with my baby. They welcomed me and I … received all the services [I needed], like clothes, food, diapers and sanitary materials, on time. I stayed for several months until they sent us back to our town, one month after the TPLF took control of the region on 28 June 2022. Thank God, it was a good experience.”
(Kihisen, 24-year-old woman, urban Tigray).

International migration often involves risky routes and high costs, with no guarantee of success

Similar to domestic mobility, international migration is driven by limited economic opportunities and ongoing conflicts. Young people pursue migration abroad primarily in search of enhanced economic prospects and an improved overall quality of life.

Border returns and deportation

A few young women pursued legal migration routes to the Middle East to engage in domestic work. However, due to the limited availability of formal migration pathways, many resorted to irregular and risky routes. Some young people who attempted to migrate abroad were either deported or forced to return at border crossings. Tamiru, a 24-year-old man from the Addis Ababa site, attempted to migrate abroad via an irregular route but was compelled to turn back at the border due to security concerns associated with the conflict in Amhara, and was intercepted along the route to Sudan via Gondar city. He shared the following account with the fieldworker:

“**When and why did you try to migrate?**

It was in 2020 … There aren’t any job opportunities here. I tried to migrate in an attempt to live a better life.

Where did you attempt to migrate to?

To Europe! I was inspired to go after witnessing my friends who moved there [to Europe] working hard to improve their lives and those of their families.

Have you tried to migrate through an irregular route?

Indeed. Even though I don’t have a passport. I am aware that the [legal] migration process is difficult.”

Driven by limited job opportunities and the pursuit of a better life, Tamiru’s attempt to migrate abroad through irregular means was ultimately aborted. However, he continues to dream of migrating to Europe.

Precarious livelihoods continue to drive many young people to pursue migration, often investing substantial sums of money that could otherwise support viable businesses within Ethiopia. Despite all the risks, peer influence, accounts of successful migration and aspirations for improved living standards sustain the persistence of these attempts. Bereket, a 31-year-old man from the Addis Ababa site who was previously forced to return from the Sudanese border, remains determined to again attempt irregular migration by saving funds to cover the costs of his journey:

“Twenty of my friends left for Europe and only four of us remain here. Those who migrated have purchased houses here costing six to seven million birr. They have transformed their lives … I am saving money, yes. It costs roughly 950,000 birr to get to Italy. To get to England, you will need 1.3 million birr. I have absolutely no interest in living here because what can I do here with 1.3 million birr? The taxes and workplace rent are a waste of money

if you attempt to work here. Nothing will change in your life. I have no idea what will occur, even in a week. I will not give up on my plan to travel elsewhere. ”

Others who attempted to migrate abroad were forcefully deported:

“ In 2018, I tried to migrate to Saudi Arabia after completing Grade 10. I decided to migrate because my friends convinced me. I told my parents about my plan but they were not convinced. I contacted them in Addis Ababa and asked them for money, which they sent me. The journey took three months. We were starving. We used to eat packed food only twice per day. I was caught … before reaching Saudi Arabia and sent back. ”
(Million, 24-year-old woman, rural Tigray)

High costs of illegal migration

Illegal migration is not only risky but also expensive, often requiring payments to brokers and, in some cases, ransoms demanded by traffickers. This places a heavy financial burden on families. Families have resorted to begging and seeking contributions from relatives, community members and even churches to secure the release of children who have been subjected to extortion along migration routes. A local administrator in Tigray highlighted the severe economic strain and social burden that irregular migration continues to impose on families and local communities:

“ Human traffickers are kidnapping youth from this area to Afar and the Red Sea coast, demanding up to 300,000 birr in ransom. If this is not paid, victims may be killed. Desperate parents often seek letters from our administration office to beg for help. This crisis is severely affecting the community. ”

Gender dynamics of migration

Men and women both migrate, but they face different challenges and opportunities. Women are often employed as domestic workers, where they face the risk of sexual harassment and violence, while men often engage in more hazardous but potentially more lucrative forms of employment. Young women, in particular, are vulnerable to deception during migration, which can bring significant hardships for themselves and their families. An official gender expert in Tigray explained how illegal migration affects girls and young women:

“ Underage girls are illegally recruited from school without their parents' knowledge. Midway through the journey, smugglers contact parents and demand immediate ransom, threatening to kill the girls if this is not paid. Parents, under pressure, sell oxen, harvested crops or borrow money to pay. Many girls die in the desert despite payments, leaving households in severe economic crisis. ”

Even young girls who successfully reach their destinations often frequently encounter labour exploitation, abuse and significant challenges in adapting to unfamiliar cultural environments. Ebiyti, a 31-year-old woman from the rural Tigray site who had migrated at age 15 for employment, found it particularly difficult to adjust to both the cultural context and the workload, ultimately returning home without achieving her economic dreams:

“ In 2010, I migrated to Sudan for domestic work at a residential house. Everything was difficult to get used to. The language was difficult [to understand]. I missed my family and I was told my father died. I had to return home after a year with no savings. ”

Individual success stories often keep dreams of successful migration alive

Most young people's international migration attempts were unsuccessful or they returned home with little or no income. However, a few have successfully realised their migration aspirations, generating earnings, sending remittances to their families, or returning to establish improved economic circumstances:

“ When we were living in a rented house, the landlord used to pressure my mother either to pay more rent or leave the house. Then I decided to migrate, earn good money and build a house for my mother. I migrated to Saudi Arabia in 2012 and sent money back. My family built a house with the money I sent. I fulfilled my aspiration. But I missed my higher education dreams. ”
(Mulu, 31-year-old woman, urban Tigray)

Although she was unable to pursue her educational aspirations, Mulu has improved her family's livelihood. Such exceptional success cases motivate others to follow their example and migrate.

Key findings on migration

- Over half (58%) of the young people interviewed in Qual 6 had migrated in recent years, including both domestic and international migration, driven by a range of factors including employment, education, marriage and family formation and conflict.
- Migration patterns vary by region, location, age cohort and gender. Mobility is higher among young men and those from urban areas, while those with better local opportunities, such as in Addis Ababa, typically show lower domestic migration but stronger aspirations to migrate internationally.
- War and conflict have displaced many young people in Amhara and Tigray, leading to temporary or permanent relocation in search of safer environments, disruption of education, and economic hardship.
- Gender differences in migration persist. While employment is the primary driver of migration across all groups, men in the Younger Cohort are more strongly influenced by conflict, while younger women are more strongly influenced by education, marriage or family-related reasons.
- Domestic migration is driven by various factors. Young men often move regions to engage in seasonal labour, while young women typically move from rural communities to urban centres in search of domestic work, or move for marriage and family formation.
- International migration is increasingly seen as a pathway to a better future for both men and women, but frequently involves irregular and risky routes, exposing young people to financial loss, physical harm, potential deportation and even loss of life.
- Young women are particularly vulnerable to exploitation, sexual harassment and deception during migration, while men tend to take more hazardous but potentially lucrative work.
- Despite the challenges, some migrants have achieved success, sending remittances home, building family wealth or establishing businesses, demonstrating resilience and determination and inspiring others to seek a perceived better life overseas.

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Acknowledgements

This report was written by Yisak Tafere, Nardos Chuta, Alula Pankhurst and Kath Ford. The authors thank Fiona Curtin for her invaluable assistance in reviewing and editing an earlier draft of this report, and Marta Favara, Kauser Mohsini, María Molina and Tanima Tanima for their insights, comments and suggestions. Special thanks to Kefyalew Endale for the analysis of Young Lives quantitative data and compiling the literature review on health services and analysis of health expenditure and health outcomes (Endale, 2026). Thanks also to Adam Houlbrook for copyediting and Garth Stewart for design, and Penny Rudling for overseeing the publication process.

We particularly wish to thank the Young Lives participants, their families and community members for generously giving us their time and cooperation.

We also sincerely thank our fieldwork teams for their dedication and expertise. Many have contributed to multiple rounds of Young Lives' research and possess deep knowledge of the communities involved, including Asmeret Gebrehiwet, Aster Shebeshi, Bizayehu Ayele, Gezach Weldu, Kiros Berhanu, Medhane Zekarias, Mesfin Minase, Solomon Gebressilasse, Yeshi Mulatu and Yilkal Tariku. They have been ably supported by Chanie Ejigu and overseen by Tassew Woldehanna.

Special thanks to the UK's Foreign, Commonwealth & Development Office (FCDO) and Irish Aid for co-funding the sixth wave of Young Lives qualitative research in Ethiopia and the publication of this report.

The views expressed are those of the authors. They are not necessarily those of, or endorsed by, the University of Oxford, Young Lives, the UK Government, the Irish Government, or other funders.

Irish Aid
An Roinn Gnóthaí Eachtracha
Department of Foreign Affairs

Young Lives is a longitudinal study of poverty and inequality, following the lives of 12,000 young people – from infancy to adulthood – in four countries (Ethiopia, India, Peru and Vietnam).

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