

NATIONAL ADOLESCENT AND YOUTH HEALTH STRATEGY (2016-2020)



FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA
MINISTRY OF HEALTH

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(2016-2020)

OCTOBER 2016

Acknowledgments

The Ministry of Health of Ethiopia has been spearheading the execution of the national adolescent and youth sexual and reproductive health strategy whose implementation culminated with the fourth health sector development program (HSDP-IV). This National Adolescent and Youth Health Strategy, brings out Ethiopia's commitment to transforming the health and wellbeing of the nation's adolescent and youth population.

The Strategy is not only a representation of the Government's continued dedication to the betterment of its citizens; it is also a milestone of extended period of work at the Ministry and specifically within the maternal and child health program. The Strategy goes beyond sexual and reproductive health and HIV, and presents an elaborated strategic framework to tackle the broader aspects of health and health related conditions. Non-communicable diseases comprising of nutrition, cardiovascular diseases, diabetes, mental health issues and psychosocial health issues, substance use, and injuries, as well as violence including gender-based violence, are duly addressed. It also realizes the efforts of sectors other than health required and further provides strategic directions towards institutionalizing partnership and collaboration in order to garner multi-sectoral support on improving the overall status of adolescents and youth in Ethiopia. The Strategy pledges commitments to local initiatives framed in the national health policy and to international initiatives, in 2015 and beyond.

This National adolescent and youth health strategy (2016-2020) was prepared by the Ministry of Health. The work involved in-depth consultations with a wide range of stakeholders through literature review, interviews, consultative meetings and reviews of the various drafts of the Strategy. The Ministry of Health feels greatly indebted to individuals and organizations who contributed in one way or another to this elaborate process. The Ministry of Health highly recognizes the partner organizations who were involved in the review of this strategy, and for the individuals who worked tirelessly with the consultants at each stage of the process.



Ephrem T. Lemango (MD, MA)
Director, Maternal and Child Health Directorate
Ministry of Health of Ethiopia

Preface

The World Health Organization (WHO) defines adolescents as those between the ages of 10-19 years and those 15-24 years as youth. The National Youth Policy of Ethiopia classifies youth as those between the ages of 15-29 years. Ethiopia has a rapidly growing population of adolescents and youth 33.8% of the estimated total population of 90 million (CSA, 2015). This young population has implications on the social, economic and political agenda of the country as it puts great demands on provision of health services, education, water and sanitation, housing and employment. At the same time, it provides opportunities for the country's development if its health and developmental needs are addressed including the attainment of educational goals and an all-round preparation for responsible adulthood. Reduction in fertility rate, coupled with improvement in health and capacity development for adolescents and youth, will help in reaping the benefits of the demographic dividend. Therefore, close attention from all sectors of government, development partners and other stakeholders is of paramount importance in attaining the goals of the Growth and Transformation Plan (GTP-2) and the Post-2015 Development Agenda of the Sustainable Development Goals (SDGs). Following the 2004 National Youth Policy, Ethiopia's first Adolescent and Youth Reproductive Health (AYRH) Strategy was developed in 2006 and implemented from 2007 to 2015. The government has made concerted efforts to respond to the needs of adolescents and youth by providing opportunities for economic development and skills development.

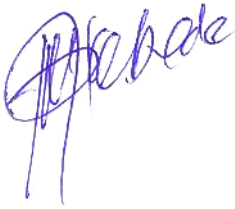
The 2007-2015 strategy laid the foundation for development of related policies, strategies and guidelines on AYSRH, enhanced partnerships between government, non-governmental and civil society organizations. It also provided a platform for improvement of knowledge and attitudes towards AYSRH among adolescents and youth, parents, health workers, teachers, religious leaders and community members. To some extent it has encouraged adolescents and youth to utilize available health services. These in turn improved the environment for implementation of adolescent and youth sexual and reproductive health (AYSRH) programs and services in the country.

Various challenges ranging from limitations in the scope of the strategy, lack of coordination among implementing partners, low stakeholder and youth involvement, inadequate resources, and social and cultural barriers to AYSRH are faced in implementing the strategy. Furthermore, local and global changes have occurred in the demographic, social, economic and technological environment that influence policy and program decisions. Particularly, ongoing changes in the epidemiological profile of adolescents and youth health conditions have been driving a shift in paradigm beyond SRH/HIV towards addressing the full spectrum of AYH and development problems and their determinants to design a comprehensive health sector response strategy.

Therefore, a comprehensive national adolescents and youth health strategy was needed. This National Adolescent and Youth Health (AYH) strategy, developed in response to the aforementioned fact, puts the strategic framework for tackling the full range of adolescents and youth health and development issues in Ethiopia. The Strategy aims to improve the overall health status of adolescents and youth in Ethiopia and contribute towards realization of their full potential in

national development. The strategy enhances and sustains the mainstreaming of adolescents and youth health and rights issues into the country's growth and transformation agenda and helps achieve the post-2015 global goals including the Global Strategy for Women's, Children's and Adolescent's Health 2016-2030. Through the implementation of this strategy, the country is expected to empower and engage adolescents and youth, their families and the community at large for better health, development and wellbeing of Ethiopian adolescents and youth. The Ministry of Health (MOH) will put every endeavor to strengthen partnership and coordination among stakeholders at all levels and develops a mechanism for joint ownership of the adolescent and youth health program in the country.

Finally, on behalf of the Ministry of Health, I would like to take this opportunity to call up on for concerted efforts of all donors, partners and stakeholders in health and development to extend their support for successful implementation of this strategy. Moreover, I would also like to urge all our stakeholders to use this National Adolescent and Youth Health Strategy as a guiding framework for their programs and interventions.



Kebede Worku (MD, MPH)
State Minister
Ministry of Health of Ethiopia

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Acronyms

AACSE	Age Appropriate Comprehensive Sexuality Education
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AYFHS	Adolescent and Youth Friendly Health Services
AYH	Adolescent and Youth Health
AYRH	Adolescent and Youth Reproductive Health
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BSS	Behavioral Surveillance Survey
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CPD	Continuous Professional Development
CQI	Continuous Quality Improvement
CSA	Central Statistical Agency
CSE	Comprehensive Sexuality Education
CVD	Cardio Vascular Disease
DHS	Demographic and Health Survey
EDHS	Ethiopian Demographic and Health Survey
e-health	Electronic Health
EMDHS	Ethiopian Mini-Demographic and Health Survey
ESPA+	Ethiopian Services Provisions Assessment Plus
FBO	Faith-Based Organization
FGAE	Family Guidance Association of Ethiopia
FGM/C	Female Genital Mutilation/Cutting
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FP	Family Planning
GBV	Gender-Based Violence
GOE	Government of Ethiopia
GTP	Growth and Transformation Plan
HC	Health Centre
HDA	Health Development Army
HEI	Higher Education Institution
HEP	Health Extension Program

HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
HPN	Health, Population and Nutrition
HPV	Human Papilloma Virus
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
HTP	Harmful Traditional Practice
ICASA	International Conference on AIDS and STIs in Africa
ICFP	International Conference on Family Planning
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IGA	Income Generating Activities
IFHP	Integrated Family Health Program
IPLS	Integrated Pharmaceuticals Logistics System
IPV	Intimate Partner Violence
IRT	Integrated Refresher Training
JCF	Joint Consultative Forum
LMIC	Low- and Middle-Income Countries
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHD	Maternal and Child Health Directorate
MDA	Men Development Army
MDG	Millennium Development Goal
m-health	Mobile Health
MICS	Multi-Indicator Cluster Surveys
MNCH	Maternal, Neonatal and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
MOWCYA	Ministry of Women, Children and Youth Affairs
MSI	Marie Stops International
MTCT	Mother-To-Child Transmission
NCD	Non-Communicable Diseases

NGO	Non-Governmental Organization
NHA	National Health Account
NNS	National Nutrition Strategy
OHT	One-Health Tool
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PIE	Pathfinder International Ethiopia
PMA	Performance Monitoring and Accountability
PMTCT	Prevention of Mother-To-Child Transmission
PNC	Postnatal Care
RHB	Regional Health Bureau
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RTA	Road Traffic Accident
SBA	Skilled Birth Attendance
SDG	Sustainable Development Goal
GBV	Sexual and Gender-Based Violence
SLOT	Strengths, Limitations, Opportunities and Threats
SMS	Short Text Message
SNNPR	Southern Nations, Nationalities and People's Region
SO	Strategic Objectives
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TOT	Training Of Trainer
TVET	Technical and Vocation Education and Training
TWG	Technical Working Group
UN-CRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Fund for Population Activities
UNGS	United Nations Global Strategy
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UHC	Universal Health Coverage
VERA	Vital Events Registration Agency
WDA	Women Development Army
WHO	World Health Organization
WMS	Welfare Monitoring Survey

Executive Summary

The World Health Organization (WHO) classifies persons in the age range of 10-19 years as adolescents and those 15-24 years as youth. While the adolescent classification is mostly universal, different continents or nations adopt different age ranges for youth. The definition of youth is also influenced by the constant changes in demographic, economic, and socio cultural circumstances. In the African Youth Charter, youth are people 15 to 35 years. The National Youth Policy of Ethiopia adopts the age of 15-29 years for youth.

The demographic dynamics within this group associated with its socio-economic values have attracted growing attention to the health of adolescents and youth in Ethiopia. Ethiopia's first Adolescent and Youth Reproductive Health (AYRH) Strategy was developed in 2006 through which a number of initiatives have been undertaken over the last decade. The government has made concerted efforts as part of the first Growth and Transformation Plan (GTP-1) to respond to the needs of adolescents and youth by providing opportunities for skill and economic development. There have been improvements in the policy and legal framework for adolescent and youth health and development, in the incidence and prevalence of HIV and STIs, and in the knowledge and attitudes towards AYSRH.

However, besides limitation in scope, the AYSRH strategy was also challenged by lack of multi-sectoral collaboration, low stakeholder and youth involvement, inadequate resources, and persistent social and cultural barriers to AYSRH. As a result, limitations still exist and adolescents and youth continue to face particular challenges to their health and development. Thus, the need for a comprehensive adolescent and youth health responsive strategy is imperative.

The preparation of the new strategy was informed by far reaching situational analysis of the trends in the mortality, morbidity, and the health system response to adolescent and youth health and development in Ethiopia. The analysis found that the health and development of adolescents in Ethiopia are determined by broad ranging health and health related behavioral conditions as SRH and HIV remain the main concern. Hence, the strategy is the first of its kind that goes beyond SRH, HIV, and addresses such target conditions as nutrition, mental health, substance use, non-communicable diseases, intentional and unintentional injuries, various forms of violence, and risks and vulnerabilities associated with disability, identified by the situational analysis.

The strategic framework is built on a set of key guiding principles. It aims to contribute to the improvement of the health of adolescents and youth through the development and strengthening of an integrated health sector response and the implementation of effective health promotion, prevention, and care programs. It employs six minimum health goals to be achieved by 2020:

- Reducing mortality and morbidity by 50%
- Reducing suicide rate by 50%
- Reducing mortality from road traffic accident by 25%
- Reducing pregnancy related deaths by 50%
- Reducing HIV incidence by 75% and,

- Reducing adolescent pregnancy rate by 75%

In order to meet these overarching goals, the strategy proposes six strategic objectives for action and promotes their systematic and simultaneous integration to address the primary causes of mortality and morbidity and fundamental social, behavioral and cultural factors. These are:

- Increasing access to AYH information and age appropriate CSE and life-skills education;
- Enhancing equitable access to high quality, efficient and effective adolescent and youth-friendly health services;
- Strengthening strategic information and research on adolescents and youth;
- Promoting a supportive and enabling policy environment;
- Supporting and facilitating youth engagement and ownership of health programs; and
- strengthening inter-sectoral coordination, networking and partnership

The framework also employs twenty-four outcome targets by key program priority areas based on the target conditions. Its respective implementation strategies, performance targets and priority interventions accompany each of these priority areas. It outlines the implementation arrangement and service delivery strategies based on the life cycle approach aligned with the HSTP's strategic lines of Population Oriented Outreach/Schedulable Services, Family Oriented Household Services, and Individual Oriented Clinical Services.

Measuring performance against set targets in the AYH program is crucial to generating essential information to guide strategic investments and operational planning. Monitoring and evaluation of the AYH strategy will rely on various systems and data sources (HMIS, population surveys, research) and aligns with performance tracking of the overall health system.

The overall cost of implementing the strategy is estimated at ETB 37.8 Billion for the five-year period. This overall cost reflects the financial sum of two categories of costs: 98 percent or ETB 36.9 Billion is the money for implementing mainly service delivery activities in integration with the mainstream primary health care programs and thus already wedged in the costed plans of the respective national program strategies and includes the following:

- Healthcare cost for delivering services on SRH, HIV/AIDS, nutrition, mental and psychosocial health, NCDs and injuries (calculated as drugs and supplies cost) – ETB 28,663,324,014.00
- Cost for supervision, review and coordination – ETB 93,994,789.00
- Infrastructure and equipment cost – ETB 8,142,526,830.00
- General program management cost – ETB 595,833.00

The second category is the new/additional money of ETB 867.5 Million or just 2 percent of the overall cost required for implementing activities that are specific to the AYH program; and includes costs for the following:

- Designing the new AYH training curriculum and developing the training package – ETB 223,324,992.00
- Training of health care providers and managers on AYH – ETB 1,959,923.00
- M&E, quality and research on AYH – ETB 10,688,177.00

- Communication, media and outreach activities – ETB 640,941,996.00
- Developing the minimum interventions package, the service protocols and related technical guidelines – ETB 1,250,000.00

1. INTRODUCTION AND RATIONALE



There are many reasons for the growing attention to the health of adolescents and youth in Ethiopia. First, this group comprises a significant proportion (33.8%) of the country's population. Second, as this cohort joins the workforce, the foundations laid in health will have profound implications for social, political, and economic development. This is particularly important given the declining fertility and mortality trends in Ethiopia. Third, healthy adolescents are a key asset and resource, with great potential to contribute to their families, communities and the nation both at present and in the future as actors in social change, not simply beneficiaries of social programs. The surge of interest in adolescent and youth health also responds to the improved global understanding of the developmental process that takes place during adolescence which guides designing and delivering tailored interventions for subgroups in this segment of the population.

A number of initiatives have been undertaken in Ethiopia over the last decades culminating in the launching of the National Adolescent and Youth Reproductive Health Strategy (AYRH) in 2006. The nine year (2007-2015) National AYRH Strategy sought to provide a multi-sectoral support to every young person living in Ethiopia with education and information that will lead to the adoption of a healthy lifestyle physically, psychologically and socially. This was to be achieved through provision of age and sex appropriate information and counseling, comprehensive health services complemented by self-care, livelihood and leadership skills or competencies.

Accordingly, many gains have been achieved. The rate of new HIV infections among 15-24 year youth has decreased significantly, the proportion of females aged below 20 years who deliver with the assistance of a skilled provider increased to 40 per cent. On the other hand, teenage pregnancy remains high (12%). Health services for adolescents are largely not integrated, are of poor and

uneven quality and coverage, with inequity in access and utilization, and are generally limited to SRH, HIV and STIs and do not fully address the broader health and health-related problems faced by adolescents and youth.

Thus, it is imperative that a new Adolescent and Youth Health Strategy for the period 2016-2020 is developed to guide programs to mitigate the dual challenge that the country faces from the emerging health threats as well as those from the unfinished agenda of preventable death and infectious diseases among its large adolescent and youth population. The formulation of this strategy is informed by the findings of the comprehensive and participatory situational analysis on adolescent and youth health in Ethiopia conducted in October and November of 2015.

The strategy goes far and beyond SRH, HIV and STIs to provide broad strategic directions to promote, prevent, and protect the health and wellbeing of Ethiopian adolescents and youth. It incorporates current recommendations on policies and programs that respond to priority health needs of the adolescent and youth, reflects the evidence base for action, captures new interventions and service delivery mechanisms, and guides on building a framework of focus to continually improve the health and development of adolescents and youth through their participation and engagement, and through effective coordination with public, private, NGO, local and international partners.

2. BACKGROUND



2.1. Political and Administrative Structure

Ethiopia is located in the horn of Africa covering an area of approximately 1.14 million square kilometers. It is bordered by Sudan and South Sudan on the West, Somalia and Djibouti on the East, Eritrea on the North and Kenya on the South. The country is administratively sub-divided into nine regional states: Tigray, Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, Southern Nations, Nationalities, and People's Region (SNNPR), Gambella and Harari, and two Administrative councils: Addis Ababa and Dire Dawa. The regions are divided into zones, woredas, and Kebeles, which are the lowest level of administration (MOH, 2014).

2.2. Demography

Projection from the 2007 population and housing census estimates the total population of Ethiopia for the year 2015 to be 90 million (CSA, 2015). According to the Ethiopian Mini-Demographic and Health Survey (EMDHS) (CSA, 2014), the country is characterized by a young population with 33.8% of its population being in the age range of 10-24 years. The age group 10-14, 15-19, and 20-24 account for 15.6%, 10.6%, and 7.6% respectively.

Ethiopia is in its second phase of the demographic transition. As the country passes through this phase, the supply of labor increases in two ways as the number of people in the working-age [15-64 years] increases, labor force gets bigger, and as fertility declines, women get more time away from childbearing and are more likely to enter the labor market. This creates a temporary period of time during which higher than average share of the population is constituted of the working-age group with a bulge in the youth population. With fewer people to support, the youth bulge translates itself into the demographic window of opportunity or a potential resource base waiting for use.

When the right social and economic policies are in place and investments are made congruent with the demand of the opportunities created, the potential to reap the benefits of demographic dividend is immense. Currently, the country is advancing with enacting and implementing favorable policies and strategies in all sectors and expects to reap the benefits of the demographic dividend in the near future. Ethiopia's first demographic dividend is projected to open in 2028 and close in 2062 (Degefa T, 2014).

2.3. Education

Education is a key determinant of individual opportunities, attitudes, as well as socio-economic development and hence is considered basic human right. Educational attainment has a strong effect on the health status, exposure to health risks, access to health services and health seeking behavior. The Government of Ethiopia (GOE) duly emphasizes on improving the educational status of its citizens as evidenced by the rapid expansion of primary, secondary and tertiary level educational institutions. The GOE's policy on women/girls empowerment through enhancing girls' education contributed to the consistent increase in the proportion of girls enrolled in primary and secondary education, exceeding 45% in 2014. The policy also has markedly improved the educational attainment of women/girls. In 2013/14, there were 21.2 million children in 30,800 primary and 2,333 secondary schools. More than 1.7 million youth were attending higher education in 1,312 TVETs and 33 universities in 2014 alone (MoE,2015).

2.4. Social and Economic Context

Adolescence and youth is a transition phase from childhood to adulthood, characterized by a number of cognitive, emotional, physical, intellectual and attitudinal changes as well as by changes in social roles, relationships and expectations. Despite the drop in the rate of unemployment among youth from 11.1 percent in 2011 to 7 percent in 2013 (MOWCYA, 2014), a significant number of youth are in poor economic conditions due to unemployment. The increasing migration of adolescents and youth from rural to urban areas further aggravates the situation.

Recreation

The benefit of recreation to overall development of adolescents and youth is found to be vital. In terms of health outcomes, different researches indicated that recreation reduces depression, relieves stress, and improves quality of life through enhancing self-esteem development; mature reasoning skill and more assertion behavior than aggression. The family, community, schools, the media, cultural institutions and religious organizations are the major institutions from which adolescent and youth spend most of their time. However, in the current era of globalization, the adolescent and youth are influenced by various other forces in degenerating and harmful ways.

2.5. Health System Organization

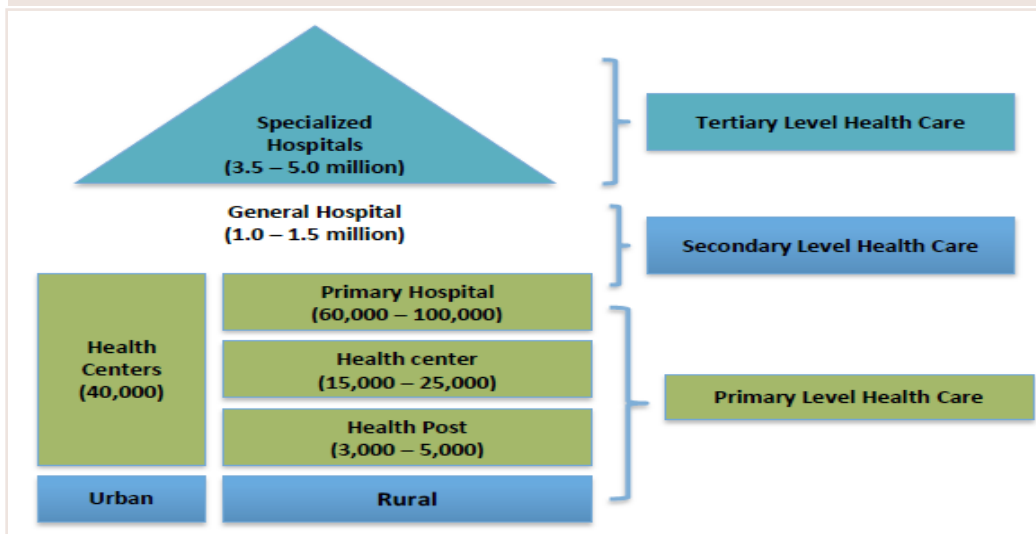
Ethiopia’s health care system is structured into a three-tier system: primary, secondary and tertiary level care. The system offers the largest available platform for the provision of health services for adolescents and youth with a primary focus on SRH.

Primary level health care is composed of a primary health care unit (PHCU)-an average of 5 health centers with five satellite health posts each and a primary hospital.

Secondary level health care comprises a general hospital, which provides inpatient and ambulatory services to an average of 1 million-1.5 million people. With an average of 234 staff, a general hospital serves as a referral center for primary hospitals and as a practical training center for both undergraduate and postgraduate programs in medicine and other health sciences. In addition to the AYFH services provided at the primary health care level, general hospitals provide specialty services in different disciplines and referral and linkage between facilities.

Tertiary level health care is provided by a specialized hospital for an average of 3.5 million - 5 million people with a standard staffing of 440 health workers. Specialized hospitals receive referrals from general hospitals, and are the ultimate centers for all health care services including AYFH services.

Figure 1: The ‘three tier’ health system of Ethiopia



3. SITUATION ANALYSIS

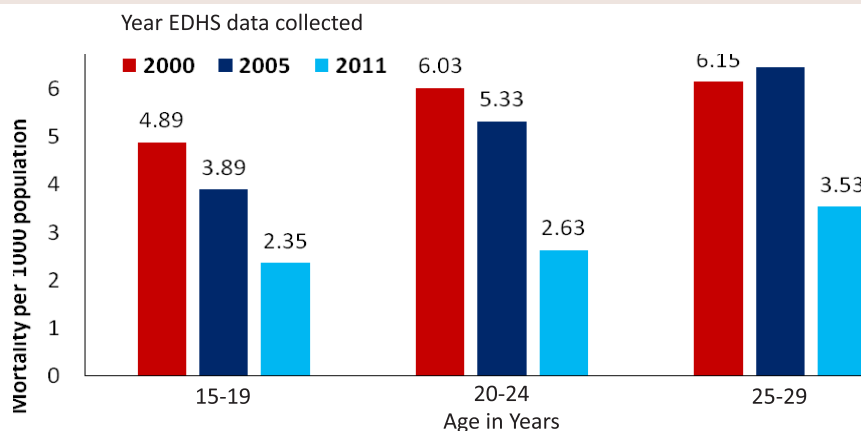


Mortality and morbidity among adolescents and youth in Ethiopia are associated with a range of health and health-related behavioral problems as well as access to and utilization of quality health services. This section describes the results of the analyses on the situation of mortality and morbidity, and the status of the health sector response on adolescent and youth health in Ethiopia.

3.1. Mortality Analysis

The overall mortality rate of any cause among Ethiopian adolescents and youth 15-29 years has shown significant decline in the last decade. Specifically, the age-adjusted female mortality rate (15-19 years) has dropped by more than half (from about 4.89 in 2000 to 2.35 deaths per 1,000 populations in 2011). The risk of mortality in females is known to increase as they enter the reproductive age because of pregnancy related health problems. However, a progressive increase in mortality rates was reported among males. Male adolescents are at higher risk of mortality than their female counterparts, mainly due to exposure to road accidents and interpersonal violence. Otherwise, population based studies indicate a parallel increased risk of mortality with age for

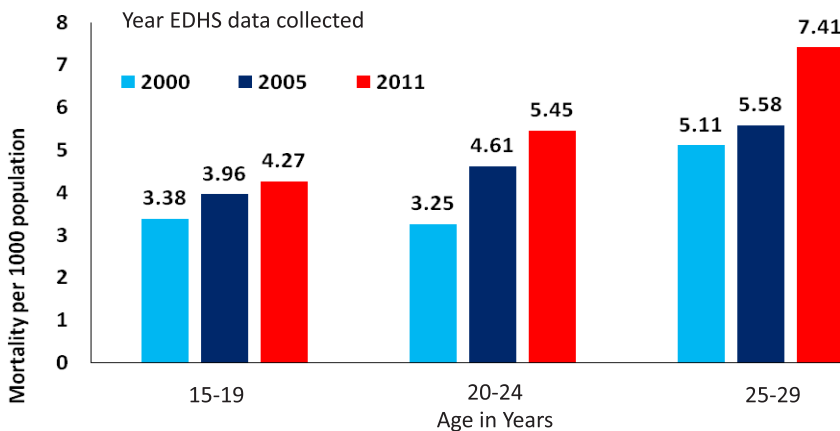
Figure 2: Female mortality rates in the age category of 15-29 years for the period of 0-6 years prior to each EDHS survey, 2000, 2005 and 2011



Ethiopia, which is in line with the 2012 WHO Global Health Report (*CSA and ORC Macro, 2000, 2005, 2011, WHO, 2012*).

According to the WHO 2012 Global Mortality Data, the top five causes of mortality among adolescents were road injury, HIV, suicide, lower respiratory tract infections and interpersonal violence. In the 15-19 age category, however, maternal causes are the second highest particularly in Africa where the late adolescent maternal mortality rate is about 34 per 100,000 people. Generally, unintentional injuries (road injuries, accidental drowning) take the lead in all continents, all age groups and all sexes as a cause of adolescents' mortality.

Figure 3: Male mortality rates in the age category of 15-29 years for the period of 0-6 years prior to each EDHS survey, 2000, 2005 and 2011



3.2. Morbidity Analysis

3.2.1. SRH, HIV, STIs

Existing evidences show that the major sexual and reproductive health problems of adolescents and youth in Ethiopia include risky sexual practices, child marriage, early child bearing, unintended pregnancy, unsafe abortion and its complications and STIs including HIV.

Early sexual debut and teenage pregnancies are common owing to the high rate of child marriages and the subsequent family and societal pressure on girls to prove their fertility. The median age at first sex for women is 16.4 years (PMA, 2015). Uneducated, poor and rural girls start sex at younger age compared to the educated, well-to-do and urban. About 40% of girls marry before the age of 18 years and 20% before 15. About of half (45%) of girls in Amhara marry before the age of 18.

The consequences of child marriage are many. Above all, early initiation of sexual intercourse is a risk for unintended pregnancy which in turn is the major reason for undesirable health and socio-economic consequences mainly induced/unsafe abortion, high fertility, obstructed labor and its complications such as obstetric fistula, and hypertensive disorders of pregnancy.

High rate of unintended pregnancy is also associated with the low utilization of family planning services by young people. The current contraceptive prevalence rate of 9% and unmet need of 30% among teenage girls (15-19) are among the lowest in sub-Saharan Africa. This is due to low access

to adolescent and youth friendly services including family planning in this age group compared to older women. The following table shows contraceptive methods mix of adolescent and youth. (CSA 2014)

Table 1: Percentage distributions of contraceptive methods (mix) among married and non-married female adolescents and youth (CSA 2014)

Age group	Any methods	Any modern	Pills	IUD	Injectable	Implants	Male condom	Any traditional
15-19	9.3	9.2	1.0	0.3	7.1	0.7	0.1	0.1
20-14	30.0	29.3	2.2	0.9	21.2	4.9	0.1	0.7
25-29	39.2	37.6	2.5	0.6	28.9	4.6	0.4	1.6

Sources: E-MDHS 2014 (CSA, 2014)

Furthermore, lack of skilled care during pregnancy and delivery in this age group also poses significant health risk to the mothers and their children compared to older women in the reproductive age group. Adolescence is particularly characterized by menarche among girls. In Ethiopia, most girls are in school between the ages 10-14 years, coinciding with menarche. Although menstrual management is included, many girls do not always have the right information on how to deal with it. Studies indicate that only 51% of school girls know about menstruation and its management, only one-third use sanitary napkins as menstrual absorbent during menstruation and, a high proportion (>50%) avoid going to school at the time of menstruation (Tegene et. al, 2014).

Evidence indicates that there is increased risk of acquiring STIs and HIV among adolescents and youth due to the early initiation of sexual intercourse and higher-risk sexual behavior. Such higher-risk behaviors include sexual intercourse with multiple partners or casual partner. Use of alcohol and drugs is known to drive young people into higher-risk sexual behavior. Furthermore, transactional sexual relationship among young people has become an emerging contributing factor to HIV/STIs. It involves socially recognized “exchange of material goods within sexual relationships, including food, cash, cosmetics, transport, mobile phone and items for children, school fees.” Technology perpetuates risky sexual behavior from exposure to sexually explicit materials in movies and the internet.

A meta-analysis has shown that out of 19,148 males aged 15-24 years who reported having sexual intercourse in the 12 months preceding the survey, 75% engaged in higher-risk sex. Specifically, the proportion of higher-risk sex among male youth aged 15–19 years was nearly 90% in 21 of the 26 countries surveyed (including Ethiopia).

The prevalence of HIV among adolescents and youth in Ethiopia particularly in the younger age group (15-19) is relatively lower (<1%) than other African countries. This is in contrast to the expected high prevalence of the disease thought to result from the high proportion of high risk sex in this age group. Prevalence is generally higher among females and increases by age: lowest (0.1%) for the 15-19 year olds, 0.6% for 20-24 year olds and 2.0% for 25-29 year olds.

In Ethiopia, comprehensive knowledge of HIV/AIDS among youth is relatively low: 24% for girls and 35% for boys. In-school and out-of-school government or NGO sexuality education programs are fragmented and non-standardized. As a result, awareness about SRH matters is generally low among Ethiopian adolescents and youth. All of these evidences suggest the need for specific interventions to reduce the risks and vulnerabilities of adolescents and youth to STIs including HIV in the country.

3.2.2. Adolescent Nutrition

Adolescence is a second window of opportunity for growth next to the first one thousand days. Adolescent girls are particularly vulnerable to malnutrition because they are growing faster than at any time after first 1000 days of life. They need protein, iron, and other micronutrients to support the adolescent growth spurt and meet the body's increased demand for iron during menstruation. When the iron demands of pregnancy are combined with the iron demands of adolescent growth, girls enter adulthood at great risk of iron deficiency. However, many boys and girls in developing countries enter adolescence undernourished, making them more vulnerable to disease and premature death. Low maternal pre-pregnancy body mass index is a known determinant of low birth weight, and contributes to the intergenerational cycle of malnutrition. The size and body composition of the mother at the start of pregnancy is one of the strongest influences on fetal growth (Kramer, 1987).

Chronic malnutrition and iron deficiency anemia are the most common forms of malnutrition among Ethiopian adolescent girls. Thirty-six percent of non-pregnant adolescent girls aged 15-19 years are chronically malnourished (BMI <18.5) and the prevalence of anemia in the same group is 13%. At the same time, 2.2% of the girls and 0.3% of the boys in this age group are overweight.

3.2.3. Substance Use

Use of and addiction to narcotic or psychotropic substances affects an individual's health and psychosocial behaviors. In Ethiopia, addictive substances such as Khat, tobacco and alcohol are widely used by adolescents and youth.

About 4.4% of Ethiopian adolescents and youth smoke cigarettes or other tobacco products. The practice is more common among urban adolescents and youth and among those in Harari, Somali and Dire Dawa regions. Nearly half (45.6%) consume alcohol more than six times in a month. Prevalence of alcohol consumption is higher among male (47.7%) than female (43.5%) adolescents and youth, among rural than urban residents. In terms of regional prevalence, alcohol consumption is higher among adolescents and youth in the regions of Amhara, Benishangul-Gumuz, Tigray and Afar compared to the other regions. Recent evidence shows that 36.6% of 15-29 years adolescents and youth are using any form of alcohol, higher among males-42.6% than females-29.5% (EPHI, 2015).

Khat is a chewable shrub that contains the stimulant chemical Cathinone known to have no therapeutic effect but predisposes to dental, gastro-intestinal, hypertensive, cardiac and mental health problems with significant economic loss to individuals. Furthermore, as a precursor to the

initiation of smoking, Khat chewing is presumed to increase the prevalence of smoking cigarettes, Shisha and other highly addictive drugs such as heroin and cocaine. The national prevalence of Khat consumption among adolescents and youth is 51%; higher among males (56.5%) than females (36.6%). Khat chewing is common in rural than urban areas as well as in Harari, Dire Dawa, Somali and Amhara than the rest of the country (CSA and ORC Macro, 2011). Among the currently 15-29 years olds the average age of starting to chew Khat is 16.9 years (EPHI, 2015).

3.2.4. Mental Health

In Ethiopia, mental illness is the leading non-communicable disorder in terms of burden. At a prevalence of 12-25% childhood mental illnesses make the highest burden of mental illnesses in the health sector. Mental health problems related to alcohol and substance use, schizophrenia, seizure disorder and bipolar disorder affect 0.5 to 1.5% of the Ethiopian population (MOH/HSTP, 2015). In the face of the lack of appropriate data, it is viable to deduce that mental illness and related conditions are among the main contributors for compromising the quality of life and productivity of adolescents and youth, owing to their high proportion among the general population. Through implementing the national mental health strategy, the MOH has made significant strides in expanding mental health care integrated in the mainstream primary health care system. However, limited access to these services remains an important challenge to effectively combat mental health concerns of adolescents and youth.

3.2.5. Non-Communicable Diseases

Studies indicate that NCDs are an emerging epidemic in Ethiopia and other low- and middle-income countries because of the increasing urbanization and the related changes in lifestyle and dietary habits. According to the 2010 WHO-NCD country profiles, NCDs are estimated to account for 34% of all deaths in Ethiopia across all age groups; where cardiovascular diseases (CVD) accounted for 15%, cancers for 4%, respiratory diseases for 4%, and diabetes for 2%. NCDs also cause significant morbidity both in urban and rural populations, with considerable loss in potentially productive years of life. The overall prevalence of diabetes in the general population is estimated at 3%, and that of hypertension ranges from 9% in rural to 30% in urban settings of Ethiopia. Nationally representative surveys or studies on the prevalence of NCDs and their risk factors among adolescents and youth are not available.

A study that included all the ten sub-cities of Addis Ababa revealed that the prevalence of hypertension among young people aged 18-24 in Addis Ababa is 6.2%, significantly higher in men than women, and increasing by 10% for every decade of life. Nearly one-half (45%) have Stage II hypertension, implying the risk for target organ damage, and existence of population that should have been on treatment but unaware of their BP (Abdissa S. et al, 2014). In general, this is a high prevalence and a major public health problem in this population.

Limited access to health care, particularly in terms of affordability, and in some instances, availability of drugs and travel costs, are potential hurdles to hypertension treatment and CVD prevention in

Ethiopia and other LMIC. Additionally, although lifestyle interventions like exercise, reduction of salt, soda and sweet, and weight loss are cost effective interventions, communities have limited awareness and understanding about these interventions.

3.2.6. Injuries

Injuries are among the leading causes of death and disability among adolescents and youth with unintentional injuries such as road traffic injuries, physical fight, drowning and burns-being the most. Physical fight, often associated with substance use and other behaviors, is common among younger adolescents, more so among boys than girls leading to severe or serious injuries.

In Ethiopia, injuries due to road traffic accidents (RTA), physical fights and drowning account for 9% of the mortality caused by NCDs (WHO, 2008). Among adolescents and youth (15-29), the prevalence of RTAs is 2.7% (3.2% male and 2% female) and that of non-RTAs is 2.4% (3% male and 1.6% female). The common non road traffic accidents are fall, burn, poisoning, cut, drowning, animal bites and violent injuries (EPHI, 2015).

Ethiopia has put in place an institutional framework for road traffic safety with the National Road Traffic Council leading the implementation of the national road safety strategy. However, safer vehicle standards are partially in place and not comprehensively implemented. Safety laws despite being passed are not adequately enforced.

3.2.7. Gender-Based Violence

Gender-based violence (GBV) refers to violence against women often including a combination of physical, sexual and emotional violence and deprivation or neglect. Intimate partner violence (IPV) or domestic violence, is a common form of GBV which causes physical injuries, neurological and behavioral changes. These traumatic experiences can lead to both immediate and later health problems and repeated victimization throughout life. The fear and power differentials associated with GBV limit the ability to negotiate safer sex and hence, increase gender inequalities and cause 'choice disability' (Andersson N et al, 2008). The Ethiopian Criminal Code of 2005 addresses human rights issues, women's and children's rights in particular including the criminalization and punishment of any act of GBV.

Studies have found that there is high prevalence of GBV among high school girls in Ethiopia. A study by Mule G. et al indicates that the prevalence of GBV (physical and/or sexual) among high school girls in northwestern Ethiopia is 57.3% in 2015. GBV is so common in Ethiopia where 68% of married women accept that a husband is justified for beating his wife. There is poor awareness about the existing legal framework more than half (53%) of married adolescent women aged 15-19 do not know the existence of law that protects women from GBV in Ethiopia, similar for the older age groups (EDHS, 2005, 2011).

3.2.8. Harmful Traditional Practices

Harmful traditional practices (HTPs) refer to deeply entrenched traditional practices which affect or violate the physical, sexual or psychological well-being, human rights and socio-economic participation of a human being in a society (MOWCYA, 2013). Female genital mutilation/cutting (FGM/C), early/child marriage, forceful abduction and domestic violence are the most widely practiced forms of HTPs that are classified as serious crimes by the Ethiopian Law (MOWCYA, 2014).

FGM/C, according to UNICEF and UNFPA, refers to the removal of all or parts of the external female genitalia or other injury to the female genital organs for non-medical reasons. There are indications that attitudes are changing and FGM/C is declining in Ethiopia. The prevalence of FGM/C in girls and women aged 15-49 has decreased from 79.9% in 2000 to 74.3% in 2005. Variation among regions ranges from 27% in Gambella and 29% in Tigray to 92% in Afar and Dire Dawa and 97% in Somali (EDHS, 2005).

The revised criminal and family laws of Ethiopia (2005) set the minimum age of marriage for women to be 18 years and state that marriage shall only take place with full consent of both parties. Despite the law, **early marriage** remains high in Ethiopia. In the 2005 EDHS, 34 and 66 percent of Ethiopian women aged 25 to 49 are married by the age of 15 and 18, respectively. In the 2011 EDHS, the respective proportions decreased to 30 and 63 percent for women of the same age group. The median age at first marriage among women of the same age group slightly increased from 16.1 years in 2005 EDHS to 16.5 in 2011 EDHS. In PMA/2014, however, median age at marriage is 17.2 years for the same group.

Due to the country's significant geographical, cultural, ethnic and religious diversity, national strategies for eliminating HTPs need to be condensed at community level, with organizations having to tailor anti-HTP initiatives and strategies that take into account the particular regional circumstances (UNFPA, 2013; UNICEF, 2013).

3.3. Vulnerable and Special Needs Groups

Adolescents and Youth with Physical Difficulties

The Ethiopian Center for Disabilities and Development in 2014 estimated that about 17 percent of adolescents and youth live with some form of physical difficulties. The Ethiopian guideline on youth friendly reproductive health service delivery considers the unique or special needs of young people with physical difficulties as a principle (*FMOH, 2007 E.C.*). Discrimination against this population group is often because of misconception and lack of knowledge linked to erroneous views about the causes and consequences of disability.

Young people with physical difficulties are often presumed erroneously to be sexually inactive, hardly use drug or alcohol, and are at minimal risk of abuse, violence or rape. However, the reality is vice versa (*UNICEF, 2013; Aderemia et al, 2014*). Studies also report a high magnitude of unmet need for family planning among women with disabilities (*Abel et al, 2015*). They have poor access to most SRH interventions including HIV and AIDS prevention programs. While continued

mainstreaming of disability into policies and strategies remains crucial, interventions also need to disaggregate the different sub-groups with varying forms of physical challenges and/or disabilities (Abel et al, 2015).

Street Children

Street children refer to children who live and survive on the streets of cities and towns. About 600,000 children are estimated to depend on street life in Ethiopia. Estimates include that about 65% of street children hardly have access to SRH services. Among sexually active street children in some bigger cities, 8.3% are involved in sexual intercourse in exchange for money, 2.3% under Khat/alcohol influence, and 2% experience rape (Demelash and Addisie, 2014).

Emerging Risk Corridors

In Ethiopia, evidences exist that Higher Education Institutions (HEI) and Mega Project Sites are currently considered as emerging risk corridors. As universities in Ethiopia are overwhelmed with large number of adolescents and youth who leave their families for the first time and lack parental supervision, the challenges faced by this population in terms of their sexual need is immense. The first national level study on risky sexual behavior and predisposing factors among Ethiopian university students showed that significant proportion of students (25.8%) reported ever using substances. Moreover, the stated study showed that significant proportion of university students (29.71%) are sexually active and are engaged in risky sexual practices (FHAPCO, 2011).

Similarly, studies reveal that commercial farms, development sites such as sugar plantations and construction sites in Ethiopia are emerging risk corridors involving huge number of casual or seasonal mobile workers.

Adolescents and Youth Engaged in Risky Jobs

Adolescents and youth engaged in domestic work (as housemaids), in paid/commercial sex are vulnerable to various health risks including HIV/AIDS. Similarly, early married adolescents as well as those living with HIV are more vulnerable to other risks and have difficulty of accessing services (Anabel, 2014). Hence, these groups require special attention.

Trafficking

In Ethiopia, trafficking of adolescents and youth from rural to urban centers is widespread. Rural women and children between the ages of 8 and 24 years who are either illiterate or school dropouts are most vulnerable to trafficking. The recurrent forms of abuse and exploitation experienced by victims of internal trafficking are identified as labor exploitation, physical, emotional and sexual abuse. Besides, external trafficking mainly for the purpose of engaging victims as housemaids in Middle East countries involves violations and abuses of different kinds.

3.4. Regions in Need of Equitable Development

With a total estimated population of 10,163,478 (including 4,675,636 females & 5,487,842

males), the pastoralist communities in Ethiopia account for 10 percent of the total population. Regions requiring equitable development lag behind the national average in many adolescent and reproductive health outcomes and their impact. Pastoralist communities are known for their high mobility and low literacy rate with remarkable gender disparities in primary school enrolment, attendance and dropout. Gender disparity is also wide-ranging including women's heavy household chores aggravated by water shortage and scarcity of firewood. Adolescents face particular challenges in accessing youth-friendly services and experience high risks of child-bearing. The result is continuing high fertility, high maternal and neonatal mortality.

Access to health service is below the national average due to the mobility of the population, the social mobilization structure (the HDA) has not started in Afar and Somali regions and knowledge about HIV/STI is very low (FHE). In addition, the contraceptive prevalence rate (CPR) for modern methods among currently married women of 15-49 years is much lower than the national average of 40.4 percent, where it is 8.7 percent in Afar and 1 percent in Somali (Mini-EDHS 2014). Relatively high teenage pregnancy rates were reported in Benishangul-Gumuz, 17 percent and Gambella 17 percent compared to the national average of 10 percent which might be accompanied by child marriage, abduction and various socio-cultural factors.

In Gambella and Benishangul-Gumuz regions, weak health systems due mainly to infrastructural problems affect the delivery of health services to adolescents and youth. The health system is hampered in its mission to spread literacy including healthy living practices among out of school adolescents and youth. School based education and information provision on adolescent and youth health is challenged by the lack of resources which has led to poor enrollment numbers and rampant teacher absenteeism, and the poor coordination between health and education sectors. Similar socio-cultural challenges often exist among the communities in the two regions (*MOWCYA, 2014*).

3.5. Response Analysis

3.5.1. Health Services and Interventions

In Ethiopia, adolescent and youth health services and information are provided in public and NGO healthcare facilities, in youth centers and schools. However, firm establishment and effective utilization of most of the many platforms is not fully realized.

The size of the school population accounts for a quarter of the population of the country. Comprehensive sexuality education (CSE) has increasingly been integrated in adolescent and youth SRH program interventions to address existing SRH information gaps of adolescents and youth in Ethiopia. Education sector HIV strategy is in place with HIV/AIDS incorporated in primary and secondary school curricula, over 20,000 teachers trained in life skills education and youth friendly HIV and RH interventions implemented in many universities supported by various partners. Recent evidences show very high testing uptake and condom use, and very low HIV prevalence among in-school adolescents and youth but they exhibit high-risk behaviors. Large-scale implementation of CSE programs has not been implemented adequately and there is very limited progress in reaching the most vulnerable young people, including the very young (10-14 years) adolescents, both in-school and out-of-school. Expert opinions point to the lack of continuous review and updating of

the content of CSE curricula, inadequate capacity of teachers, volunteers, peers, outreach workers, HEWs and HDAs as key factors limiting the quality and scale of interventions. Furthermore, there is lack of strong institutional framework for effective monitoring, coordination and harmonization of programs (FHAPCO, 2014).

The 1,589 youth centers in the country are unevenly distributed (mostly urban located) and are not fairly promoted. Despite the popularity of youth centers, even those in rural locations serve only a small proportion of the target population – mostly those who live nearby, with significant gender differences in use. Further gaps include limitations in staff number and capacity, infrastructure, leadership and information management.

National standards for adolescent and youth friendly health services in health facilities have been developed to address the barriers to access through a quality of care framework. However, the principle of adolescent and youth-friendly services often has not been applied adequately to mainstream primary and referral-level services. The standards focus on limited range of health issues, namely, sexual and reproductive health and HIV. The progress in expanding the coverage of AYFHS in public health facilities has been protracted and is at 44.8% nationally.

Quality of health services for adolescents and youth is challenged by inadequacy of infrastructure including equipment and supplies, health workers' incompetence and lack of compassion and respect, among others. The way that services are currently organized is also contributing to the low coverage and utilization of health services for adolescents and youth. The creation of separate services for adolescents and youth by partner organizations involved in direct service delivery is also a challenge to advancing the government's efforts of expanding AYFHS in an integrated fashion. Moreover, a functional, un-interrupted referral and linkage network across the entire health system is not yet fully guaranteed.

The 2014 EMDHS shows that only about 20% of teenage mothers had received antenatal care (ANC) for their most recent birth, only 19% of teenage deliveries were assisted by skilled health personnel and postnatal checkup within the first two days after birth is as low as 11%. Despite the law that allows access to contraceptives without parental or guardian consent, in Ethiopia, women who are young, unmarried, have few or no children, do not have the support of their partners, or are less educated, are not adequately accessing family planning services or obtain their preferred family planning method. Nearly one in three adolescent girls has an unmet need for contraception, and recent data from the Performance, Monitoring and Accountability 2020 (PMA2020) project suggests that while unmet need is decreasing among married women, it is continuing to increase among unmarried adolescents indicating limited access to contraceptives when needed. Even though LARCs are safe, effective, inexpensive, and reversible, require little to no maintenance, and have much better compliance rates than other hormonal methods, their use is not widespread among young women.

On the other hand, encouragingly, AYH program is being implemented and scaled up through ongoing national initiatives: elimination of obstetric fistula, eMTCT of HIV, and elimination of FGM/C, scaling up long acting FP methods through HEWs, scaling up and strengthening of comprehensive abortion care, expansion of EmONC services; as well as medical male circumcision programs in developing regional states (Gambella) and adolescent de-worming (Amhara, SNNPR and Oromia)

and Social and Behavioral Change Communication (SBCC) on adolescent nutrition.

3.5.2. Health Systems

Human resources for adolescent and youth health: In Ethiopia, a variety of professionals is involved in health care for adolescents and youth including: primary care physicians/general practitioners, nurses, health extension workers, health educators, pharmacists, specialist physicians and midwives. However, access to and utilization of health services for adolescents and youth is affected by the unavailability of suitable health personnel. Barriers to services exist due to the lack of a critical mass of health care providers trained to adequately respond to the needs of young people in the country. Typically, older professionals with insufficient or no training to provide adolescent and youth friendly service give the service. When adolescents and youth attempt to utilize services, they encounter unfriendly environments including breaches in confidentiality, judgmental and disapproving attitudes relating to sexual activity and substance use, and discrimination. This results in failure to provide important services and increase the vulnerability of particular groups. For example, refusing contraception to unmarried sexually active girls can increase the risk of early or unwanted pregnancy and its complications.

Social communication, technology and innovations: e-health and m-health technologies can complement efforts to bring services closer to adolescents and youth as they can achieve high coverage at low cost. They can also provide confidential and anonymous interactions, easy access all days of the week and the possibility for personalized interaction all of which can be appealing to adolescents. They have shown potential for effectiveness in the area of sexual and reproductive health, smoking cessation and alcohol-related problems. In addition to the rich experience of the AIDS Resource Center (consultation through hotlines), learning lessons from the growing prospect in the private sector (“Tebta Ambulance”, “Hello Doctor”) can provide strategic guidance to scale up best practices and tackle the growing scale of multi-dimensional health problems among adolescents and youth. Integration with school health services can present an opportunity to reach more adolescents in remote schools and other similar institutions. The involvement of mass media and social media platforms can provide opportunities for intensifying behavioral change communication. However, these platforms are not being utilized effectively to reach the accessible population and help increase access to information and education among the general adolescents and youth.

Strategic information, M&E and research: A series of Behavioral Surveillance Surveys (BSS) among adolescents and youth have been conducted at certain intervals to assess risky sexual behaviors and SRH service use. However, there are limitations both in the amount of research and the quality of research results in their application for M&E, and policy and program design.

In general, the existing data sources have the following gaps regarding adolescent and youth health.

- The Demographic Health Survey works with age brackets that are too broad which focus on the 15-49 age group. Information on the 10-14, the lower ages of adolescence is completely missing out. Once married, adolescents are treated like adults. In addition, the relationships of these adolescents with their husbands as well as their family planning needs are poorly addressed.
- Lack of adequate operational researches on adolescent and youth friendly services and limited

population based researches to estimate the magnitude and determinants of AYH at the community level.

- Because of the sensitive nature of adolescent and youth SRH, limited studies and data exist in the country on the most important areas.
- As multiple development partners are working on SRH and HIV, the effect of each intervention is difficult to ascertain, which necessitates well designed M&E system.
- With the current strategic focus on adolescent and youth health problems beyond SRH, work is needed to avail data which is especially nonexistent on the major mortality and morbidity drivers in the adolescent age bracket like mental health/depression, substance use, suicide, injuries/road traffic accidents etc.
- Age appropriate data on sexual and reproductive health is also not captured through HMIS (age disaggregated data for FP, ANC, and SBA etc.)
- Indicators for programmatic monitoring are in general insufficient in HMIS and even existing indicators on availability of adolescent and youth friendly services are not being reported

Financing: despite the known economic burdens among adolescents and youth, particularly those lacking parental or other means of support, there are limited initiatives and strategies that fully protect them from financial risks. Similar to the other sector of the population, adolescents and youth remain vulnerable to healthcare financial risks from out-of-pocket expenditures. The ongoing revision and development of the healthcare financing strategy for Ethiopia needs to take these and other emerging issues related to adolescent and youth health. Current insurance schemes need to implement effective prepaid pooling arrangements for adolescents and must be designed to cover priority services for adolescents and youth.

Policy and Legal Framework

Ethiopia has made several international and national commitments that recognize the right to health, and entitle all persons, in particular adolescents and youth, to available, accessible, acceptable and quality health-care facilities and services. Despite the existence of policies, strategies, guidelines and plans, there is a general lack of awareness among health service providers, teachers, parents, adolescents and youth, and the community at large about the existing policies and strategies and the health needs of adolescents and youth. Moreover, in the existing network of the public and private health system, the existence and functioning of youth friendly services are not sufficient to address the growing health needs of large number of adolescents and youth in the country. The few available general services are also branded by the majority of youth as not being youth friendly. The socio-cultural and religious norms and practices are also found to be constraints to the promotion and provision of adolescent friendly services, including the use of condoms and other contraceptive methods while on the other hand promotion of culturally appropriate sexuality interventions such as upholding virginity didn't get enough attention.

Current and anticipated focus on the health and development of children 5-9 years as well as the shift in paradigm to the broader adolescent and youth health than just SRH are key policy changes contributing to the improvement in the overall adolescent and youth health.

Adolescent and Youth Participation

A key strategic objective of the GTP-2 is to promote and support the participation of adolescents and youth in the country's development and economic growth. The health sector's excellent track record and success in community based health promotion and prevention emanates from the creation of strong community ownership as the foundation of the health extension program (HEP). The HEP is hailed for the unparalleled success gained in improving the health of mothers and children in the country, compared with the health gains in any other population group including adolescents and youth. Though not absolutely generalizable, it is yet possible to tell that adolescents and youth were not equally visible and might have fallen through the cracks of policy/program deliberations and resource allocation. Moreover, the prevailing challenge in appropriately organizing and building the capacity of HDAs in the developing regional states and urban areas may widen the inequalities in access to quality services and health outcomes among the general adolescents and youth.

Governance, Collaboration and Partnership

Policy and strategic advocacy has been put in place to ensure coordination among the different public, private, and civil society entities. Various bi-lateral and multi-lateral organizations, international and local NGOs as well as youth organizations are contributing to adolescent and youth development efforts. Nonetheless, it remains unclear if there is strong coordination between the different actors to meet gender sensitive, life skills based sexual and reproductive health education, sexual and reproductive health services, and active participation of adolescents and youth in issues of their concern.

The fact that adolescent and youth health is not entirely addressed by the MOH alone requires an institutional arrangement to establish a functional multi-sectoral AYH management body to oversee, coordinate and harmonize the planning, implementation, and M&E of key programs for adolescent and youth health and development under MOH, Ministry of Education (MOE), Ministry of Women and Children Affairs (MOWCA), Ministry of Sports and Youth Affairs (MOSYA), and Ministry of Labor and Social Affairs (MOLSA), and youth and women associations.



4. STRATEGIC FRAMEWORK

The Strategic Framework proposes an integrated and comprehensive adolescent and youth health care package that comprises health promotion, preventive and curative interventions across all levels of care. The package promotes focus on innovative community-based approaches for health promotion and prevention models in addition to the provision of facility based curative services. It holds on to key basic principles at all levels and stages of program planning, implementation, and monitoring and evaluation.

4.1. Guiding Principles

Right based approach: the strategy promotes and advances the right for participation, decision making, choice of services, and confidentiality, privacy and respect to gender equality.

Adolescent and youth ownership: Based on the HDA experience, the focus is to capitalize on community participation as a core element for sustainability. Building on past experiences and the participatory undertaking of current and future initiatives towards full engagement and ultimately ownership for youth to play active decision-making roles in programs of their issues is underscored.

Partnerships and inter-sectoral collaboration: The health sector has a pivotal role in direct service provision and cross-sectoral coordination of AYH programs but cannot be successful on its own. The MOH leads initiatives, develops strategies and makes compelling case for action, and disseminates evidence-based interventions and good practices. The focus is to enhance synergistic action with other sectors such as education, agriculture, youth organizations, social welfare, and media.

Equity and inclusion: The strategy focuses on ensuring that the health system responds effectively and appropriately to the specific needs of adolescents and youth, in comparison with other groups in the population and that they are reached with evidence-based interventions. The strategy guides health programs to recognize and address the needs of adolescents and youth of both genders in an equitable, non-discriminatory manner that is free from stereotyping.

Life-course approach: a life-course approach is based on the recognition that adult health and illness are rooted in health and experiences in previous stages of the life-course and it systematically reflects economic, social, environmental, biomedical and other relevant factors that influence health. Efforts are targeted to break or disrupt negative intergenerational cycles that are created by or contribute to health inequities. These adolescents in turn will create the condition for healthy future generations as parents, grandparents and caregivers.

Comprehensive care – Care that responds to the full range of health problems of an individual or a given community – is widely recognized as key to the overall quality of care (WHO, 2015). Comprehensive means not only that care responds to the full range of health problems, but also that care for any condition encompasses, in a coherent way, health promotion and prevention, as well as diagnosis and treatment or referral (WHO, 2015).

Adolescent and youth-centered services: An approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. It requires that people should have the education and support they need to make decisions and participate in their own care.

Integration: Integration of approaches, for program and service management, and for service delivery is emphasized. Focus is on integration of adolescent and youth health services within the existing primary and referral care systems; the systematic integration of basic adolescent and youth health indicators in regular information systems; and coordination and implementation through the integration of actions and strategic areas at all levels.

Affordability: Most adolescents and youth are dependent on their parents and/or caregivers. Therefore, health services provided to adolescents and youth must be cost effective and affordable or free if possible.

Innovations: Wide use of interactive media and technologies for SBCC and as a means of service delivery is the focus. More investment will be made for testing and scaling up of new technologies, products and theories/models to increase access, utilization and coverage of services.

Evidence-informed approach: with focus on effective health promotion, health protection and disease prevention, priority is generating and strengthening the evidence base for action on adolescent and youth health, development and well-being on existing and new interventions to prevent and protect the health of adolescents and youth.

Compassionate, respectful and competent human resource: The MOH focuses on compassionate, respectful and competent health care by ensuring adequate skill mix of human resources at all levels of the health system. Care, empathy, trust, and enabling environment for informed decision making characterize the relation between service providers and their clients.

4.2. Target Conditions

The target conditions identified in the situational assessment and analysis account for the majority of the adolescent and youth mortality and morbidity in Ethiopia, and are therefore the focus for interventions in this Strategic Plan. These conditions are: sexual and reproductive health problems, infectious diseases, non-communicable diseases, malnutrition, mental and psychosocial disorders, substance use disorders and injury as well as violence. Universal coverage with effective high-impact interventions targeting these conditions would mean saving the lives of the majority of adolescents and youth in the country.

4.3. Goal

The strategy aims for improved health status of Ethiopian adolescents and youth by achieving the following critical health goals by 2020:

Goal 1:	Reduce overall adolescent and youth mortality by 50%
	Reduce the mortality rate among adolescents aged 10-14 years by 50%
	Reduce the mortality rate among adolescents aged 15-19 years from 5.73 to 2.86 per population of 1,000
	Reduce the mortality rate among young adults aged 20-24 5.88 to 2.94 per population of 1,000
Goal 2:	Reduce the rate of suicide among youth aged 15-24 years by 50%
Goal 3:	Reduce mortality from road traffic injuries among youth aged 15-24 years by 25%
Goal 4:	Reduce maternal mortality among adolescent girls and young women
	Reduce maternal mortality ratio among adolescent girls aged 15-19 years from 308 to 154 per 100,000 live births (EDHS, 2011)
	Reduce maternal mortality ratio among young women aged 20-24 years from 556 to 278 per 100,000 live births (EDHS, 2011)
Goal 5:	Reduce the incidence of HIV among youth aged 15-24 years from <0.03% to 0.01%
Goal 6:	Reduce the unintended adolescent pregnancy rate from 12% to 3%

4.4. Outcome Targets

Family Planning/Contraception	2015 Baseline	2020 Target
Increase CPR among all female youth aged 15-24 years	18.30%	30%
Reduce unmet need for modern contraception among adolescent aged 15-19 years	32.80%	10%
Reduce unmet need for modern contraception among youth aged 20-24years	21.80%	10%

Maternity Care		
Increase the proportion of young mothers aged 15-24 years with ANC4+	43%	95%
Increase the proportion of skilled deliveries among young mothers aged 15-24 years	40%	90%
Increase the proportion of young mothers aged 15-24 years with PNC (≤ 7 days)	35%	95%
HIV/AIDS/STIs		
Increase the rate of consistent and appropriate condom use during high risk sex among sexually active youth aged 15-24 years	55%	75%
Increase the proportion of adolescents and youth who have comprehensive knowledge of HIV	35%	90%
Increase the percentage of HIV testing and counseling	12%	90%
Increase the proportion of adolescents aged 9-13 years vaccinated for HPV	0	50%
Increase the median age (years) at first sex among female adolescents	16.4	>18
Nutrition and Physical Activity		
Decrease the prevalence of iron deficiency anemia among adolescent girls aged 10-19 years	30%	15%
Increase the proportion of adolescents and youth engaging in regular physical activity		40%
Mental/Psychosocial Health and Substance use		
Reduce the prevalence of alcohol consumption among adolescents and youth	45.6%	23%
Reduce the prevalence of tobacco use among adolescents and youth	4.40%	2.2%
Reduce the prevalence of Khat chewing among adolescents and youth	51%	25.50%
Reduce the prevalence of depression among adolescents and youth aged 15-24 years	12%	6%
Injury, GBV and HTPs		
Reduce the prevalence of injuries from RTAs among adolescents and youth aged 15-29 years	2.70%	2.02%
Reduce the prevalence of injuries from non-RTAs among adolescents and youth aged 15-29 years	2.4%	1.8%
Reduce the prevalence of FGM/C	23%	5%
Increase median age (years) at first marriage among female adolescents	16.5	≥ 18

Reduce the prevalence of child marriage	40%	<10%
Decrease the number of young women with obstetric fistula (number of cases)	9000	<1600
Reduce the prevalence of GBV	57%	<10%

4.5. Priority Areas, Strategies, Performance Targets and Interventions

The Strategic Framework proposes the following six priority areas for action: increasing access to AYH information and age appropriate CSE and life-skills education; enhancing equitable access to high quality, efficient and effective adolescent and youth-friendly health services; strengthening strategic information and research on adolescents and youth; promoting a supportive and enabling policy environment; supporting and facilitating youth engagement and ownership of health programs; and strengthening inter-sectoral coordination, networking and partnership. Each of these priority areas is accompanied by its respective strategies, performance targets and priority interventions (Table 4).

Table 2: Priority areas and proposed strategies, expected targets and interventions

Priority Areas	Strategies	Performance Targets	Priority Actions
<p>Increase access to AYH information and education</p>	<p>Enhance innovative social behavior change communication through the HEP(HDA, HEW), schools, mass media and digital technology</p>	<ul style="list-style-type: none"> By the year 2020, at least 50% of adolescents and youth have access to comprehensive AYH information and sexuality education 	<ul style="list-style-type: none"> Work with and support MOE and MOYAS/MOWCA to integrate comprehensive life skills, family life, sexuality education and nutrition into in-school, out-of-school, and higher learning programs and training curricula. Support the provision of age-appropriate AYH and nutrition education and information through IEC/BCC in healthcare facilities and existing outreach models Promote provision of accurate information on dangers of drug and substance abuse among adolescents through in- and out-of-school programs Leverage existing community level structures such as the HEP involving HEWs and HDAs, FBOs, religious institutions, Sunday schools, and other traditional community platforms to provide AYH information, AACSE, life-skill training, nutrition and family life education Revise and update the minimum package of the HEP to focus on AYH with a component on interventions for vulnerable adolescents and youth Generate community support for the delivery and uptake of the new adolescent and youth health interventions package Develop age-appropriate information and behavior change communication tools to raise awareness about the health needs of adolescents Train and sensitize teachers and families on age-appropriate information, behavior change communication tools, and parenting roles Undertake community-based initiatives for demand creation through work with peers, health extension workers, counselors and others Train HEWs, WDAs and MDAs on adolescent and youth health and development Incorporate adolescent and youth health in the HEW and HDA training curricula Incorporate essential AYH components (such as healthy life style, nutrition, mental health concerns, etc.) in to in-school and out of school education Enhance the collaboration and linkage between the ministries of education and health (MOE and MOH)

Priority Areas	Strategies	Performance Targets	Priority Actions
			<ul style="list-style-type: none"> • Develop and implement mechanisms to create youth champions in schools, colleges and universities where they will act as influential models • Synthesize and scale up the experience of Modeling and Reinforcement to Combat HIV: The MARCH Approach to Behavior Change • Adapt and implement strategies for social communication, social mobilization, and behavioral change including AYH mass media campaigns (radio soap opera, edutainment) • Facilitate innovative approaches to enhance access to AYH information including utilization of digital platforms (mHealth and eHealth) and mass media • Establish a center for documentation, bibliographic information, and web-based knowledge sharing and learning on AYH • Develop a generic and comprehensive training manual for the FBOs on adolescent and youth health and life skill development to be adopted based on specific doctrines and contexts • Develop and avail user-friendly IEC/BCC materials for adolescents and youth with special needs such as materials that use brail, sign languages, and relevant other communication techniques • Incorporate AYH communication activities into existing outreach programs • Provide health education on physical activity and nutrition to adolescents, parents and caregivers • Enhance communication aimed at promoting understanding of causes of GBV and developing attitudes against it • Provide education on protection of women from domestic violence and child protection from sexual abuse • Enhance communication aimed at promoting understanding of causes of injury and developing attitudes against it • Educate adolescents, youth, parents and communities to raise awareness about the health effects of physical fights, drowning and their prevention and response
<p>Enhance equitable access to high quality AYHS</p>	<p>Improve sexual, reproductive and maternal health</p>	<p>By the year 2020;</p> <ul style="list-style-type: none"> • CPR will be increased from 18% to 30% among young 	<ul style="list-style-type: none"> • Build the capacity of health providers to manage and provide AYFHS with a compassionate, respectful and caring manner • Work in collaboration with FMOE on the integration of AYFHS into the

Priority Areas	Strategies	Performance Targets	Priority Actions
		<p>women aged 15-24 years</p> <ul style="list-style-type: none"> Unmet need for modern FP will be reduced to 10% among young women aged 15-24 years Unintended adolescent pregnancy rate will be reduced from 12% to 3%. ANC 4+, skilled care at birth and PNC (within 7 days) will be increased from 43% to 95%, 40% to 90% and 35% to 95%, respectively among young women aged 15-24 years Median age at first sex among adolescent girls increased to at least 18 years <p>By 2017;</p> <ul style="list-style-type: none"> Pilot program on Safe Space model will be completed (testing, evaluation and adaptation) and by 2020, will be nationally scaled-up 	<p>pre-service training curriculum of health professionals</p> <ul style="list-style-type: none"> Equip health facilities and the health structure at different levels to provide AYFHS Ensure all pregnant adolescents, including the poor and 'hard-to-reach', have access to skilled care throughout pregnancy, delivery and postnatal periods Enhance establishment of linkages for effective referrals to relevant services for pregnant adolescents Strengthen programs such as safe space programs to delay sexual debut and promote abstinence among adolescents Support review of all maternal and perinatal deaths and provide adolescent and youth-specific maternal death reports Promote male involvement in prevention of early and unintended pregnancy Enhance provision of high quality safe abortion and post-abortion care services to adolescents and youth Support sensitization and implementation of the affirmative action policy and a social support system for adolescent girls Advocate for enforcement of laws and policies to prohibit marriage of girls below 18 years Strengthen and scale up social protection for vulnerable adolescent girls to delay sexual debut as well as to improve mental health and educational outcomes Pilot and scale up the planned safe space program Scale up the provision of AYF sexual, reproductive and maternal health services in 100% of public health centers, hospitals, university clinics youth centers, and selected private health service outlets with defined minimum service package Promote supportive attitudes and behavior by health workers to better engage adolescents and youth in health care services and programs
	<p>Reduce the burden of STI/HIV and HPV</p>	<p>By the year 2020;</p> <ul style="list-style-type: none"> The prevalence of HIV among young people aged 15-24 years will be reduced by 95% 	<ul style="list-style-type: none"> Promote screening and treatment of reproductive tract infections including STIs Provide HIV testing and counseling for all youth under 15, as well as other adolescents and youth with a focus on those most at risk

Priority Areas	Strategies	Performance Targets	Priority Actions
		<p>(from 0.2% to 0.01%)</p> <ul style="list-style-type: none"> 90% of adolescents and youth will have comprehensive knowledge on HIV The proportion of sexually active adolescents and youth (aged 15-24 years) that use condoms consistently and appropriately during risky sex will be increased to 75% from 55% 90% of adolescents and youth will have access to counseling and testing/screening for HIV 70% of adolescents and youth with STIs will be diagnosed and treated 50% of adolescents (aged 9-13 years) will be vaccinated for HPV 	<ul style="list-style-type: none"> Promote Voluntary Medical Male Circumcision (VMMC) for in- and out-of-school adolescent boys and young men in targeted regions Promote and scale up implementation of HPV vaccine programs for adolescents Establish and promote adolescent and youth-friendly HIV counseling and testing in AYFS, including linkages with other services Ensure availability of skilled and caring, respectful and compassionate (CRC) healthcare workers at all levels of healthcare for the provision of integrated, high quality AYH services in the context of STIs and HIV to adolescents and youth Ensure availability and accessibility of all types of modern contraceptives, including LARC, for adolescents and youth who are sexually active. Enhance integration of HIV and AIDS information and services among other STIs into AYH services at all levels of health care Facilitate revision, where appropriate, of age and sex related restrictions that prevent adolescents from accessing full HIV and SRH services Support community-based approaches to improve treatment adherence and retention in care of adolescents and youth living with HIV
	<p>Improve nutritional status</p>	<p>By the year 2020;</p> <ul style="list-style-type: none"> The prevalence of IDA will be reduced to <5% among adolescent girls De-worming will be provided to 100% in-school and 60% out-of-school adolescents 90% of adolescent girls aged 15-19 years will be provided with weekly iron-folic acid tablets in areas where anemia prevalence is 20% and above; 40% of adolescents and youth who access health services will be assessed and 	<ul style="list-style-type: none"> Promote consumption of balanced diet with emphasis on locally available nutritious and iron rich foods Promote healthy dietary habits, personal hygiene and food sanitation Impart knowledge about inter-generational effects of under-nutrition through health education Conduct counseling with emphasis on nutritional needs of pregnant and lactating adolescents and youth Provide screening for BMI and anemia for adolescent girls in schools, communities, and health facilities Provide weekly iron-folic acid tablet supplementation to adolescent girls (aged 15-19 years), where anemia prevalence is 20% and above Provide nutritional counseling and assessment for all adolescents and youth who access health services Provide supplementary feeding to prevent and treat under-nutrition Strengthen referral and management of low BMI and severe anemia, as

Priority Areas	Strategies	Performance Targets	Priority Actions
		<p>counseled for nutritional problems</p>	<p>per protocols</p> <ul style="list-style-type: none"> • Conduct de-worming in schools and communities • Mobilize resources and collaborate with partners to look for opportunities for school feeding for extremely poor adolescents and youth
	<p>Reduce drug and other substance use</p>	<p>By the year 2020:</p> <ul style="list-style-type: none"> • The prevalence of tobacco use among adolescents and youth aged 15-24 years will be reduced from 4.4% to 2.2% • The prevalence of Khat chewing among adolescents and youth aged 15-24 years will be reduced from 51% to 25.5%. • The use of alcohol among adolescents and youth will be reduced from 45.6% to 23% 	<ul style="list-style-type: none"> • Support provision of medical, legal and psychological services at all levels, including rehabilitation for adolescents exposed to drug and substance abuse • Encourage re-admission into school of adolescents and youth after rehabilitation • Advocate and support the passing of a law against tobacco smoking and its enforcement • Support enforcement of relevant legislation on drug, alcohol and other substance abuse amongst adolescents and youth • Establish multi-sectoral linkages between MOH (FMHACA, PFSA, EPHI) and law enforcement agencies, for the prevention and control of drug and substance use • Promote skills to counter pressures to experiment with tobacco, alcohol and drugs • Promote supportive and safe environments among families and institutions such as schools, TVETs, teen clubs in order to counter pressures to experiment with tobacco, alcohol and drugs
	<p>Improve mental and psychosocial health</p>	<ul style="list-style-type: none"> • By the year 2020, the prevalence of depression among adolescents and youth will be reduced by 50% 	<ul style="list-style-type: none"> • Promote protective factors such as self-esteem, healthy relationships, low levels of conflict, and social support among adolescents and youth through knowledge, skill and attitude focused training • Train health workers on the diagnosis, management and referral of adolescents with behavioral and developmental disorders including intellectual disability • Train and sensitize teachers, HDA networks, youth associations and community and religious leaders on mental health, including developmental and behavioral disorders • Strengthen screening and therapeutic interventions for anxiety, stress, depression, and suicidal tendencies, as per the provisions of primary mental health care • Facilitate referral and management of mental health disorders through

Priority Areas	Strategies	Performance Targets	Priority Actions
	Prevent non-communicable diseases among adolescents and youth	<p>By the year 2020:</p> <ul style="list-style-type: none"> Prevalence of moderate physical activity will be increased by 40% among young people The proportion of adolescents and youth who have had their blood pressure checked within the last year will be 40% Proportion of dieting will be 40% 40% will be checked for lipid at least once a year 	<p>linkage with the national mental health program</p> <ul style="list-style-type: none"> Promote physical activity and healthy life styles that focus on exercise and dietary habit Provide screening and management services for NCDs through relevant programs Advocate for and support the incorporation of physical activity in schools and life-skills-focused adolescent and youth education programs Conduct early identification and treatment of childhood problems having long term consequences
	Prevent harmful traditional practices, reduce violence, including GBV, among adolescents and youth, and improve response	<p>By the year 2020:</p> <ul style="list-style-type: none"> The prevalence of child marriage (<18 years) will be reduced from 40% to <10%; Median age at first marriage will be at least 18 years; The national prevalence of FGM/C will be reduced from 23% to <5%; 	<ul style="list-style-type: none"> Strengthen capacities of institutions, communities, families and individuals to prevent and respond to harmful traditional practices that affect adolescents Encourage male involvement in prevention of harmful traditional practices Support management of health consequences of harmful traditional practices Support reintegration to school of adolescents in child marriage and FGM situations Empower adolescents to challenge gender stereotypes, discrimination and violence within peers/families, educational institutions, workplaces and public spaces Provide screening, identification, support, management and referral services for cases of GBV as per the protocol Promote male involvement in prevention of GBV Strengthen provision of integrated medical, legal and psychosocial support for adolescent survivors of GBV Strengthen capacity of multiple stakeholders involved in prevention, response and management of GBV
	Prevent injuries among	<p>By the year 2020:</p> <ul style="list-style-type: none"> Morbidity attributed to 	<ul style="list-style-type: none"> Scale up emergency and ambulatory health care for the prevention and management of injuries

Priority Areas	Strategies	Performance Targets	Priority Actions
	adolescents and youth	<p>injuries due to RTAs will be reduced by 25% (from 2.7% to 2.02%)</p> <ul style="list-style-type: none"> Morbidity attributed to injuries due to non-RTAs will be reduced by 25%, from 2.4% to 1.8% 	<ul style="list-style-type: none"> Enforce safety laws and increase knowledge of traffic rules at the community level Promote positive and peaceful relationships among adolescents and youth and provide parenting skills on how to resolve conflicts
	Address the special health needs of marginalized and vulnerable adolescents and youth	<ul style="list-style-type: none"> By the year 2020, at least 60% of vulnerable and marginalized adolescents and youth will be reached with targeted interventions 	<ul style="list-style-type: none"> Map vulnerable and marginalized adolescents by age, gender, physical condition, geographic location and other relevant socio demographic variables Support provision of disability-friendly AYH information and services Design comprehensive disability-focused AYH interventions guidelines for adolescents and youth with physical difficulties Support evidence generation and utilization of data on marginalized and vulnerable adolescents and youth to guide AYH programming Support linkages of AYH programs with livelihood opportunities for all marginalized and vulnerable adolescents and youth Ensure data collection tools capture adolescents and youth with special needs Organize periodic outreach health services for street adolescents and youth through mobile health teams
Strengthen strategic information and research	Improve collection, analysis, and utilization of age and sex disaggregated data on adolescents and youth	<ul style="list-style-type: none"> By the end of 2017, the HMIS will start to generate, collect, compile and submit quality data on AYH and their determinants at the national and sub-national levels By 2018, AYH programs/units will produce complete bi-annual/annual reports on the epidemiology and health behavior of, and interventions for, adolescents and youth for program monitoring and review at national and sub- 	<ul style="list-style-type: none"> Identify and establish a national list of key indicators for all categories of the AYH program Integrate an adolescent and youth component into all data collection tools of the HMIS and MNCH scorecard and capture all data on the first 30 years of life disaggregated by 5-year age groups and sex Integrate adequate and appropriate adolescent and youth health variables into the Demographic and Health Surveys (DHS) and other wide-scale population-based surveys such as MICS Encourage local use of data at all levels for local decision making Integrate AYH program monitoring into the HSTP review and monitoring process Strengthen the civil registration and vital statistics system to capture adolescent and youth relevant data and information Work with research institutions to prioritize AYH issues as a top thematic

Priority Areas	Strategies	Performance Targets	Priority Actions
		<p>national levels</p> <ul style="list-style-type: none"> At least two studies will be conducted annually that are published and inform program design and resources By 2020, EDHS, MICS and other population-based study tools will accommodate adequate AYH variables for upcoming surveys 	<p>research area and conduct and share research results with MOH</p> <ul style="list-style-type: none"> Study and update evidence in the introduction of Human Papilloma Virus (HPV) and other vaccines Study the impact of innovations such as the provision of safe space and application of modeling (e.g. 'Betegna Drama and use of community Radios') to improve the health and development of adolescents and youth and the dissemination of effective interventions and best practices Support development of guidelines for conducting HIV and STI research among adolescents and youth Support programs and research on harmful traditional practices and promote appropriate evidence-based interventions Implement facility based surveillance and research on injuries in order to enhance strategic information on injuries Strengthen research advisory council on RMNCAYH
<p>Promote supportive and enabling environments</p>	<p>Strengthen the legal and policy framework</p>	<ul style="list-style-type: none"> By the year 2020, MOH and other priority/line ministries will have adequate evidence-based policies (and mechanisms of enforcement) that integrate responses to the main health issues and determinants affecting adolescents and youth as a way to increase this group's access to health care 	<ul style="list-style-type: none"> Develop or amend and enforce legislation and policies that are in line with ensuring protective, supportive and enabling environments and with human rights principles, including gender equality for all adolescents and youth Support implementation of appropriate policies and programs, as well as enforcement of legislation, to reduce prevalence of harmful traditional practices, with special emphasis on regions requiring equitable development Protect and ensure attainment of adolescent and youth Health and Rights Mainstream discussions of gender and address gender concerns in all AYH programs Strengthen capacities of institutions, service providers and communities to provide appropriate information and services to adolescents and youth who require them Support prioritization and allocation of resources to AYH Support advocacy for implementation of legal instruments that protect the rights of adolescents and youth Enhance capacity of law enforcement bodies and health service providers on prevention, response and mitigation of GBV
<p>Support and facilitate</p>	<p>Support adolescent and youth</p>	<ul style="list-style-type: none"> By the year 2020, 100% of 	<ul style="list-style-type: none"> Develop and implement a roadmap on youth participation, engagement

Priority Areas	Strategies	Performance Targets	Priority Actions
<p>youth engagement and ownership of health programs</p>	<p>participation and leadership in AYH planning and programming at all levels</p>	<p>adolescent and youth organizations and groups will engage in health sector planning and M&E</p>	<ul style="list-style-type: none"> • and ultimate ownership of health programs and services • Expand youth representation in working groups and taskforces related to AYH programs nationally and sub-nationally • Identify adolescent and youth associations and forums, build their capacity, and involve them in decision-making for health policies and programs that affect their health and well-being • Engage youth organizations in annual and strategic planning, review missions and meetings on the HSTP • Create functional linkage between youth associations and professional associations (EPHA, EMA, ESOG) for learning, professional development, and improved participation • Develop and/or strengthen youth leadership programs, particularly among pastoralist and semi-pastoralist adolescents and youth; provide capacity building on management and leadership skills • Engage adolescents and youth in the provision of technical support to sector ministries and relevant federal and regional government bodies for developing policies, plans, and programs that integrate responses to priority health issues affecting this group; • Strengthen involvement of adolescents, youth, families and communities in the prevention of drug and substance abuse among adolescents and youth • Promote adolescent and youth participation in key decision making around policy, advocacy, budgeting, planning, research and implementation processes
<p>Strengthen inter-sectoral coordination, networking and partnership</p>	<p>Strengthen the governance, management and partnership arrangement for AYH</p>	<ul style="list-style-type: none"> • By 2016, multi-sectoral AYH coordination platform is established at national and sub-national levels • By 2016, AYH coordination entity is established within the MOH and RHBS; all woreda/zone health offices will have AYH focal persons • As of 2016, AYH annual operational plans and budgets will be prepared and portrayed 	<ul style="list-style-type: none"> • Identify potential partners and social actors (NGOs, youth organizations, private sector enterprises) for a multi-sectoral adolescent and youth health and development plan • Identify areas for cross-sector collaboration, develop plan of action and expedite the work • Assess and identify key structural forces that affect health and drive disparities, including gender-related structural and institutional biases across sectors • Enact broad-ranging cross-sector policies to advance shared goals and address challenges that can't be resolved by a single sector alone. • Assess policies and interventions in different sectors to identify potential

Priority Areas	Strategies	Performance Targets	Priority Actions
		<p>in the national and regional health sector plans</p> <ul style="list-style-type: none"> As of 2017, 100% of AYH sensitive sectors/ ministries will assign an AYH focal person for the sector As of 2017, 100% of AYH sensitive sectors will integrate AYH into their annual workplan and reporting in line with the AYH strategy 	<p>health risks</p> <ul style="list-style-type: none"> Develop and finance integrated health and development programs for early adolescence that combine efforts across sectors Enact joint monitoring of policies and interventions in different sectors that have impact on health and consider and report on them as core health indicators Establish AYH Case Team at MOH/MCHD and RHs and support and ensure assignment of AYH focal persons at zonal and woreda health office levels Revitalize the AYRH TWG with increased scope into AYH TWG at national and sub-national levels Strengthen medium or long-term operational planning and allocation of resources, including budget and person(s) in charge, by the work of national and sub-national AYH Case Teams and sector ministries (as AYH committee) Strengthen coordination of multi-sectoral and multi-pronged responses to GBV and FGM/C Enhance collaboration and linkage between the Ministries of Health and Transport as well as road traffic control authority for the prevention of road traffic accidents Advocate for multi-sectoral and multi-pronged approaches for addressing AYH issues among adolescents and youth



5. IMPLEMENTATION ARRANGEMENT

The central focus for service delivery in this strategy is the life-course approach. Childhood development is the key step that affects the subsequent changes in biological and social roles. Social determinants in turn affect the health behavior of adolescents and youth. Among other factors, health choices by adolescents and youth also ultimately impact their health.

Therefore, interventions and services in this strategy are designed to serve a double-pronged response:

- Work toward building protective factors to help adolescents and youth develop the imagination and confidence to stand firm against negative behaviors and to rather support and participate in the prevention of these behaviors and promote positive norms
- Reorient the existing health care delivery structure to address the full range of adolescent and youth health and health related conditions and maximize access and utilization; hence, responding to the paradigm shift in adolescent and youth health

5.1. Key Interventions

Universal coverage requires that high-impact interventions for improving adolescent and youth health which tackle these target conditions: sexual and reproductive health problems, infectious diseases including HIV/AIDS, non-communicable diseases including malnutrition, mental and psychosocial disorders, substance use disorders, injury, and violence including GBV, are available and accessible and that health-care providers, adolescents and youth and their parents know about these services. Hence, interventions are arranged to provide information, commodities and services at the community level and to map referral linkages through the three-tier public health system. The health extension program will be strengthened and the capacity of HEWs and HDAs (MDAs and WDAs) will be built and improved in order to actively engage with adolescent

and youth, their respective associations, and civil society organizations to enhance access and utilization of services.

The strategy goes beyond reproductive health and HIV and works through a multi-sectoral partnership framework to address a range of adolescent and youth health and development needs by instituting effective, appropriate, acceptable and accessible service packages. The interventions reflect the life-course perspective in order to both contend with current disease problems experienced by Ethiopian adolescents and youth, while also seeking to prevent disease during and beyond adolescence and youth by addressing risk factors and vulnerabilities. The table below describes the services delivered through the different channels at all levels of care. Please refer to the “Annex” section to see the selected high-impact interventions with respective coverage of their baselines and projected targets. The upcoming minimum AYH service standard shall describe and clarify the specific services that will be provided at each of the health facilities and at other facilities such as youth centers.

5.2. Service Delivery Strategies

This strategy employs promotion, prevention and management as key approaches based on the model of integration and delivered through different platforms and modalities of service delivery.

5.2.1. Service Delivery Platforms

Health services for adolescents and youth will be provided in line with the policies that consent to community based and healthcare facility based service delivery mechanisms. In order to build on the success of the government’s flagship *HEP program*, this strategy gives due focus to AYH as an integral part of the health extension package, with the priority of scaling-up *community-based* AYH interventions through the HEWs, WDAs and MDAs.

Schools and higher education institutions (HEIs) will be widely utilized for comprehensive sexuality and life skills education, and for counseling, treatment and referral services. Additionally, *out-of-school* platforms such as youth centers, peer clubs and associations provide spaces for education on adolescent and youth health and development and for information provision through health workers, e-health, and helplines. The healthcare facility-based approach uses spaces in the existing public health system. Priority will be given to scaling up facility-based interventions (counseling, treatment and referrals) in government *health centers* and *hospitals* delivered by primary care providers and specialists working at primary and referral levels. AYFHS will also be provided in private health facilities per the standard. The strategy also addresses the use of electronic, print and outdoor mass media for communication and information dissemination to adolescents and youth.

5.2.2. Implementation Modality

Three key implementation modalities are employed: *family-oriented* house-to-house services by HEWs; *population-oriented* outreach services delivered by health workers through routine/regular

outreach or schedulable programs like child health days and campaigns; and *individual-oriented* clinical services that address individual specific clinical services required by adolescents and youth.

The strategy seeks to gain from the opportunity of integrating adolescent and youth health services into existing population based programs and health education and to initiate and scale up preventive school health programs for adolescents and youth.

The strategy focuses on investing on integration with mainstream services rather than creating separate/parallel programs for adolescents and youth. Special emphasis is given to areas or populations that are underserved, as well as marginalized groups and early adolescents (aged 10-14 years). Such investments provide opportunities for both health promotion as well as prevention of unhealthy behavior in order to significantly reduce morbidity and mortality later in life and to strike a balance on service equity.

5.2.3. Standards for the Provision of AYFH Services

The strategy supports access to and provision of high quality and affordable adolescent and youth-friendly AYH services at all levels of health service provision. The standards shall be described further in the national guidelines and the minimum package of interventions for adolescent and youth-friendly AYH services.



6. MONITORING AND EVALUATION

Measuring performance against set targets in the AYH program is crucial to generating essential information to guide strategic investments and operational planning. Monitoring and evaluation of the AYH strategy will rely on various systems and data sources (routine and periodic), supported and maintained by numerous stakeholders. A comprehensive list of key performance indicators from the strategic document will be integrated within the HMIS, MNCH scorecard and associated monitoring tools. Data will be collected for several categories and levels of indicators. The indicators for monitoring and evaluation of AYH are built into the framework of four core sequential domains: inputs and processes, outputs, outcomes and impact (Figure 5). A comprehensive list of indicators is included in Annex 10.5: Monitoring and Evaluation Matrix. The AYH program will use different mechanisms of M&E to monitor these indicators that will be collected from different sources across different programmatic platforms.

6.1. Performance Tracking Systems

Service utilization data will be collected through the HMIS, population based surveys such as DHS and PMA 2020, and studies that provide data on services, such as the ESPA+ Survey. The MOH and working groups will routinely use the information generated to track progress in mobilizing resources and in achieving results against set program targets. This mechanism will help ensure that implementation efforts conform to the plan and that results achieved align with performance targets. Process monitoring will also allow for corrective and preventive action along the way, including and planning and coordination.

Supervision will be essential at and between various levels of the health system, especially for the success of programs. Frequent and regular joint supportive supervisions will be done to help identify problems early on and to take immediate remedial actions using the integrated supervisory mechanism and checklist with attendant human resources and financial commitments.

Bi-annually, the MOH will convene a joint progress review meeting to assess the progress of AYH implementation against targets and to agree on priorities for the upcoming period. The RHBs will also attend these bi-annual progress review meetings to share and discuss progress in their districts. The meetings will therefore serve to assess AYH program outputs/outcomes as a key accountability mechanism to assess implementation. The meetings will also involve review of the planning and programming process in time to make recommendations for the next annual work planning cycle or for long-term strategic planning. Key performance indicators that hinge on strategic priorities will also be assessed during Joint Review Missions and will be presented at the HSTP ARMs to provide a snapshot view of the program's status and to assess implementation progress.

Different research and surveys will be used to assess the progress made in the implementation of interventions, outcomes and impacts and to triangulate data collected routinely by the health information system. Formal mid-term and end-term/final evaluations of the AYH strategy will be conducted to assess progress and identify areas of preventive or corrective action.



7. COSTING

The UN's One-Health Tool (OHT) was used to determine the cost of implementing the activities of the strategic plan. Core activities are broken down into respective/individual cost elements (cost items), unit costs assigned, and number of units calculated based on the activity target. The costing also took into account the frequency and recurrence of activities over the period of the strategic plan (2016-2020) and cost per year was estimated. The costs are summarized for the interventions and program management activities, broken down by thematic areas.

7.1. Costing Assumptions

Cost estimates are based on the best accessed information on disease profiles and official figures for base year population demographics. It assumed that facilities are functioning and the minimum required staff is in place. While national protocols and expert opinions were used for clinical practices, expansion targets were set to meet the standards as based on population figures. Service coverage targets were set in line with the impact assumptions of the health sector transformation plan and the national growth and transformation plan.

High-impact intervention costs were calculated using international standards (price list) and presented as drug and supplies costs. Program activities costs were calculated using unit costs per MOH's standards. All costs are based on current costs (of December 2015) and have not been adjusted for inflation over time.

7.2. Costing Summary

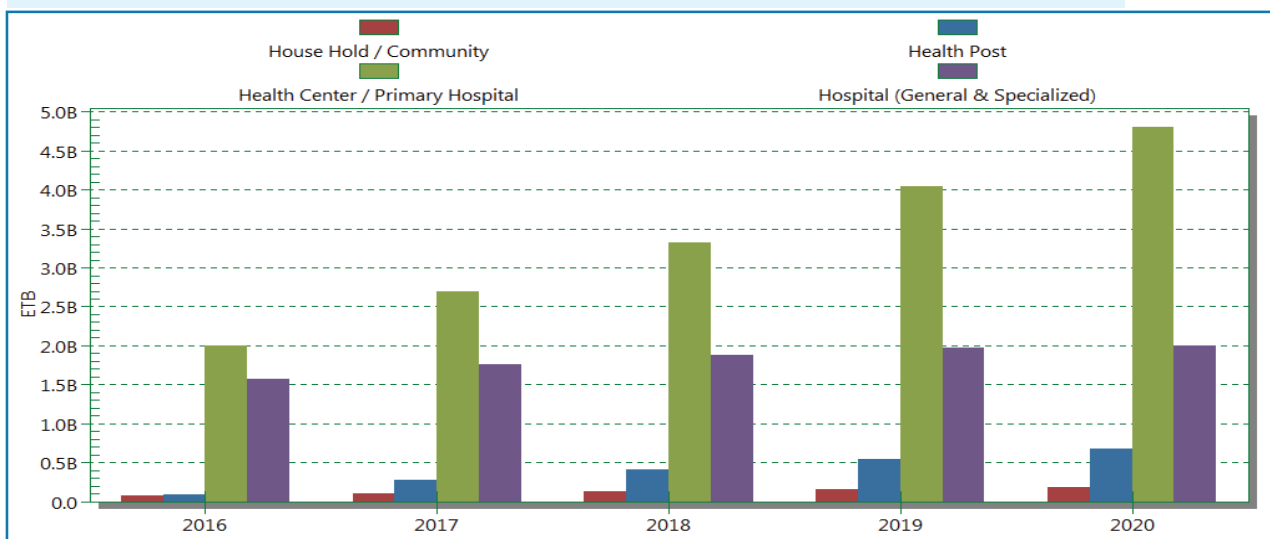
The overall cost of implementing the strategy over the five-year period is estimated at ETB 37.8 Billion. This overall cost reflects the financial sum of two categories of costs: 98 percent or ETB 36.9 Billion is the money for implementing joint activities with the mainstream health care system and thus already wedged in the costed plans of the respective national program strategies and includes the following:

- Healthcare cost for delivering services on SRH, HIV/AIDS, nutrition, mental and psychosocial health, NCDs and injuries (calculated as drugs and supplies cost) – ETB 28,663,324,014.00
- Cost for supervision, review and coordination – ETB 93,994,789.00
- Infrastructure and equipment cost – ETB 8,142,526,830.00
- General program management cost – ETB 595,833.00

The second category is the new/additional money of ETB 867.5 Million or just 2 percent of the overall cost required for implementing activities that are specific to the AYH program; and includes costs for the following:

- Designing the new AYH training curriculum and developing the training package – ETB 223,324,992.00
- Training of health care providers and managers on AYH – ETB 1,959,923.00
- M&E, quality and research on AYH – ETB 10,688,177.00
- Communication, media and outreach activities – ETB 640,941,996.00
- Developing the minimum interventions package, the service protocols and related technical guidelines – ETB 1,250,000.00

Figure 4: Drug and supply costs (drugs and supplies) all program areas combined



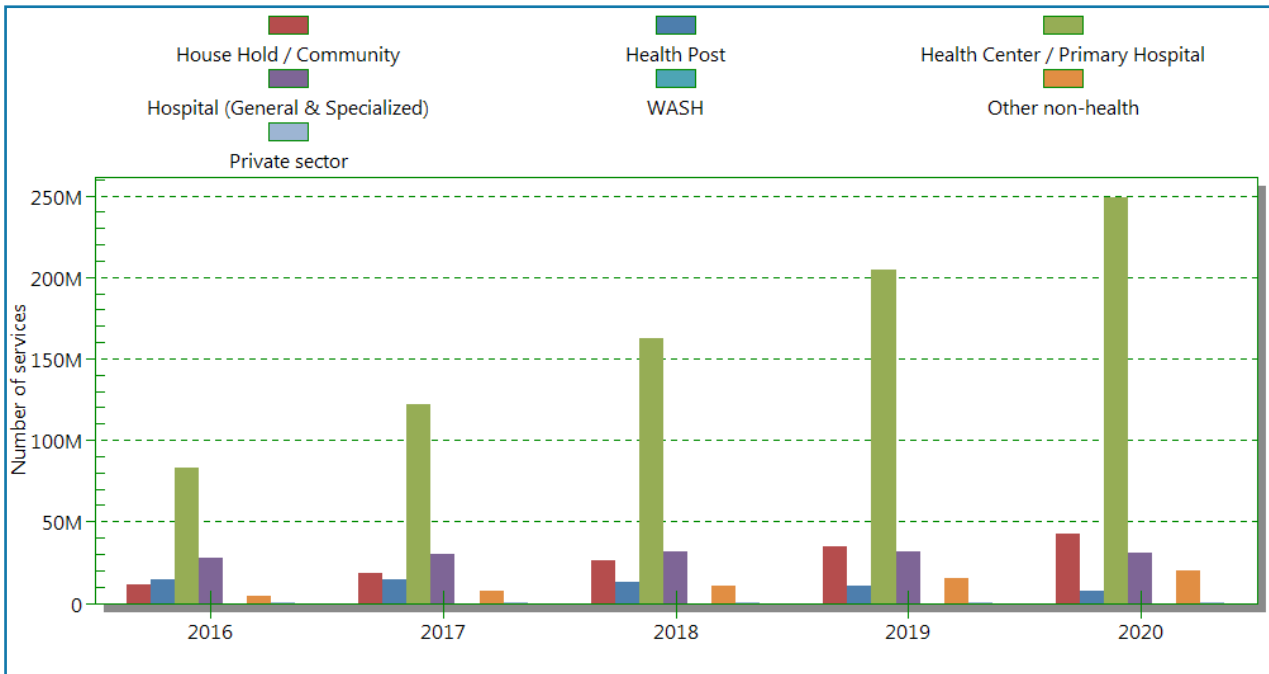
The cost per person for program and service delivery activities combined is ETB 352.06 or US\$ 16.37 per year. This average cost is reasonable given the government's policy that aim on maximum efficiency and effectiveness (through implementing low-cost, high-impact primary health care interventions) and the economy of scale generated from the large-scale implementation of national programs for the country's very large population in this age group. The table below provides summary costs for major disease areas and programs.

Table 3: Summary costs – major areas

Intervention	2016	2017	2018	2019	2020
Sexual and Reproductive Health	3,146,271,592	4,002,718,471	4,648,500,288	5,308,569,161	5,923,756,062
HIV/AIDS	155,181,497	229,348,589	306,617,932	386,501,741	468,497,750
Nutrition	235,450,186	318,336,722	402,981,382	489,394,372	577,652,699
Non-communicable Diseases	159,405,311	228,266,508	329,265,312	455,128,154	620,355,711
Mental, Psychosocial and Substance Use Disorders	5,852,628	12,540,875	25,941,043	49,300,087	50,350,699
Injury and Violence	21,816,505	23,488,968	25,758,374	26,303,220	29,772,177
Totals	3,723,977,719	4,814,700,133	5,739,064,331	6,715,196,735	7,670,385,098
Program Activity	2016	2017	2018	2019	2020
Training	46,111,048	47,399,327	44,992,903	44,191,843	42,589,723
Supervision and Review/Coordination	14,027,509	16,085,814	18,448,282	21,160,080	24,273,104
M&E and Research	3,241,883	1,702,035	1,446,730	1,486,572	2,810,956
Infrastructure and Equipment	602,195,922	1,188,211,644	1,652,792,366	2,117,373,088	2,581,953,810
Communication, Media & Outreach	134,261,999	124,064,999	129,859,999	125,814,999	126,939,999
General Program Management	332,233	65,900	65,900	65,900	65,900
Other	1,250,000				
Totals	801,420,594	1,377,529,719	1,847,606,180	2,310,092,482	2,778,633,492

As indicated in the picture below, more than 1.2 billion services will be provided over the five-year period to implement the high-impact interventions.

Figure 5: Total number of services by service package, All programme areas combined



8. ANNEX – INDICATIVE WORKPLAN AND M&E MATRIX

ANNEX 1. Strength, Limitation Opportunity and Threat Analysis

	Strength	Limitation
Health Impact	<ul style="list-style-type: none"> Progressive decline in the mortality rates due to all causes among female Ethiopian adolescents and youth Efforts towards achieving MDGs-4,5,6 have had positive impacts on adolescents' health Significant decline since 2000 of deaths due to pregnancy and childbirth complications among adolescents 	<ul style="list-style-type: none"> Preventable causes of adolescent and youth deaths have not been fully addressed Increasing trend of mortality rates of all causes among male adolescents and youth Despite early achievement of MDG-4, adolescents still die from infectious diseases that have been addressed successfully among infant and child populations, as evidenced by decreasing mortality Despite MDG-5 related achievements, maternal mortality is still a significant contributor to deaths of adolescents and youth Despite MDG-6 related achievements, HIV is still associated with a majority of deaths among adolescents and youth, as are transport accidents, physical violence, and maternal causes Generally low socio-economic status related to high unemployment and poverty rates
Service coverage and quality	<ul style="list-style-type: none"> Steady improvement in sexual and reproductive health and behavior over the last decade Improvements in the knowledge, attitude and practice related to SRH and HIV/STIs Decrease in the rate of child marriage Steady increase in the proportion of young women with median age at first sex of >18 years Improvements in family planning knowledge Substantial decline in HIV prevalence among young people More than 83% reduction in the prevalence of HIV among young pregnant women aged 15-24 years over the last decade Generally low HIV prevalence among students and young people 	<p>Despite the improvements, there are still problems:</p> <ul style="list-style-type: none"> Low CPR for modern contraceptives High unmet need for modern contraceptives, including LARCs Persistence of child marriage and early sexual debut (<18 years old) mainly in rural Amhara Rates of adolescent pregnancy and fertility remain high with pregnancy and birth complications (fistula), unsafe abortion and its complications Existence of high risk sexual practices (sex with female sex workers or non-regular partners) despite reduction in prevalence of HIV

	Strength	Limitation
Human resources for adolescent health	<ul style="list-style-type: none"> • A wide range of categories of health professionals involved in adolescent and youth care • Increased focus on and resources for strengthening general HRH, providing an excellent opportunity for AYH • Strong political will on the development of adolescent and youth competent HRH • Training and upgrading of health extension workers (HEWs) • Introduction and scale up of health development army (HDA)-WDAs and MDAs • Well-integrated health extension program (HEP) and HDA in agrarian regions to promote AYH • Focus on quality education and capacity building through competency-based training initiatives 	<ul style="list-style-type: none"> • Unavailability of suitable health personnel contributing to service barriers • Available health professions are too old, untrained and unprepared, contributing to poor clinical competence • Most health workers are judgmental, disapproving, less caring, less respectful, uncompassionate, and less motivated, thus contributing to poor non-clinical competence • Training programs and tools for key cadres of health workers lack competency modules on AYH • Training programs do not address non-health professionals who are working in the health system nor well as staff in other sectors • Lack of standard training tools on AYH in other sectors • Absence of coordination of capacity building efforts across sectors • Absence of innovative performance improvement mechanisms such as PBF targeting AYH • Lesser role of HEWs in AYH compared to the gains in HEW involvement in maternal and child mortality • Lack of opportunities for continued professional development
Social communication, technology and innovations	<ul style="list-style-type: none"> • Boom in infrastructure and technological expansion • Rich experience of the use of the AIDS Resource Center (hotline consultations) • Prospect of m-health in the private sector • Great advances made in child health through the successful introduction of new vaccines over the past decades • Preparations underway for the introduction of HPV vaccination in 2017 • Innovations in service delivery approaches such as primary health care model (HEP, PHCU) 	<ul style="list-style-type: none"> • Limited scale up of application of e- and m- technologies for AYH; access to existing services is significantly urban • Despite the recent boom in expansion, internet and telecom user-base among adolescents and youth, including access to TV among rural households, is still small • Extent of mass media involvement in health promotion and prevention to reach the accessible adolescents and youth is limited • Inadequate coverage of SBCC programs for adolescents and youth • Absence of defined standards of capacity for media engagement in health promotion, including standards for monitoring the content and quality of information (e.g. those aired through the wide variety of FM radio channels, mostly utilized by adolescents) • Fragmented and disintegrated approach in social communication interventions among programs and across sectors • No clear ethical or legal framework for using or monitoring the use of social media for health promotion • Shortage of local expertise and adequate investment in m- and e- health to guide scale up efforts in ways that would not merely expand programs but also help achieve the mortality reduction targets, • Need for strong public-private partnership to improve health communication • Innovations for integrating SBCC in the PHC model that engage wide range of media and communication platforms

	Strength	Limitation
Financing for AYH	<ul style="list-style-type: none"> • Initiatives for free maternal and newborn health services at public health facility • Initiation of community based health insurance (CBHI) and social health insurance schemes • Free family planning services 	<ul style="list-style-type: none"> • No pooled financing arrangements for adolescents and youth • Current financing policies and strategies pay little focus to AY • Priority AYH services are not identified for financial arrangements • Low knowledge and awareness of financial protection rights due to limited participation in health programs
Strategic information, M&E and research	<ul style="list-style-type: none"> • Population based surveys such as the EDHS, PMA to measure impact at regular intervals • Use of Health and Health-related indicators • Existence of a national health information system • Series of research and publications by academic institutions on AYH 	<ul style="list-style-type: none"> • Poor health information and vital registration systems with lack of age-disaggregated data and overall documentation obscure the magnitude and extent of disease burden • AYH data and indicators not integrated within HMIS tools • Research and publications on AYH are not sufficient to reinforce existing data nor support innovations • Weak generation, collection, analysis of data and dissemination of information on AYH in health facilities and health offices and bureaus • Available data and information on AYH are of low quality and rigor • EDHS age bands are too wide to provide disaggregated data and miss important age groups (aged 10-14 years)
Policy and legal framework	<ul style="list-style-type: none"> • Strong commitment to several global and regional policies on AYH • Ethiopia's commitment to endorse and implement the new UNGS global strategy on women's, children's and adolescent health • National policies, strategies, and legislations (NYP, NHP, Health Sector Vision 2016-2035, HSTP 2016-2020) that recognize and prioritize the health of adolescents & youth • Strong MOH ministerial and MCH leadership • Strong legal framework in place: a 2005 law criminalizing child marriage served as a powerful tool for discouraging child marriage; a law permits adolescents and youth to use contraceptives without third party consent; and a revised abortion law improved access to and use of CAC services • Education sector HIV prevention and control strategy 	<ul style="list-style-type: none"> • Previous strategy focused on SRH and HIV/AIDS; failed to accommodate the broad range of problems and conditions • Scope of clinical service protocols and technical guidelines limited to SRH and HIV/AIDS and does not integrate nutrition, mental health, substance use and other areas • Available laws and regulations not adequately enforced; more inter-sectoral work on law enforcement must be done • Absence of policies concerning financial risk protection for adolescents and youth • Poor awareness of current policies, laws and regulations among adolescents and youth and the larger community • Delay in implementing the tobacco control bill • School HIV policy does not comprehensively guide implementation and monitoring of school HIV programs. HIV related performance is not tracked by the education sector Information Management System

	Strength	Limitation
Community participation	<ul style="list-style-type: none"> • MOH has many success stories and a successful international track-record regarding community based health promotion and prevention with HEWs and HDAs which will be applied to scale up AYH • Existence of strong community network for health development activities • Community-facility referral linkages are established with HDA as the smallest unit • The National School Health and Nutrition Strategy (MOE, 2012) 	<ul style="list-style-type: none"> • Low awareness about risks of pregnancy and importance of service use • High proportions of harmful traditional practices (high FGM/C, abduction, and child marriage) • High prevalence of physical and sexual violence • Women’s literacy and decision-making authority at home is low • Poor knowledge of adolescent and youth nutrition • High youth unemployment, particularly young women • Low education attainment among young females • High proportion of polygamy, transactional sexual relationships, or commercial sex • Very low health care seeking for adolescent and youth friendly health service • School health services are fragmented and weakly implemented • Absence of large scale initiatives and programs on CSE (10-14) • Programs are missing content on gender equality, power relations, and human rights • School CSE curricula are not reviewed or updated and are less participatory than desired • Weak coordination among CSE partners or stakeholders, MOH and MOE
Governance, collaboration and partnership	<ul style="list-style-type: none"> • Strong sectoral presence to advance the adolescent and youth agenda, including: line ministries (MOH, MOE, MOYAS, MOLSA), civil societies, academia, development partners, and youth organized into 85,000 federations in the country • Existence of multi-sectoral nutrition platform to learn lessons and apply best practices • Youth participation in HSDP review and AYRH strategy development • Youth representation and participation in national and international forums 	<ul style="list-style-type: none"> • Absence of multi-sectoral forum for sufficient coordination, collaboration and partnership of AYH programs at all levels • Structural and staffing limitation at MOH, RHBs and lower levels for AYH program management • Limited engagement of the private sector in adolescent and youth health services and programs • Limited youth participation in strategy development and leadership leading to poor youth ownership of programs • Lack of clear mechanism or tools to guide meaningful participation and engagement of youth in health policies and programs

ANNEX 2. Activity Plan of Action

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Enhance innovative health education and prevention information through the HEP, schools, mass media and digital technology	Strengthen AYH information and AACSE programs for out-of-school and in-school adolescents and youth					
	Work with and support MOE and MOYAS/MOWCA to integrate comprehensive life skills, family life and sexuality education into school and out-of school training curricula					
	Support the provision of age-appropriate AYH education and information through IEC/BCC in healthcare facilities and existing outreach models					
	Leverage existing community health structures to provide AYH information and AACSE – utilize the HEP involving HEWs and HDAs					
	Revise and update the minimum package of the HEP to focus on AYH with a component on interventions for vulnerable adolescents and youth					
	Generate community support for the delivery and uptake of the new adolescent and youth health interventions package					
	Develop age-tailored information and behavior change communication tools to raise awareness about the health needs of adolescents					
	Extend the age-tailored behavior change interventions (health information) to primary school children (10-14 years) to shape early behaviors that are less likely to be modified during adolescence by training and sensitizing teachers and families on parenting roles					
	Undertake community-based initiatives for demand creation through peers, health extension workers, counselors and others					
	Train HEWs, WDAs and MDAs on adolescent and youth health and development					
	Incorporate adolescent and youth health in the HEW and HDA curricula					
	Include nutrition education in in-school and out of school training curricula					
	Incorporate mental and psychosocial health concerns into life skills-focused adolescent and youth education programs in schools and out of schools					
	Train level-I HDAs and second generation HEWs (level-III) on AYH to serve at least one per Kebele					
	Train school teachers, TVET, and university instructors on adolescents and youth health and development					
	Enhance the collaboration and linkage between the Ministries of Education and Health (MoE and MoH)					
	Develop and implement mechanisms to create youth champions in schools, colleges, and universities to act as influential models					
	Strengthen and engage community based forums and FBOs, including religious institutions, one-to-five networks, and community support groups, in improving adolescent health					
	Adapt and implement strategies for social communication, social mobilization, and behavioral change, like an AYH mass media campaigns (radio soap opera and edutainment)					
	Facilitate innovative approaches, including utilization of digital platforms (m-health and e-health) and mass media, to enhance access to AYH information					

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
	Establish center for documentation, bibliographic information, and web-based knowledge sharing and learning about AYH	■	■			
	Create social networks among adolescents and youth to promote healthy behaviors through the use of new technologies	■	■	■	■	■
	Establish and promote school programs that are integrated, holistic, and strategic and that produce better health and education outcomes through initiatives such as the WHO Global School Health Initiative		■	■	■	
	Assist FBOs to establish and harmonize adolescent and youth health intervention/activity plans per the national strategy	■	■	■	■	■
	Provide technical assistance to religious institutions to revise their existing curriculum, taught in Sunday Schools, to align with the AYH strategy		■	■		
	Develop and make available user-friendly IEC/BCC materials that use brail, sign language, and relevant other communication techniques for adolescents and youth with physical difficulties	■	■	■	■	■

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Improve sexual, reproductive and maternal health	Promote provision of accurate information and services in order to prevent early and unintended pregnancies among adolescents					
	Enhance existing service provision channels to provide accurate information and services on a wide range of contraceptive methods in order to capture diverse needs of adolescents					
	Ensure all pregnant adolescents, including the poor and 'hard-to-reach', have access to skilled care throughout pregnancy, delivery and postnatal periods					
	Enhance establishment of linkages for effective referrals to relevant services for pregnant adolescents					
	Strengthen programs to delay sexual debut and promote abstinence among adolescents					
	Support review of all maternal and perinatal deaths and provide adolescent and youth-specific maternal death reports					
	Promote male involvement in prevention of early and unintended pregnancy					
	Enhance provision of high quality comprehensive abortion care services to adolescents and youth					
	Support sensitization and implementation of the affirmative action policy and a social support system for adolescent girls					
	Strengthen community involvement in prevention of early and unintended pregnancy					
	Encourage political leaders, planners, and community leaders to enforce laws and policies that prohibit marriage of girls below 18 years of age					
	Support interventions that influence family and community norms to delay marriage of girls until they attain 18 years of age					
	Promote educational opportunities for girls through formal and non-formal channels to delay marriage until they attain 18 years of age					
	Strengthen and scale up social protection for vulnerable adolescent girls to delay sexual debut as well as improve mental health and educational outcomes - pilot and scale up the planned safe space program					
	Scale up the provision of AYF sexual, reproductive and maternal health services in 100% of health centers, hospitals and university clinics					
	Provide information about contraceptive use and the risks of early conception					
	Address social pressure and concerns related to child marriage , conception and contraception					
	Provide counseling for contraceptive use and method choices					
	Increase access to quality contraceptive services, including emergency contraception, through social marketing					

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Prevent and control infectious and communicable diseases	Support provision of accurate information on HIV and AIDS, as well as other STIs, to adolescents for risk reduction and ART adherence					
	Promote screening and treatment of reproductive tract infections, including STIs					
	Promote HIV testing and counseling among adolescents, including information on the potential benefits and risks of disclosure of their HIV status to others					
	Promote Voluntary Medical Male Circumcision (VMMC) for in- and out-of school adolescent boys and young men in targeted regions					
	Promote and scale up implementation of HPV vaccine programs for adolescents					
	Promote generation of adolescent-specific disaggregated data and its utilization for decision making					
	Support development of guidelines for conducting HIV and STI research among adolescents					
	Establish and promote adolescent and youth-friendly HIV counseling and testing sites including linkage with other services					
	Ensure adequate capacity of healthcare workers at all levels of healthcare for the provision of integrated, high quality AYH services in the context of STIs and HIV					
	Support meaningful participation of adolescents throughout HIV programming cycle					
	Enhance integration of information on and services for HIV and AIDS, as well as other STIs, into AYH services at all levels of health care					
	Facilitate revision, where appropriate, of age and sex related restrictions that prevent adolescents from accessing full HIV and SRH services					
	Support community-based approaches to improve treatment adherence and retention in the care of adolescents living with HIV					

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Improve nutrition	Promote consumption of a balanced diet with emphasis on locally available nutritious and iron rich foods					
	Promote healthy dietary habits, personal hygiene, and food sanitation					
	Impart knowledge about inter-generational effects of under-nutrition					
	Sensitize the community on gender bias in food distribution in households					
	Provide weekly iron-folic acid tablets to anemic adolescent girls aged 15-19					
	Scale up facility-based nutritional assessment and counseling					
	Provide supplementary feeding to prevent and treat under-nutrition					
	Create awareness about the importance of footwear to prevent worm infestations, targeting adolescents and youth, influencers, and care-givers					
	Advocate and promote food fortification					
	Counseling services to emphasize nutritional needs of pregnant and lactating adolescents and youth					
	Conduct de-worming in schools and communities					
	Screening for BMI and anemia					
	Referral and management of low BMI and anemia, as per protocols					
	Mobilize resources and collaborate with partners for school feeding opportunities and programs for extremely poor adolescents and youth and those affected by recurrent drought					
	Reduce drug and substance use	Promote provision of accurate information on dangers of drug and substance abuse among adolescents through in- and out-of-school programs				
Support provision of medical, legal and psychological services at all levels, including rehabilitation for adolescents exposed to drug and substance abuse						
Strengthen involvement of adolescents, youth, families and communities in the prevention of drug and substance abuse among adolescents and youth						
Encourage re-admission into school of adolescents and youth after rehabilitation						
Support enforcement of relevant legislation on drug, alcohol, and other substance abuse amongst adolescents and youth						
Establish multi-sectoral linkages between MOH (FMHACA, PFSA, EPHI) and law enforcement agencies for the prevention and control of drug and substance use						
Communication and promotion of awareness of adverse effects and consequences of tobacco, alcohol, and drugs						
Promote skills to counter pressures to experiment with tobacco, alcohol, and drugs through in-school counseling and guidance						
Promote supportive environment in families and institutions such as schools, TVETs, and teen clubs to counter pressures to experiment with tobacco, alcohol, and drugs						

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Enhance mental and psychosocial health	Promote protective factors such as self-esteem, healthy relationships, low levels of conflict, and social support among adolescents and youth					
	Train and promote skills for dealing with stress and conflicts positively among adolescents and youth					
	Provide screening and treatment for anxiety, stress, depression, suicidal tendencies, as per the provisions of primary mental health care					
	Facilitate referral and management of mental health disorders through linkage with the national mental health program					
Prevent non-communicable diseases	Promote physical activity and healthy life styles, with focus on diet, and against tobacco and alcohol use					
	Provide education and counseling on behavior risk modification (feeding habits, sedentary lifestyles, tobacco, alcohol) for adolescents and youth					
	Provide screening and management services for NCDs through relevant programs					
	Initiate RF prevention activities for early adolescents in and out of school					
	Strengthen diagnosis and treatment of RF in health facilities					
Reduce harmful traditional practices	Strengthen capacities of institutions, communities, families, and individuals to prevent and respond to harmful traditional practices to adolescents					
	Encourage male involvement in prevention of harmful traditional practices					
	Support management of health consequences of harmful traditional practices					
	Support implementation of appropriate policies and programs, as well as enforcement of legislation to reduce prevalence of harmful traditional practices					
	Support sensitization of communities on existing legislation and policies that protect adolescents from harmful traditional practices					
	Support programs and research on harmful traditional practices and promote appropriate evidence-based interventions					
	Support sensitization of reintegration to school of adolescents in child marriage and FGM situations					

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Prevent and reduce sexual and GBV and promote response	Enhance communication aimed at promoting understanding of causes of GBV and developing favorable attitudes against it					
	Provide education on protection of women from domestic violence and child protection from sexual abuse					
	Empower adolescents to challenge gender stereotypes, discrimination, and violence within peers/families, educational institutions, workplaces, and public spaces					
	Provide screening, identification, support, and referral services for cases of GBV as per the protocol					
	Provide referral and management of GBV as per protocol					
	Promote awareness among adolescents and youth, family, and communities about existing GBV response services					
	Promote male involvement in prevention of GBV					
	Strengthen provision of medical, legal, and psychosocial support for adolescent survivors of GBV					
	Strengthen capacity of multiple stakeholders involved in prevention, response, and management of GBV					
	Support advocacy for implementation of legal instruments that protect the rights of adolescents and youth					
	Enhance capacity of law enforcers and health service providers on prevention, response, and mitigation of GBV					
	Strengthen coordination of multi-sectoral and multi-pronged response to GBV					
	Prevent injuries	Enhance communication aimed at promoting understanding of causes of injury and developing favorable attitudes against it				
Enhance the collaboration and linkage between the ministries of health and transport as well as road traffic control authority for the prevention of road traffic accidents						
Scale up emergency and ambulatory health care for the prevention and management of injuries						
Implement facility based surveillance and research on injuries to enhance strategic information on injuries						
Enforce safety laws and increase community's knowledge of traffic rules and knowledge						
Educate adolescents, youth, parents, and communities to raise awareness about the health effects of physical fights, drowning, and their prevention and response						
Promote positive and peaceful relationships among adolescents and youth and educate parents on parenting skills to avoid conflicts						
Prevention, assessment, and management of cases of injuries, including alcohol-related						
Prevent suicide and manage self-harm/suicide risks						

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Address the special health needs of marginalized and vulnerable adolescents and youth	Conduct assessment and quantify, and map vulnerable and marginalized adolescents by age, gender, and geographic location	█	█			
	Design comprehensive disability-focused AYH intervention guidelines for adolescents and youth with physical difficulties	█	█	█		
	Support provision of disability-friendly AYH information and services	█	█	█	█	█
	Support evidence generation and utilization of data on marginalized and vulnerable adolescents and youth to guide AYH programming	█	█	█	█	█
	Support linkages of AYH programs with livelihood opportunities for all marginalized and vulnerable adolescents and youth	█	█	█	█	█
	Ensure data collection tools capture adolescents and youth with physical difficulties		█	█		
	Organize periodic outreach health services for street adolescents and youth through mobile health teams	█	█	█	█	█

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Improve collection, analysis, and utilization of age and sex disaggregated data on adolescents and youth	Search and compile the existing set of AYH indicators by indicator category under each AYH program					
	Identify missing and additional set of indicators for AYH (by category and program priority) focusing on mental health, substance use, violence/GBV, HTPs, and injuries					
	Develop and agree on a national standardized list of all basic indicators for AYH including equity indicators for measuring disparities in health status and health services					
	Integrate an adolescent and youth component into all data collection tools of the HMIS and MNCH scorecard and enable to capture all data on the first 30 years of life disaggregated by 5-year age groups and sex					
	Ensure monitoring and evaluation of interventions that are geared towards prevention, response, and mitigation of traditional practices;					
	Integrate adolescent and youth health variables in the Demographic and Health Surveys (DHS) and other wide-scale population-based surveys such as MICS					
	Encourage local use of data at all levels for local decision making					
	Integrate AYH program monitoring into the HSTP review and monitoring processes					
	Record and link data collected within the health sector and across sectors for broader program synthesis					
	Expand civil registration and vital statistics system to increase access to services and entitlements in order for adolescents and youth to realize their rights to proper health care, education and basic social benefits					
	Improve the quality and capture of adolescent and youth mortality and morbidity data					
	Work with research institutions to prioritize AYH as top thematic research area and share research results with MOH					
	Study and update evidence in the introduction of Human Papilloma Virus (HPV) and other vaccines					
	Study the impact of innovations, such as the provision of safe space and application of modeling (e.g. 'Betegna Drama and use of community Radios), to improve the health and development of adolescents and youth, and for the dissemination of effective interventions and best practices					
	Conduct research on traffic deaths of adolescents and youth that involve alcohol and on the effectiveness of interventions to reduce the number of crashes, accidents, and deaths involving alcohol					
	Conduct research on the links between alcohol and violence among adolescents and youth and the costs of these associated behaviors to society					
	Conduct analysis of health problems using determinants to identify vulnerabilities among adolescents and youth and the targeting of interventions by geographical area, socioeconomic status and gender					
	Conduct studies to assess and identify health needs of vulnerable and hard to reach adolescents and youth and with special needs					
	Rigorously assess and evaluate sexuality education programs other interventions aimed at affecting health, social, and economic outcomes for adolescents and youth					
	Conduct other relevant policy, operations and actions research on the dynamics of access to information and services, health care delivery systems, and health care seeking behavior of adolescents and youth					

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Strengthen the legal and policy framework	Protect adolescent and youth health and rights, and ensure attainment of these rights					
	Promote adolescent and youth participation in key decision making around policy, advocacy, budgeting, planning, research, and implementation processes					
	Promote education of parents and the community on the health and rights of adolescents and youth					
	Mainstream gender and address its concerns in all AYH programs					
	Advocate for multi-sectoral and multi-pronged approaches to addressing AYH issues among adolescents and youth					
	Strengthen capacities of institutions, service providers and communities to provide appropriate information and services to adolescents and youth who require them					
	Support prioritization and allocation of resources to AYH					
	Support adolescent and youth participation and leadership in AYH planning and programming at all levels	Develop and implement roadmap on youth participation, engagement and ultimate ownership of health programs and services				
Expand youth representation in working groups and taskforces related to AYH programs nationally and sub-nationally						
Identify adolescents and youth associations and forums and build their capacity and engagement in decision-making for health policies and programs that affect their health and well-being						
Engage youth organizations in annual and strategic planning, review missions, and meetings of the HSTP						
Create functional linkage between youth associations and professional associations (EPHA, EMA, ESOG)						
Promote supportive attitudes and behavior from health workers for engaging adolescents and youth in health care services and programs						
Develop and/or strengthen youth leadership programs, particularly among pastoralist, and semi-pastoralist adolescents and youth; provide capacity building on management and leadership skills						
Expand age-appropriate opportunities for broader socioeconomic and political participation while ensuring participation in health programs						
Engage adolescents and youth in the provision of technical support to sector ministries and relevant federal and regional government bodies for developing policies, plans, and programs that integrate responses to priority health issues affecting this group						

Strategic Initiative	Priority Interventions	2016	2017	2018	2019	2020
Strengthen the governance, management, and partnership arrangement for AYH	Identify potential partners and social actors (NGOs, youth organizations, private sector enterprises) for a multi-sectoral adolescent and youth health and development plan					
	Identify strategic areas for cross-sector collaboration, develop strategic plan of action, and expedite the work					
	Enact broad-ranging cross-sector policies to advance shared goals and address challenges that lone sectors cannot resolve					
	Assess policies and interventions in different sectors to identify potential health risks					
	Develop and finance integrated health and development programs for early adolescence that combine efforts across sectors					
	Enact joint monitoring of policies and interventions in different sectors that impact health and report on them as core health indicators					
	Establish AYH Case Team at MOH/MCHD and RHs and form similar structures at zonal and woreda health offices					
	Revitalize the AYRH TWG with increased scope into AYH TWG at national and sub-national levels					
	Strengthen medium or long-term operational planning and allocation of resources, including budget and person(s) in charge by national and sub-national AYH Case Teams and sector ministries					

ANNEX 3. Base and Projected Coverage of High-Impact Interventions

	2015	2016	2017	2018	2019	2020
Sexual and Reproductive Health						
Family planning						
Modern FP methods	18	21	23	26	28	30
Safe abortion						
Safe abortion	35	43	51	59	67	75
Management of abortion complications						
Post-abortion case management	40	50	60	70	80	90
Management of ectopic pregnancy care						
Ectopic case management	20	36	52	68	84	100
Pregnancy care – ANC						
Daily iron and folic acid supplementation	17	34	50	67	83	100
Tetanus toxoid	60	67	74	81	88	95
Syphilis detection and treatment	35	46	57	68	79	90
Basic ANC	43	53	64	74	85	95
Pregnancy care - Treatment of pregnancy complications						
Hypertensive disorder case management	35	46	57	68	79	90
Management of pre-eclampsia (MgSO ₄)	35	46	57	68	79	90
Management of other pregnancy complications	35	46	57	68	79	90
Deworming (Pregnant women)	60	66	72	78	84	90
Operative delivery for dystocia and other pregnancy complications	35	46	57	68	79	90
Childbirth care - Facility births						
Labor and delivery management	40	50	60	70	80	90
Active management of the 3 rd stage of labor	35	46	57	68	79	90
Pre-referral management of labor complications	35	46	57	68	79	90
Management of eclampsia (MgSO ₄)	35	46	57	68	79	90
Neonatal resuscitation	35	46	57	68	79	90
Management of obstructed labor	35	46	57	68	79	90
Kangaroo mother care	1	19	37	54	72	90
Feeding counseling and support for low-birth-weight infants	12	28	43	59	74	90
Childbirth care - Home births						
Clean practices and immediate essential newborn care (home)	8.8	9.04	9.28	9.52	9.76	10
Childbirth care – Other						
Antenatal corticosteroids for preterm labor	35	46	57	68	79	90
Antibiotics for pPRoM	35	46	57	68	79	90
Induction of labor (beyond 41 weeks)	35	46	57	68	79	90
Postpartum care - Treatment of sepsis						
Maternal Sepsis case management	35	46	57	68	79	90
Postpartum care - Treatment of newborn sepsis						
Treatment of local infections	1	20	39	57	76	95
Newborn sepsis - Full supportive care	10	27	44	61	78	95
Newborn sepsis - Injectable antibiotics	1	20	39	57	76	95
Postpartum care – Other						
Clean postnatal practices	35	46	57	68	79	90

	2015	2016	2017	2018	2019	2020
Mastitis	35	43	51	59	67	75
Treatment of postpartum hemorrhage	35	46	57	68	79	90
Chlorhexidine	0	18	36	54	72	90
PMTCT						
PMTCT						
Management of Obstetric Fistula						
Obstetric fistula case screening	10	28	46	63	81	99
Obstetric fistula case identification	10	28	46	63	81	99
Obstetric fistula case treatment	10	28	46	63	81	99
Management of STIs						
Treatment of syphilis	38	42	47	51	56	60
Treatment of gonorrhoea	38	42	47	51	56	60
Treatment of Chlamydia	38	42	47	51	56	60
Treatment of trichomoniasis	38	42	47	51	56	60
Treatment of PID	12	22	31	41	50	60
Others						
HPV vaccination	0	0	17	28	39	50
Menstrual hygiene management	5	23	41	59	77	95
Management of menstrual disorders	3	9	15	21	27	33
HIV/AIDS						
Voluntary counseling and testing	45	36	52	67	83	99
Condoms	12	29	47	64	82	99
Nutrition						
Intermittent iron-folic acid supplementation	0	30	40	50	60	70
Nutritional assessment and counseling	10	20	25	30	35	40
School de-worming	15	70	80	90	100	100
Non-communicable diseases						
Screening for risk of CVD/diabetes	5	7	10	15	21	30
Treatment of cases with rheumatic heart disease (with benzathine penicillin)	3	4	9	19	24	25
Mental, Psychosocial and Substance Use Disorders						
Basic psychosocial treatment for anxiety disorders (mild cases)	0	3	6	9	12	15
Basic psychosocial treatment and anti-depressant medication for anxiety disorders (moderate-severe cases)	0	3	6	9	12	15
Depression						
Basic psychosocial treatment and anti-depressant medication of first episode moderate-severe cases	1	2	5	10	21	20
Basic psychosocial treatment for mild depression	1	2	5	10	21	20
Psychosis						
Basic psychosocial support and anti-psychotic medication	2	3	10	22	29	30
Bipolar disorder						
Basic psychosocial treatment, advice, and follow-up for bipolar disorder, plus mood-stabilizing medication	2	3.9	7.7	15.2	30	30
Behavioral disorders						
Basic psychosocial treatment, advice, and follow-up for behavioral disorders	0	3	6	9	12	15
Alcohol use/dependence						

	2015	2016	2017	2018	2019	2020
Identification and assessment of new cases of alcohol use/dependence	1	2	4	8	15	15
Brief interventions and follow-up for alcohol use/dependence	1	2	4	8	15	15
Restrict consumption of alcohol and tobacco products by banning advertising and influence the increasing taxation	10	28	46	64	82	100
Drug use/dependence						
Smoking cessation	0	3	6	9	12	15
Identification and assessment of new cases of drug use/dependence	0	3	6	9	12	15
Brief interventions and follow-up for drug use/dependence	0	3	6	9	12	15
Self-harm/suicide						
Assess and care for person with self-harm	0	3	6	9	12	15
Basic psychosocial treatment, advice, and follow-up for self-harm/suicide	0	3	6	9	12	15
Injury and Violence						
Prevention and Treatment of Injury						
Ambulance service	40	40	42	45	45	50
Trauma management service	40	40	42	45	45	50
Surgical emergency service	40	40	42	45	45	50
Gynecologic emergency service	33	40	45	50	55	55
Prevention and Management of GBV/IPV						
Identification of GBV/IPV	0	16	32	48	64	80
Clinical care for survivors of sexual assault	0	10	20	30	40	50

ANNEX 4. Total Number of Services by Service Year

	2016	2017	2018	2019	2020	Total
Sexual and Reproductive Health						
Family planning						
Pill	149,616	175,989	204,298	234,367	207,552	971,822
Condom	16,570	18,734	20,930	23,137	25,957	105,327
Injectable	1,714,378	1,940,761	2,171,112	2,403,133	2,659,262	10,888,647
IUD	21,155	21,864	23,959	26,065	49,962	143,005
Implant	106,702	111,796	122,936	134,148	155,942	631,525
Female sterilization	8,418	10,943	13,869	17,038	21,993	72,260
Safe abortion						
Safe abortion	3,711,106	4,369,584	5,011,221	5,633,120	6,231,725	24,956,756
Management of abortion complications						
Post-abortion case management	353,850	442,099	392,404	417,019	373,904	1,979,275
Management of ectopic pregnancy care						
Ectopic case management	31,070	44,553	57,756	70,624	83,090	287,093
Pregnancy care – ANC						
Daily iron and folic acid supplementation	645,560	942,459	1,251,956	1,535,235	1,827,973	6,203,183
Tetanus toxoid	5,782,421	6,340,181	6,879,812	7,398,724	7,893,519	34,294,656
Syphilis detection and treatment	3,970,020	4,883,653	5,775,645	6,642,036	7,478,070	28,749,424
Basic ANC	4,608,676	5,466,264	6,302,248	7,112,864	7,893,519	31,383,570
Pregnancy care - Treatment of pregnancy complications						
Hypertensive disorder case management	198,501	244,183	288,782	332,102	373,904	1,437,471
Management of pre-eclampsia	19,850	24,418	28,878	33,210	37,390	143,747
Management of other pregnancy complications	119,101	146,510	173,269	199,261	224,342	862,483
De-worming	5,696,116	6,168,825	6,625,004	7,062,419	7,478,070	33,030,434
Operative delivery for dystocia and other pregnancy complications	595,503	732,548	866,347	996,305	1,121,711	4,312,414
Childbirth care - Facility births						
Labor and delivery management	4,315,239	5,140,687	5,945,517	6,726,113	7,478,070	29,605,626
Active management of the 3 rd stage of labor	3,970,020	4,883,653	5,775,645	6,642,036	7,478,070	28,749,424
Pre-referral management of labor complications	595,503	732,548	866,347	996,305	1,121,711	4,312,414
Management of eclampsia	79,400	97,673	115,513	132,841	149,561	574,988
Neonatal resuscitation	198,501	244,183	288,782	332,102	373,904	1,437,471

	2016	2017	2018	2019	2020	Total
Management of obstructed labor	397,002	488,365	577,564	664,204	747,807	2,874,942
Kangaroo mother care	5,111	9,376	13,081	16,171	18,688	62,427
Feeding counseling and support for low-birth-weight infants	7,503	11,067	14,139	16,664	18,688	68,061
Childbirth care - Home births						
Clean practices and immediate essential newborn care	23,406	23,773	24,096	24,289	24,428	119,993
Childbirth care – Other						
Antenatal corticosteroids for preterm labor	5,955	7,301	8,606	9,830	10,993	42,685
Antibiotics for pPROM	3,930	4,819	5,680	6,488	7,255	28,172
Induction of labor (beyond 41 weeks)	1,429	1,752	2,065	2,359	2,638	10,244
Postpartum care - Treatment of sepsis						
Maternal Sepsis case management	2,382	2,920	3,442	3,932	4,397	17,074
Postpartum care - Treatment of newborn sepsis						
Treatment of local infections	51,265	98,885	145,285	189,636	232,070	717,140
Newborn sepsis - Full supportive care	1,867	2,626	3,088	3,242	3,087	13,909
Newborn sepsis - Injectable antibiotics	236	415	552	626	673	2,502
Postpartum care – Other						
Clean postnatal practices	119,100	146,021	172,114	196,604	219,856	853,696
Mastitis	2,227	2,613	2,987	3,335	3,664	14,825
Treatment of postpartum hemorrhage	198,501	244,183	288,782	332,102	373,904	1,437,471
Chlorhexidine	26,854	66,475	110,081	155,065	200,508	558,984
PMTCT						
PMTCT	7,459,290	7,753,772	7,758,493	7,700,604	7,631,975	38,304,135
Management of Obstetric Fistula						
Obstetric fistula case screening	4,266	3,920	3,164	2,402	3,385	17,137
Obstetric fistula case identification	6,464	5,939	4,795	3,639	5,129	25,966
Obstetric fistula case treatment	6,464	5,939	4,795	3,639	5,129	25,966
Management of STIs						
Treatment of syphilis	3,432,691	3,885,117	4,350,303	4,824,084	5,303,169	21,795,364
Treatment of gonorrhoea	3,432,691	3,885,117	4,350,303	4,824,084	5,303,169	21,795,364
Treatment of Chlamydia	3,432,691	3,885,117	4,350,303	4,824,084	5,303,169	21,795,364
Treatment of trichomoniasis	3,432,691	3,885,117	4,350,303	4,824,084	5,303,169	21,795,364

	2016	2017	2018	2019	2020	Total
Treatment of PID	274,483	406,482	543,961	686,018	831,779	2,742,723
Others						
HPV vaccine	0	1,227,800	2,045,581	2,879,684	3,729,527	9,882,593
Menstrual Hygiene Management	2,432,202	4,398,183	6,409,744	8,464,576	10,562,667	32,267,372
Management of menstrual disorders	511,581	868,247	1,234,974	1,610,167	1,992,397	6,217,366
HIV/AIDS						
Voluntary counseling and testing	7,627,255	11,272,608	15,070,438	18,996,770	23,026,918	75,993,989
Condoms	3,150,378	5,142,967	7,222,106	9,375,655	11,589,953	36,481,059
Nutrition						
Intermittent iron-folic acid supplementation	7,160,868	9,681,740	12,256,082	14,884,205	17,568,451	61,551,345
Nutritional assessment and counseling	9,547,825	12,102,175	14,707,298	17,364,905	20,078,229	73,800,432
School de-worming	16,708,693	19,363,479	22,060,947	24,807,008	25,097,787	108,037,913
Non-communicable diseases						
Screening for risk of CVD/diabetes	1,707,830	2,478,129	3,591,223	5,200,743	7,529,336	20,507,261
Diagnosis and treatment of cases with rheumatic fever	31,443	70,257	152,251	193,425	204,257	651,634
Mental, Psychosocial and Substance Use Disorders						
Basic psychosocial treatment for anxiety disorders (mild cases)	351,535	720,923	1,106,805	1,506,955	1,918,910	5,605,128
Basic psychosocial treatment and anti-depressant medication for anxiety disorders (moderate-severe)	159,789	327,692	503,093	684,980	872,232	2,547,786
Depression						
Basic psychosocial treatment and anti-depressant medication of first episode moderate-severe cases	901	1,954	4,229	9,133	8,839	25,056
Basic psychosocial treatment for mild depression	901	1,954	4,229	9,133	8,839	25,056
Psychosis						
Basic psychosocial support and anti-psychotic medication	1,418	4,164	10,048	13,093	13,956	42,679
Bipolar disorder						
Basic psychosocial treatment, advice, and follow-up for bipolar disorder, plus mood-stabilizing medication	6,647	13,457	27,189	54,798	55,823	157,915
Conduct disorders						

	2016	2017	2018	2019	2020	Total
Basic psychosocial treatment, advice, and follow-up for behavioral disorders	63,916	131,077	201,237	273,992	348,893	1,019,114
Alcohol use/dependence						
Identification and assessment of new cases of alcohol use/dependence	12,570	25,134	50,130	101,035	102,923	291,792
Brief interventions and follow-up for alcohol use/dependence	11,931	23,856	47,581	95,897	97,690	276,955
Restrict consumption of alcohol and tobacco products by banning advertising and influence the increasing taxation	28,085,281	47,220,378	67,196,251	87,999,791	109,609,788	340,111,489
Drug use/dependence						
Smoking cessation	9,587	19,662	30,186	41,099	52,334	152,867
Identification and assessment of new cases of drug use/dependence	9,587	19,662	30,186	41,099	52,334	152,867
Brief interventions and follow-up for drug use/dependence	9,587	19,662	30,186	41,099	52,334	152,867
Self-harm/suicide						
Assess and care for person with self-harm	20,453	41,945	64,396	87,677	111,646	326,117
Basic psychosocial treatment, advice, and follow-up for self-harm/suicide	20,453	41,945	64,396	87,677	111,646	326,117
Injury and Violence						
Prevention and Treatment of Injury						
Ambulance service	85,221	91,754	100,619	102,747	116,298	496,638
Trauma management service	85,221	91,754	100,619	102,747	116,298	496,638
Surgical emergency service	85,221	91,754	100,619	102,747	116,298	496,638
Gynecologic emergency service	21,179	24,428	27,776	31,193	31,769	136,345
Prevention and Management of GBV/IPV						
Identification of GBV/IPV	2,677,469	5,459,632	8,339,103	11,307,221	14,356,674	42,140,099
Clinical care for survivors of sexual assault	1,673,418	3,412,270	5,211,939	7,067,013	8,972,922	26,337,562
Total	141,506,132	192,401,858	244,291,674	297,955,654	350,805,894	1,226,961,210

ANNEX 5. Program Cost

	2016	2017	2018	2019	2020	Total
1. Training						
In-service / Refresher Training	43,595,422	46,680,432	44,967,132	44,166,072	42,563,952	221,973,010
Training of Trainers	913,926	360,672	25,771	25,771	25,771	1,351,912
Development of Training Materials	851,700	358,223	0	0	0	1,209,923
Design and integration of pre-service curriculum	750,000	0	0	0	0	750,000
2. Supervision and Review/Coordination						
Coordination/Review Meetings	13,111,081	15,077,743	17,339,405	19,940,315	22,931,363	88,399,907
Program supervision: national-RHB-Zones-Woredas	916,428	1,008,070	1,108,877	1,219,765	1,341,742	5,594,882
Clinical supervision	0	2,214,300	4,428,600	6,642,900	8,857,200	22,143,000
3. Monitoring and Evaluation and Research						
Design of M&E Frameworks and Systems	554,000	0	0	0	0	554,000
Design of Quality Control and Assurance	739,000	0	0	0	0	739,000
Research	1,948,883	1,702,035	1,446,730	1,486,572	2,810,956	9,395,177
4. Infrastructure and Equipment						
Renovate/Upgrade existing rehab centers	8,500,000	0	0	0	0	8,500,000
Construct new rehab centers	65,000	130,000,000	130,000,000	130,000,000	130,000,000	520,065,000
Program equipment/materials	593,630,922	1,058,211,644	1,522,792,366	1,987,373,088	2,451,953,810	7,613,961,830
5. Communication, Media & Outreach						
Development of Communication Materials	120,000	0	120,000	0	0	240,000
Mass Media	22,492,000	22,440,000	22,440,000	22,440,000	22,440,000	112,252,000
Printed Materials	78,499,999	83,624,999	84,249,999	85,374,999	86,499,999	418,249,996
Social Outreach Activities	33,150,000	18,000,000	23,050,000	18,000,000	18,000,000	110,200,000
6. General Program Management						
Design and Review of Country Strategy	266,333	0	0	0	0	266,333
Development and Review of Annual Work Plan	65,900	65,900	65,900	65,900	65,900	329,500
7. Other						

	2016	2017	2018	2019	2020	Total
Revise and update the minimum package of interventions for AYH	500,000	0	0	0	0	500,000
Develop and distribute service delivery protocols/ checklists for health workers	750,000	0	0	0	0	750,000
Totals	801,420,594	1,379,744,019	1,852,034,781	2,316,735,383	2,787,490,692	9,137,425,470

ANNEX 6. Monitoring and Evaluation Matrix

SN	Indicator	Type	2015	'16	'17	'18	'19	2020	Freq	Source
1	Mortality rate from all causes, age 10-14 (per 1,000 population)	Impact	TBD					↓ by 50%		
2	Mortality rate from all causes, age 15-19 (per 1,000 population)	Impact	5.73					2.86	5 years	DHS
3	Mortality rate from all causes, age 20-24 (per 1,000 population)	Impact	5.88					2.94	5 years	DHS
4	Maternal mortality ratio adolescent girls age 15-19 (per 100,000 LBs)	Impact	308					254	5 years	DHS
5	Maternal mortality ratio young women age 20-24 (per 100,000 LBs)	Impact	556					278	5 years	DHS
6	Adolescent pregnancy Rate (%)	Impact	12					3	5 years	DHS, PMA
7	HIV new infection among adolescents and youth 15-24 years	Impact	0.02					0.01	5 years	DHS
8	Contraceptive Prevalence Rate (CPR) among all young women (15-24) (%)	Outcome	18.3					30	1 or 5yearly	PMA/ DHS
9	Unmet need for modern contraceptives among adolescents age 15-19 (%)	Outcome	32.8					10	5 years	EDHS
10	Unmet need for modern contraceptives among youth age 20-24 (%)	Outcome	21.8					10	5 years	EDHS
11	% of pregnant women age 15-24 who have ANC4+	Outcome	43					90	1 or 5yearly	HMIS/ DHS
12	% of pregnant women age 15-24 who deliver with SBA	Outcome	40					90	1 or 5yearly	HMIS/ DHS

SN	Indicator	Type	2015	'16	'17	'18	'19	2020	Freq	Source
13	Early PNC (≤ 7 days) coverage among pregnant women age 15-24 (%)	Outcome	35					95	1 or 5 yearly	HMIS/DHS
14	% adolescents and youth (15-24 years) tested for HIV	Outcome	35.4					90	1 or 5 yearly	HMIS/DHS
15	HPV vaccination coverage among adolescents (9-13 Years)	Outcome	0					50	2-3 years	SS
16	Prevalence of IDA among female adolescents age 10-19	Outcome	30					15	2-3 or 5 years	SS/DHS
17	Prevalence of depression among adolescents and youth (15-24 years)	Outcome	12					6	2-3 years	SS
18	Prevalence of tobacco use among adolescents and youth (15-24 years)	Outcome	4.4					2.2	2-3 years	SS/DHS
19	Prevalence of Khat consumption among adolescents and youth (15-24 years)	Outcome	51					25.5	2-3 years	SS/DHS
20	Prevalence of alcohol consumption among adolescents and youth (15-24 years)	Outcome	45.6					23	2-3 years	SS/DHS
21	% of adolescents and youth (10-24 years) having access to comprehensive AYH information	Outcome						50	2-3 years	SS/DHS

SN	Indicator	Type	2015	'16	'17	'18	'19	2020	Freq	Source
22	% of adolescents and youth (10-24 years) having access to comprehensive sexuality education							62.5		
23	% of adolescents and youth having comprehensive knowledge on HIV/AIDS	Outcome	28.4					95	2-3 years	SS/DHS
24	Median age at first sex (years)	Outcome	16.5					≥18	1 or 5 yearly	DHS/PMA
25	Prevalence of child marriage <18 years (%)	Outcome	8					0.5	5 years	DHS
26	Median age at first marriage (years)	Outcome	16.4					≥18	5 years	DHS
27	Prevalence of FGM/C	Outcome	24.3%					<0.5%	5 years	DHS
28	Prevalence of injuries from RTAs among 15-29 years	Outcome	2.7%					2.02%	2,3 years	STEPS
29	Prevalence of injuries from non-RTAs among 15-29 years	Outcome	2.4%					1.8%	2,3 years	STEPS
30	Proportion of adolescent and youth engaged in regular physical activity	Outcome						40	2,3 years	SS
31	% adolescents and youth screened for hypertension (blood pressure) (15-29)	Outcome	17 (STEPS)					40	2,3 years	HMIS/SS
32	% adolescents and youth screened for diabetes (blood glucose) (15-29)		1.6 (STEPS)							
33	% eligible adolescents and youth diagnosed and treated for STIs	Output	38					70	Annual	HMIS

SN	Indicator	Type	2015	'16	'17	'18	'19	2020	Freq	Source
34	% eligible adolescents and youth diagnosed and treated for rheumatic fever	Output						40	Annual	HMIS
35	% adolescents and youth who access health services and assessed and counseled for nutritional problems	Output						100	Annual	HMIS
36	% adolescent girls (10-19) provided with iron folate supplementation	Output						50	Annual	HMIS
37	Proportion of adolescents received de-worming tablets							75		
38	% vulnerable and marginalized adolescents and youth received AYH interventions	Output						60	Annual	Admin
39	% of adolescent and young pregnant women attending ANC develop birth preparedness and complication readiness plan	Output						90	Annual	Admin/SS
40	% of WDGs/MDGs trained and sensitized on AYH services	Output						80	Annual	Admin
41	% of HEWs providing AYH services	Output						80	Annual	Admin
42	% of health professionals trained and providing AYH services (disaggregated by category)	Output						100	Yearly	Admin
43	Number of School and TVET colleges providing AYFH services	Output						50	1 or 2-3 years	Re-ports/Survey

SN	Indicator	Type	2015	'16	'17	'18	'19	2020	Freq	Source
44	Number of university clinics providing AYFH services							100	1 or 2-3 years	Re-ports/ Survey
45	% of public health facilities providing minimum package of AYFS	Output						100	1 or 2-3 years	Admin/ ESPA+
46	% of adolescents and youth utilizing need based, full range AYH care	Outcome						62.5	2-3 years	SS
47	% of facilities and Woreda Health Offices implementing CQI for AYH	Output						50	Yearly	Admin
48	Minimum AYH service package developed	Input						1	Once in 2016	Admin
49	% of adolescents and youth covered by health insurance scheme	Input						80	Once in 2016	Admin
50	% of adolescents and youth having access to m-health and e-health	Output						100	2-3 years	SS
51	AYH core indicators identified and integrated in HMIS and population based surveys such as DHS	Output						100	Yearly	Admin
52	Minimum number of AYH related research conducted and published	Output						≥10	Annually	Admin
53	National multi-sectoral coordination of AYH established (#)	Output						1	Once in 2016	Admin
54	Regional multi-sectoral coordination of AYH established (#)	Output						11	Once in 2016	Admin

SN	Indicator	Type	2015	'16	'17	'18	'19	2020	Freq	Source
55	National MOH AYH units established/strengthened (#)	Output						1	Yearly	Admin
56	RHB AYH units established/strengthened (#)	Output						11	Once in 2016	Admin
57	AYH focal persons assigned per WoHO	Output						All	Once in 2016	Admin
58	AYH focal persons in AY sectors	Output						All	Once in 2016	Admin
59	% of adolescent and youth organizations engaged in AYH programs	Output						100	1 or 2-3 years	Admin / Survey

ANNEX 7. Roles and Responsibilities

7.1. MOH Leadership and Governance

MOH Structure	Key Roles and Responsibilities
FMOH/MCHD	<ul style="list-style-type: none"> • Develop, lead and coordinate national policy, regulations and strategies on adolescent and youth health and development • Ensure the presence of a formal structure at national, regional and sub-regional levels that is responsible for adolescent and youth health programming and implementation • Ensure effective intra-ministerial convergence among national programs (MCH, communicable and non-communicable diseases including mental health and cancer) • Lead and coordinate detail operational planning and budgeting of the AYH program and its inclusion in the overall annual operational plan of the MOH; and joint technical and managerial supervision of the program • Manage capacity building: <ul style="list-style-type: none"> ▪ Develop technical resource material (operational frameworks, guidelines, training material for capacity building) for all thematic areas identified in the strategy and train health workers ▪ Facilitate training of service providers on adolescent and youth health and development issues and use existing platforms whenever possible • Ensure that there is adequate capacity in terms of staffing, equipment, and supplies at the health facility level • Strengthen Health Management Information System (HMIS)/monitoring and supportive supervision of AYH program; ensure that the AYH agenda is addressed at all coordination forums (JCF, JCCC, etc.) • Coordinate national partnerships and technically manage the program through chairing the AYH TWG (development and/or implementing partners, youth associations, civil societies, relevant public and private organizations) • Strengthen information, commodities and services including counseling: enhance focus on health education and health promotion at the community and facility levels, provision of commodities, and essential preventive and curative health services • Lead and capacitate the RMNCAYH-N research council to support research and publications; and periodic surveys and evaluations of AYH interventions • Guide and support RHBs and lower levels as they lead the establishment of AYFS services in health facilities within their respective jurisdictions • Actively work with other relevant ministries (Ministry of Education, Ministry of Youth Affairs and Sports, Ministry of Women and Children Affairs, Ministry of Labor and Social Affairs), Ethiopian Youth Federation, and other organizations, and networks to establish the AYH Multi-Sectoral Coordination Forum at national and sub-national levels • Work seamlessly with the new multi-sectoral platform to reinforce sectoral interventions; advocate and mobilize resources for improving AYH and development outcomes • Explore and establish joint monitoring and reporting mechanisms between participating ministries, especially MOE, MOYAS and MOWCA • Lead the development of AYH standards, tools and guidelines

MOH Structure	Key Roles and Responsibilities
<p>Regional Health Bureaus</p>	<ul style="list-style-type: none"> • Coordinate the planning, implementation, monitoring and evaluation of all adolescent and youth health programs in the region in line with the Adolescent and Youth Health Strategy 2016-2020; and the strategies of related programs such as child and newborn survival, reproductive health, and nutrition • Management of health service delivery, including management of health facilities, personnel and health training institutions in the region • Ensure the development of sound annual operational plans and their inclusion in the overall health sector plan of the region • Conduct strategic communication activities on the new national strategy to sensitize and create awareness about the shift in paradigm in AYH including the current global initiatives to decision makers including the regional administration council, the cabinet, the judiciary, youth leadership, and local communities • Coordinate the inputs of partners and NGOs working on adolescent and youth health in their respective region • Disseminate technical and managerial guidelines on adolescent and youth health • Work with MOH and lower levels to ensure the availability of all essential equipment and supplies to health facilities within the region • Facilitate capacity building and training of health staff on AYH and appropriate staffing of health facilities through equitable deployment including in remote and hard to reach locations • Develop approaches to meet the adolescent and youth health needs of special population groups in their respective region • Collaborate with the regional offices for education, women and children, youth affairs and sport, on activities relevant to adolescent and youth health and development including the establishment and proper functioning of the regional multi-sectoral committee on AYH • Support zone and woreda health offices and relevant sector offices in operational planning and budgeting; and technical and managerial supervision including problem identification and solving, and review of progress in implementing interventions/service delivery • Coordinate and lead (with zones and woredas) the establishment of AYFS services in health facilities and community intervention platforms • Ensure the establishment and operationalization of a structure (including assigning focal persons and allocating budget) to lead and manage the AYH program in the region; support zones, woredas, and health facilities to establish and run strong AYH structures • Establish and lead strong regional AYH TWGs that cater all stakeholders involved in technical AYH program implementation

MOH Structure	Key Roles and Responsibilities
Woreda Health Offices	<ul style="list-style-type: none"> • Ensure a focal person for adolescent and youth health is assigned in the office • Coordinate the planning, implementation, supervision and support of all adolescent and youth health activities in the woreda • Ensure that all adolescent and youth health interventions are incorporated in the annual operational plans of the woreda and implemented effectively • Coordinate the inputs of partners and NGOs in the woreda in the area of adolescent and youth health • Improve care seeking behavior through community dialogue and the Health Development Army (HDA) networks • Establish linkage with other sector offices (education; women and children affairs; youth affairs and sports) on activities relevant to adolescent and youth health and development • Organize and conduct clinical supervisions of health workers including supervision of HEWs • Ensure adequate staffing of health facilities with health workers trained and qualified on AYH, as well as availability of spaces and stocks of essential supplies and equipment to ensure the AYFS provision in the facilities • Monitor and review adolescent and youth health activities, including data management, periodic reviews of progress, and problem solving

7.2. Key Collaborators

Collaborator	Key Roles and Responsibilities
Ministry of Education	<ul style="list-style-type: none"> • Implement AACSE in-line with the Education Sector Policy Support utilization of ICT and other innovative approaches, such as modeling youth champions in delivery of AYH information • Enhance implementation of the promoting girls' education initiative • Facilitate provision of information to parents on AYH within the school set-up • Support implementation and scale up of school health and nutrition programs as per the school health and nutrition strategy • Collaborate with MOH for expanding adolescent and youth-friendly health and nutrition information and services in all university clinics and strengthening health referral system • Support the implementation of equitable school health policies that promote skills-based health education and ensure safe and healthy school environment for promotion of psychosocial and physical wellbeing that include sufficient safe water and sanitation facilities as well as sound, welcoming and secure physical structures (buildings, paths and latrines) • Strengthen life skill training manual implementation for primary and secondary school

Collaborator	Key Roles and Responsibilities
Ministry of Youth Affairs and Sports	<ul style="list-style-type: none"> • Make the health and development of adolescents and youth a political priority • Support policy advocacy, resource mobilization, and generation of data/information • Integrate AYH into youth empowerment programs • Support mainstreaming youth in all AYH and related programs • Enact and ensure enforcement of laws that protect adolescents and youth with regards to alcohol, drugs, and tobacco • Enact and ensure enforcement of laws that protect adolescents and youth with regards to alcohol, drugs and tobacco • Create awareness on harmful effects of alcohol, drugs and tobacco • Ensure greater livelihood opportunities for adolescents and youth in line with existing laws • Create sports and recreational outlets and mobilize adolescents and youth to engage in leisure-time (sports and recreational) activities • Provide age-sex disaggregated data for alcohol, drugs, and tobacco use for decision making • Provide organizational capacity building support to youth organizations and enhance their meaningful participation in programming of AYH related policies, strategies, and plans
Ministry of Women’s and Children’s Affairs	<ul style="list-style-type: none"> • Protect adolescents and youth against harmful cultural practices, child marriages, child labor, and trafficking • Ensure implementation of the Prohibition of FGM Act, the revised criminal law on child marriage, and other AYH related acts • Lead and coordinate the implementation, monitoring and evaluation of the national strategy and action plan on HTPs against women and children, including advocacy on elimination of GBV and monitoring anti-FGM interventions • Collaborate with law enforcement bodies and relevant AYH sensitive sectors and ensure the effective enforcement of laws and administration of justice to protect adolescents and youth <ul style="list-style-type: none"> ▪ Complaints on violations of the rights of adolescents and youth are received ▪ Violations of the rights of adolescents and youth are properly investigated ▪ Implementation of AYH commitments and obligations are monitored • Provide age-sex disaggregated data on FGM and GBV for decision making • Support promotion of adolescent nutrition and influence HTP and social norms affecting adolescent nutrition

Collaborator	Key Roles and Responsibilities
Media and Communications	<ul style="list-style-type: none"> • Position the health of adolescents and youth as a priority item on the news agenda • Lead and coordinate in developing social media and digital platforms to give adolescents and youth a voice and to support utilization of ICT in delivery of AYH information • Regulate media content on adolescent and youth health and nutrition information • Implement mass media campaigns to advocate and create public awareness on matters related to AYH work with MOH and others to publish more evidence-based stories about the health of adolescents and youth, coverage gaps and young people who miss out on needed services • Communicate responsibly and accurately on public health issues using information received from academia and the government in a careful and considered way
The Private and Business Sector	<ul style="list-style-type: none"> • Support government policies aimed at universal health coverage, better nutrition and healthier foods • Identify and address with partners the external consequences of business actions that might harm the health and nutrition of adolescents and youth • Support efforts to improve access to good-quality health services and life-saving commodities • Explore new drugs, technologies and interventions to improve emerging health challenges and bring the most promising innovations to market • Use business expertise to create and scale up interventions that promote adolescent and youth health, such as essential interventions and education on sanitation and hygiene and access to improved nutrition
CSOs, CBOs, FBOs	<ul style="list-style-type: none"> • Support provision of AYH information and services to adolescents and youth and communities • Advocate for increased attention to, and investment in, adolescents' and youth's health • Strengthen community and youth capabilities to implement the most appropriate and affordable interventions and to participate meaningfully in the governance of services • Forge multi-sector partnerships for adolescents' and youth's health; build community and stakeholder support for AYH policies and programs • Support efforts to close gaps in data about marginalized and vulnerable adolescents and youth • Support research and policy formulation and dissemination on AYH • Support sustainable programs seeking to empower adolescents and youth • Meaningfully involve adolescents and youth in policy formulation, program design, implementation, research, and M&E • Advocate and mobilize resources for policy implementation • Design and implement innovations to enhance special efforts that empower adolescent girls and boys who are especially vulnerable • Track progress and hold itself and all other stakeholders accountable for commitments • Support promotion of adolescent nutrition and influence HTP and social norms affecting adolescent nutrition

Collaborator	Key Roles and Responsibilities
Youth Organizations, Associations, and Networks	<ul style="list-style-type: none"> • Participate meaningfully in research, policy, and planning, and program implementation • Champion adolescent AYH interests through existing relevant structures at all levels • Design, develop, implement, and evaluate innovative AYH interventions at all levels • Generate demand for health programs and support their implementation • Actively support positive changes to social norms and attitudes that impede progress • Advocate for adolescent and youth health and hold governments and duty-bearers to account • Create and support special provisions to foster participation and inclusion of adolescent girls • Discipline members who violate code of conduct on matters relating to AYH • Undertake research on AYH and knowledge sharing
Academic and Research Institutions	<ul style="list-style-type: none"> • Enhance AYH content in medical and allied health sciences curricula at pre-service level • Advocate for targeted research and increased budgets for research and innovation • Build institutional research capacity in low- and middle-income countries • Conduct continuous research on AYH and generate, translate and disseminate evidence and best practices to inform decisions for effective and equity-oriented AYH policies and programs • Strengthen networks of academics and researchers to promote knowledge exchange
Bilateral Development Partners and Philanthropic Institutions	<ul style="list-style-type: none"> • Mobilize additional resources for adolescent and youth health, including through innovative financing, to complement domestic investments, and align these resources with country plans and priorities • Deliver effective technical support for country-identified adolescent and youth health priorities, while enhancing local capacities to develop, finance, implement, and monitor evidence-based national plans and programs that support adolescent and youth health • Invest in innovation and research, including implementation research, to better meet country needs through effective health interventions, tools, and delivery mechanisms • Enhance cross-sector collaboration in line with best practice; integrate health, nutrition, water and sanitation interventions, and strengthen links with sectors, such as education and gender equity

Collaborator	Key Roles and Responsibilities
Multilateral Organizations and UN Agencies	<ul style="list-style-type: none"> • Mobilize resources to fill funding gaps at country level, including through innovative financing mechanisms, and invest in public health and goods that improve adolescents’ and youth’ health • Provide technical support to develop and cost national plans and to implement them by working with a full range of stakeholders • Define evidence-based norms, regulations and guidelines to underpin efforts to improve the health of adolescents and youth • Support the creation of dedicated safe spaces for adolescents and youth, e.g. support the GOE’s efforts to implement Citizens’ Charters • Support and participate in systems that track progress and identify gaps to strengthen action and accountability for AYH

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List of contributors

Members of the Technical Working Group (TWG) that contributed to Adolescent Youth Health Strategy for the year 2016-2020 under the leadership of the FMOH/MCH, whose names and the organizations they represent appears below deserve special thanks for their contributions

Name	Institution
Abiy Hiruye, Dr.	Pathfinder International
Assefa Alem, Dr.	EH
Aster Teshome (Coordinator)	FMOH
Berhanu Tesfaye	MOE
Difabachew Setegn	FGAE
Ephrem Tekele, Dr. (MNCAYH-N) Director	FMOH
Ephrem Birhanu	Talent Youth Assn
Eshetu Girma, Dr.	AAU
Etenesh Gebreyohanes	FMOH
Fetlework Haile	AACAHB
Gurmessa Tura, Dr.	Jimma University
Hailemichael Amsalu	MOWCA
Haimanot Ambelu, Dr.	WHO
Haney Shamil	MOH-AIHA
Hanna Berhane	ACIP
Kurabachew Abera, Dr.	Save the children
Lisanu Tadesse, Dr.	UNICEF
Luwam Teshome Dr.	WHO
Maerg Wagne	FMOH
Mentwab Geday	MWCA
Meron Negussie	UNFPA
Metsehate Ayeneku	PSI
Mirgissa Kaba, Dr.	AAU
Mitike Sisay, Dr.	AAU
Muludesta Workneh	MWCA
Nixon Omollo	Volunteer
Sheleme Humnessa	FMOH
Sintayehu Abebe	FMOH
Teshome Admassu	Packard Foundation
Worknesh Kereta	Pathfinder International
Wogen Shiferaw Dr.	WHO
Yared Abera, Dr.	FMOH
Yared Dagne, Dr.	IPAS
Yayeh Negash, Dr.	UNICEF
Yeshiwork Ayane	MOYS
Yetayesh Maru	UNICEF
Yifru Berhane, Professor.	Hawassa University
Zenebe Akale	FMOH

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MoH

Ministry of Health
P.O. Box 1234
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