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MINISTRY OF HEALTH - ETHIOPA
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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

Minimum Service Package And Standards

For Adolescents and Youth Health

At Workplaces in Ethiopia

MCAYH-N Directorate
June, 2022

Acknowledgments

This Minimum Service Package (MSP) for Adolescents and Youth at Workplaces has benefited from extensive in-person and virtual consultative workshops held with experts from the Ministry of Health of the Federal Democratic Republic of Ethiopia and various national and international partners. These recurrent consultative meetings were held with the aim of ensuring that "minimum services" are exhaustively identified and addressed in the document, and to enrich the content thereof.
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List of Acronyms

AIDS	*Acquired Immunodeficiency Syndrome*
ANC	*Ante-Natal Care*
AYH	*Adolescent and Youth Sexual and Reproductive Health*
BCC	*Behavioural Change Communication*
CAC	*Comprehensive Abortion Care*
CORHA	*Consortium of Reproductive Health Associations*
CSR	*Corporate Social Responsibilities*
DMPA	*Depot-Medroxyprogesterone Acetate*
ECPs	*Emergency Contraceptive Pills*
FMOH	*Federal Ministry of Health*
FP	*Family Planning*
GBV	*Gender Based Violence*
HIV	*Human Immunodeficiency Virus*
HMIS	*Health Management Information Systems*
HSTP	*Health Sector Transformation Plan*
HTPs	*Harmful Traditional Practices*
IEC	*Information Education Communication*
ILO	*International Labour Organization*
IPDC	*Industrial Park Development Corporation*
IPPFP	*Immediate Postpartum Family Planning*
IUCD	*Intra-Uterine Contraceptive Devices*
LDCs	*Least Developed Countries*
MCAYH	*Maternal, Child, Adolescent and Youth Health*
MCAYHD	*Maternal, Child, Adolescent and Youth Health Directorate*
MoH	*Ministry of Health*
MSP	*Minimum Service Package*
NPC	*National Plan Commission*
PAFP	*Post Abortion Family Planning*
PMTCT	*Prevention of Maternal to Child Transmission*
PNC	*Post-Natal Care*
PPFP	*Postpartum Family Planning*
PWD	*Persons with Disability*
RHB	*Regional Health Bureau*
RTI	*Reproductive Tract Infection*

SBCC	*Social and Behavioural Change Communication*
SDG	*Sustainable Development Goal*
SDP	*Service Delivery Point*
SGBV	*Sexual and Gender-Based Violence*
SRH	*Sexual and Reproductive Health*
STIs	*Sexually Transmitted Infections*
UNFPA	*United Nations Population Fund*
WHO	*World Health Organization*
WoHO	*Woreda Health Office*
YFS	*Youth Friendly Service*
ZHD	*Zonal Health Department*

Foreword

The young segment of the population of Ethiopia constitutes the majority of the workforce engaged in mega-projects such as industrial parks, large scale farms, Horticulture and floriculture farms, … across the nation – a significant bulk of this group being women and young girls who face significant challenges including sexual and reproductive health (SRH)-related problems.

One of the most effective interventions to address the rapid population growth in the country has been to empower adolescent and youth to exercise their reproductive health rights. Exercising reproductive rights and making informed choices, in turn, require empowerment in economic status.

Guided by the Sustainable Development Goals (SDGs), the National Population Policy of Ethiopia, the National Reproductive Health (RH) and Adolescent and Youth Sexual and Reproductive Health (AYH) Strategies, the Family Planning (FP) National Guideline, and other related documents, the Federal Ministry of Health (MoH) has developed this **"Minimum Service Package for Adolescent and Youth Health at Workplaces in Ethiopia"** to address major problems endured by adolescents and youth in workplaces.

This document is intended to create a healthy workplace for adolescents and youth – one in which they strive together towards social and organizational conditions that protect and promote health and safety in workplaces such as industrial parks, floriculture and large-scale irrigation farms, factories and large-scale business industries, and other mega-projects such as sugar factories, road construction sites, dry ports, and hydroelectric power plants.

The document outlines the overall activities to be undertaken in order to create a supportive environment, generating awareness among adolescents, organizing and delivering quality Youth-friendly Services (YFS) services, improving capacity of service providers, and monitoring service provision and utilization.

Hence, I would like to call upon all parties who are directly or indirectly responsible to the implementation of this document to give due emphasis to the overall development of adolescents and youth at workplaces.

Executive Summary

Youth unemployment and under-employment have become a growing concern worldwide. According to the International Labour Organization (ILO), the challenge of youth unemployment is especially immense in countries in Sub-Saharan Africa, where young people aged 15 to 24 accounts for 36% of the working-age population. In Ethiopia, the young population between ages 10 to 29 accounts for 42% of the total citizenry.

To improve the health status of its growing population, the Government of Ethiopia has adopted far-reaching policy environments such as the Health Sector Transformation Plan-II (HSTP - II), the RH strategy, the AYH strategy and FP guideline, the National Youth Policy, and the Youth Development Package.

With the intention of creating additional job opportunities for its increasing young population, Ethiopia has invested heavily on mega-projects which have now employed tens ofthousands of workers – of which a significant majority are poorly educated young females from rural areas. Despite the many socioeconomic benefits they present, adolescents and youth working in these mega-projects face unique sexual, reproductive and other health risks.

This document is divided into seven sections, and discusses, among others, the background of adolescent and youth populations in Ethiopia at large, and at workplaces in particular; the guiding principles, intended audiences, and the minimum service packages. The goal of this minimum service package (MSP) is "to enhance comprehensive health and well-being among adolescents and youth at workplaces in Ethiopia," with particular emphasis on furnishing information and counselling on adolescent and youth health issues such as:

- Comprehensive Sexual and Reproductive Health (SRH) services;
- Nutritional screening and counselling;
- Gender-based violence (GBV);
- Psycho-social support services;
- Injuries and non-communicable diseases;
- COVID- 19 and other epidemics.

Outreach services, competent service providers, capacity building trainings, referral linkage, and the monitoring and evaluation (M&E) of the minimum service standards are also discussed in the document.

M&E is also discussed in regard to performance measurement methods, including supportive supervision and program monitoring. Continuous (routine) data collection mechanisms including Health Management Information Systems (HMIS), patient records, observation, and periodic data collection methods such as client exit interviews, providerinterviews, and simulations of care are also discussed in this document.

Section I: Background

I. Introduction

Globally, there are over 1.8 billion adolescents and youth aged 10 to 24 years, 90% of whom live in developing countries. In Africa, 32% of the population belongs to the age group of 10 to 24 years. In Ethiopia, this age group accounts for 33% of the population, over three-quarters of who live in rural areas. (1)

The population of Ethiopia has remained predominately young, with 44.9% under the age of 15, and over half (52%) of the population in the age group between 15 and 65 years. Only three per cent of the total population ages over 65 years, while 42% of the population falls in the agerange 10 to 29 years. The ratio of male-to-female populations in Ethiopia is almost one-to- one, and women of reproductive age account for 23.4% of the population. Women of child bearing age make up 57% of the female population and 30% of the total population. (2)

The economy of least developing countries (LDCs) in general is highly dependent on agriculture, and most people in LDCs live in rural areas and absolute poverty. Industrial parks/mega-project corridors are then the contemporary strategy for rapid industrialization in developing countries, and it is considered as one of the major policy directions which can provide opportunities for investment, increase exports to earn foreign currency, and pave avenues for job opportunities for young and poor people in a given country.

With a vision of becoming a manufacturing hub in Africa, and on a global scale at large, by 2025, Ethiopia has embarked on establishing and expanding mega-project corridors. Thus, exploiting the advantages of the conducive economic factors, including the wide-ranging incentives packages for priority sectors and export-oriented investments, private developers are working on the development of industrial parks in different parts of the country in addition to similar efforts by the Government of Ethiopia. These development efforts have attracted a large volume of workers to the workplace, including adolescents and youth, where more than 80% of workers in industrial parks are below the age of 24. (3)

Despite the many socioeconomic benefits, however, recent studies suggest that the health and safety of adolescents and youth at workplaces in Ethiopia are at a higher risk. (4)

Working Definitions and Scope of the document:

Adolescents – According to the World Health Organization (WHO), adolescents are individuals in the age group of 10 to 19 years; however, adolescents targeted in this minimum package are those between ages 15 and 19 years.

Youth – According to the WHO, youth are individuals from 15 to 24 years of age; however, youth targeted in this minimum package are those between the ages of 15 and 29 years, as per the youth policy of Ethiopia (2004).

Decent Work – refers to "productive work for women and men in conditions of freedom, equity, security and human dignity." In general, work is considered as "decent" when: it pays a fair income, guarantees a secure form of employment, and safe working conditions. (5)

Workplace: For the purpose of this document, Workplace is defined as –

"Those places where many adolescents and youth are hired to work whether they are living there or not"

Scope of the Document: Hence, the scope of the term workplace in this document includes (but not limited to) the following:

- Industrial Parks
- Floriculture farms
- Horticulture farms
- Sugar Factories
- Hydropower Dam projects
- Dry ports
- Factories /Industries
- Large-scale Irrigation farms
- Agro-industries
- Coffee plantations
- Large scale husbandry farms
- Poultries farms
- Dairy farms
- Other mega projects which fulfil the nature of the organization as stated in the document

Healthy Workplace – According to the WHO, a "healthy workplace" is a place where everyone works together to achieve an agreed vision for the health and well-being of workers and the surrounding community, which provides all members of the workforce with physical, psychological, social and organizational conditions that protect and promote health and safety. It also enables managers and workers to increase control over their own health and to improve it, and to become more energetic, positive and contented. (6)

Standard – a statement of desired quality.

Accessible – readily accessible services are provided.

Acceptable – healthcare that meets the expectations of service users

Appropriate – required care is provided; unnecessary and harmful care is avoided.

Comprehensive – care provision covers prevention, counselling, treatment, care, and support.

Effective – healthcare produces positive change in the health status of adolescents and youth.

Equitable – services are provided to all adolescents and youth who need them (including those belonging to low socioeconomic status, vulnerable, marginalized, difficult-to-reach groups).

Equality – providing services equally without partiality in terms of quantity, degree, value, rank, or ability, colour, race, etc.…

Efficiency – providing quality service for adolescents and youth by performing tasks successfully and achieving goals with minimal resource utilization.

Respect – service should be provided for caretakers with high regard and in an honourable manner, with good interaction in a friendly approach.

Sustainable – service provided to adolescents and youth should not be interrupted.

Safe – the workplace should be free from any fears and threats to reduce negative impacts on the environment, and the health and comfort of the care seekers.

Inclusive – giving equal access and opportunities, and getting rid of discrimination and intolerance (removal of barriers).

II. Situational Analysis

1. Geography and Demography

Located in the Horn of Africa, Ethiopia covers an area of 1.1 million square-kilometres with rich geographical diversity, including rugged mountains and deep river valleys, that ranges from 148 meters below sea level (Dallol in the Danakil Depression) to 4,620 meters above sea level (Ras Dashen of the Siemen Mountains).

According to a World-meter estimation based on UN data, Ethiopia's 2020 mid-year population was estimated at 114,963,588 people, which makes the country the second-most

populous in Africa, and ranked it 12th in the world.

The population density is 115 persons per square-kilometre calculated from the total land area of 1,000,000 square-kilometres. The estimated urban population of the country in 2020 constituted 21.3% of the total population, and the median age of Ethiopians was 19.5 years. (7)

Ethiopia is also characterized by a rapid population growth rate (2.6%), a young age structure, a high dependency ratio, and a declining average fertility trend. Total fertility rate is 4.1 births per woman, with a high rural-urban disparity (2.3 in urban and 5.2 in rural areas), and a corresponding crude birth rate of 32 per 1,000 in 2016. Life expectancy at birth for both sexes combined in Ethiopia is 67.8 years.

2. Socio-economy

The Government of Ethiopia has implemented a comprehensive economic reform program over the past few decades, during which period the economy has registered a rapid average annual growth of 10.9%. The Gross Domestic Product (GDP) growth rate of Ethiopia in 2017 was 10.25%, with a Real GDP of $57,710,624,012, while GDP per capita was $542 for the same year. (7)

Consequently, there has been an improvement in the labour market in Ethiopia over the last decades, which in turn has resulted in a significant increase in wages, and the level of unemployment has also decreased from 18% in 2004 to 14.4% in 2013. (8)

Ethiopia's youthful population is a tremendous asset and untapped resource for positive growth. Of Ethiopia's population, estimated at 104 million, 41% is under the age of 15. More than 28% is aged 15 to 29.

Nonetheless, youth unemployment is estimated at nearly 27%. One reason for the high youth unemployment rate is low literacy (68%). Ethiopia's secondary school gross enrolment rate is 39.8% — far too inadequate for a country with Ethiopia's natural resources, economic potential and global ambitions. Technical and vocational education and training reached 352,000 students in 2015, and female enrolment continues to be higher than male enrolment. (3)

Despite these facts, adolescents and youth still face precarious conditions in the labour market.Almost three-quarters of the youth in the workforce earn below the average monthly wage. Moreover, the majority of employed young people work in the informal sector or as unpaid family workers. Nearly one-quarter of the employed youth, particularly young people

aged 15to 19 years who have no bargaining power, worked in the informal sector in 2013. (8)

The Impact of Education on Health and Economy

The participation of adolescents and youth in the labour force is strongly determined by geographical, socioeconomic and gender disparities. Ethiopian young women are more than twice as likely to be unemployed as compared to their male counterparts. Besides the high gender inequality, youth employment in Ethiopia is characterized by a strong duality between rural and urban locales. In addition, the vast majority of young Ethiopians suffer from a lack of access to high-quality education, decent formal sector employment, and governmental employment programs. As the skills acquired in the Ethiopian school system do not satisfy the needs of the national labour market, there is a high demand for technical and vocational education and training programs.

In rural areas, young people leave school at a very early age and start to work in subsistence agriculture: low labour income, large underemployment, and limited chances to enter the formal sector mark their working life. On the other hand, in urban areas, the youth face higher rates of unemployment, strong disadvantages compared to adults, and a school-to-work transition that is more than twice as long as in rural areas. This reflects the realities of the rural-urban migrations of unskilled young workers, as well as new graduates seeking job opportunities in urban economic centres. (9)

Regarding the health of society, education is known to be one of the most important social determinants of health. People are observed to have differences in health status, exposure to health risks, access to health services, and healthcare seeking behaviour due to the differencesin their educational status. The relationship between education and the health of women, youth and adolescents is especially significant, where women's educational attainment has a strong effect on their awareness of RH issues such as family health, reproductive behaviour, fertility, attitude, and use of family planning, infant and child mortality and morbidity. (10)

Educational Status of Adolescents and Youth at Workplaces

According to UNICEF Ethiopia's "Education Advocacy Brief, for Every Child, an Education," Ethiopia has made remarkable progress in education over the past decade with primary school enrolment tripling between 2000 and 2016, and youth literacy rate (for ages 15 to 24) improving from 49.9% (2004) to 69.5% (2015).

Although a cross-sectional study conducted on 30 horticulture and industrial parks in five regions (Addis Ababa, Amhara, Oromia, SNNP and Tigray) in Ethiopia has shown that nearly

85% of women and 95% of men have attended formal education, it also indicated that a higher proportion of them attended only primary school. The majority of these subjects (both male and female) have never been married. Seventy per cent of the workers interviewed were aged 25 years or less, and the majority of the respondents were single/never been in a marital relationship, and literate. (11)

The Impact of the COVID-19 Pandemic on Adolescents and Youth at Workplaces in Ethiopia

A research conducted to provide timely information to the government and related stakeholders about the impacts of COVID-19 on Ethiopia's industrial parks, and the potential policy implications thereof has shown that the COVID-19 pandemic poses a grave set of challenges for Ethiopia's industrialization agenda, with medium and long-term persistent adverse effects on industrial parks. While some firms in these industrial parks have been able

To re-purpose their production towards personal protective equipment, many had to put theirlabour force on temporary leave.

To quantify the impacts of COVID-19 on firms in Ethiopia's export processing industrial park zones, the World Bank Group, in cooperation with the Government of Ethiopia, had administered a phone survey of industrial park firms that reached about 70% of eligible firms (11 out of 14 parks). The survey data suggested that the pandemic severely impacted the ability of firms to produce and sell their output. Firms reported that they expected orders to decrease by an average of 20%, and employment by 17% in the next six months, compared to the same period the previous year.

Overall, firms in industrial parks in Ethiopia have been significantly impacted by the COVID-19 pandemic. About 10% of interviewed firms reported temporarily closing due to COVID-19. Over three-quarters of firms have seen a decline in sales and their production volumes. On average, sales decreased by 42% and production by 40%. (12)

The Ethiopian Labour Force Proclamation

This Proclamation, cited as the "Labour Proclamation No.1156/2019" was initiated due to "… the need to create [a] favourable environment for investment and achievement of national economic goals without sacrificing fundamental workplace rights by laying down well-considered labour administration; and determine the duties and responsibilities of governmental organs entrusted with the power to monitor labour conditions; occupational health and safety; and environmental protection together with bilateral and tripartite social dialogue mechanisms; political, economic and social policies of the Country "

It has also defined “Condition of Work” as “… the entire field of labour relations between workers and employers, including hours of work, wage, leave, payments due to dismissal, workers’ health and safety, compensation to victims of employment injury, dismissal because of redundancy, grievance procedure and any other similar matters ” (13)

Despite this fact, forced overtime, wage withholding, and abusive work conditions have been documented across the board, with women being most at risk given their lower status jobs and more limited communication skills. With low wages, high cost of living and almost uniformly difficult working conditions, it was found that only one in six workers made it through their first year. (14)

Workplaces in Ethiopia

There are a number of workplaces in Ethiopia that accommodate a large group of urban and semi-urban youth. These include industrial parks, large-scale farms, mega-projects, development corridors and others.

Industrial Parks

In order to create new job opportunities for its increasing young population, meet the SDG goals, and fulfil its aspiration of becoming a middle-income country by 2025, Ethiopia has invested heavily in different mega-projects including export-oriented manufacturing industrial parks ranging from textile industries to floriculture farms. (15) Each of these industrial parks now employs tens to hundreds of thousands of workers – nearly all young and mostly poorly educated female migrants from rural areas. (16)

Hence, targeting an annual investment of one billion U.S. dollars in industrial parks over the next decade, and boosting exports to rank Ethiopia as Africa's top manufacturer, the Government of Ethiopia has prepared the legal ground under the “Industrial Parks Proclamation No. 886/2015” that allows any profit-making, public, public-private, or private enterprise to develop industrial parks in the country

Inspired by the full support of the government, the Ethiopian Industrial Park Development Cooperation (IPDC) was established in 2014. Currently, the IPDC is becoming an engine for rapid industrialization that nurtures manufacturing industries to accelerate economic transformation, promote and attract both domestic and foreign investors through availing industrial land, and making accessible pre-built shades equipped with all-encompassing utilities and infrastructural facilities that meet international standards. (17)

Horticulture/Floriculture Farms

The Ethiopian horticultural industry is composed of over 130 investments in the sector. The sector provides employment for approximately 183,000 people and has been growing exponentially. (18)

Mechanized Agricultural Farms

In a study conducted on "Agricultural Investment and the Role of Commercial Farming in Benishangul Gumuz Region," it was found that 221 functional projects have created job opportunities for 42,186 employees at the regional level.

In countries like Ethiopia with limited access to farm machineries and mechanized farms, commercial farms may provide direct employment opportunities that enable generating income to individuals hired at the farms, with indirect engagement afforded to additional individuals in grain and seed marketing and processing jobs. (19)

The Grand Ethiopian Renaissance Dam (GERD)

The 1,780 meter long and 145 meter high gravity dam on the Blue Nile River is located in the Benishangul-Gumuz Regional State, at about 45 kilometres off the border of Sudan. The Roller-Compacted Concrete (RCC) saddle dam is constructed using the most up-to-date construction technology, with a water retention capacity of 74 billion cubic meters upon its completion. With the primary purpose of hydroelectric power generation as high as 6,000 megawatts to relieve Ethiopia's acute energy shortage and export electricity to neighbouring countries, it has been under construction since 2011. The project, which is fully funded by the people and Government of Ethiopia, is expected to benefit not only Ethiopia, but also its neighbours. Currently, the overall construction progress has reached more than 84% and has started generating 375 megawatts of power from one of its turbines.

Up to 12,000 jobs, a significant number of which are taken up by both male and female youth and adolescents, have been created in the construction of the dam; and it is expected that the dam will create more and more employment opportunities for adolescents and youth.

3. Health

Health is defined by the WHO as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition."

Although Ethiopia has made significant progress regarding access to basic health facilities,

young people still face a number of health challenges, including inadequate access to sexual and reproductive health information/services, malnutrition, prevalence of HIV/AIDS, substance abuse (particularly khat, tobacco, alcohol and narcotics), and persistent gender inequalities. Young women represent a high-risk group in Ethiopia, being especially vulnerable to gender-based violence, female genital mutilation, early marriage, and other harmful traditional practices.

In order to tackle the current health and health-related problems of adolescents and youth in the country, the Adolescent and Youth Health Strategy (2021-2025) framework employs eight strategic priorities for positive health development.

Moreover, this MSP document is developed by the MoH to tackle the significant challenges endured at workplaces by adolescents and youth that cannot be easily addressed through the National AYH strategy.

Health Status of Adolescents and Youth at Workplaces

The socioeconomic benefits of establishing industrial parks in Ethiopia aside, recent research suggests that the health and safety of young workers in these establishments are at risk. For instance, adequate training and protective gear are sorely lacking for workers in the floriculture industry that they are exposed to toxic agrochemicals, leading to high rates of illness and mortality. (20)

Unsafe sexual practices among workers, limited awareness on available services at workplaces and surrounding facilities, and unavailability of sufficient toilets and sanitary materials for female workers have significant effects on their health. All forms of physical, verbal, and psychological harassment are common at most workplaces. Moreover, there are weak sexual and gender-based violence (SGBV) reporting and response mechanisms, and a lack of support from the surrounding community. (21)

For young girls in particular, low levels of knowledge and confidence around SRH issues, combined with the abrupt transition from living in traditional home settings to living alone in areas with more men, create a higher potential for risks such as sexually transmitted infections, HIV, SGBV and unwanted pregnancy. This is because they work in an environment where awareness/information on sexual and reproductive health is inadequate, vulnerability to sexual and gender-based violence is high, access to SRH services is limited, and gender roles and norms prohibit women from accessing those limited services.

The SRH risks to adolescents and youth in general, and the risk to young girls at workplaces in particular, include: exposure to unprotected sex, engaging in sex work for additional

income that supplements their meagre earnings from their occupations; increased exposure to sexually transmitted infections (STIs) and HIV contractions, unwanted pregnancies, and abortions. In terms of health service response, sex workers have a day-to-day exposure to SRH risks and have peculiar service needs in information, counselling, contraceptive services, and other SRH support. (22)

Young and adolescent males/boys are also at higher risk of contracting STIs and HIV since their new working environment is one where awareness/information on SRH is deficient, and access to services is limited. Hence, one important factor that should be properly addressed in this regard is the lack of a contextualized and standardized SRH service package at workplaces.

For these reasons, providing quality and sustainable reproductive health services to adolescents and youth at workplaces will significantly and positively impact their lives by preventing unwanted pregnancies, sexual and gender-based violence, exposure to HIV/AIDS, and other related health problems. (14)

Service-level Challenges: Some of the current service-related challenges at workplaces include:

- Unavailability of health facilities;
- Absence of comprehensive SRH services;
- Competing priorities for AYH services;
- Lack of YFS-trained service providers;
- Lack of functional linkages to public health institutions outside the workplace;
- Inconvenient working hours of public health facilities;
- Resistance from workplace managers to get service during working hours.

III. Purpose of the Document

Many adolescents and youth are working with limited access to SRH and other health services in different mega-projects including:

- Industrial parks
- Floriculture and large-scale irrigation farms
- Factories and large-scale business industries
- Other mega-projects such as sugar factories, road construction sites, dry ports, etc.

Hence, this document calls for immediate tailored and targeted interventions to meet the diverse needs and realities of adolescents and youth at workplaces. With the aim of improving access, quality, and utilization of appropriate health services, the document specifies the minimum service package and the standard of health services for adolescents and youth at workplaces in Ethiopia. The document is specifically designed to serve as a platform for the implementation of a standards-driven initiative to improve the quality and expand the coverage of health service provision to adolescents and youth at workplaces.

In addition, the service package will ensure that service quality is uniform across all health service delivery points at workplaces. Overall, it is expected that adhering to the MSP and specified national standards will appropriately improve the access and utilization of services by adolescents and youth at workplaces.

IV. Intended Audience and Beneficiaries

The primary intended beneficiaries of this document are:

- Adolescents and youth at workplaces in Ethiopia;
- Service providers at workplaces (government, non-government, and private sectors);
- Health sector offices at all levels (FMoH, RHBs, ZHDs, WoHOs);
- Local/international development partners;
- Donors supporting YFS programs;
- Civil society and community-based organizations and associations;
- Academic institutions and professional associations;
- Policy/decision makers and program managers;
- Media institutions;
- SRH communicators and advocates;
- Training providers;
- Community members;
- Law enforcement agencies;
- Other government sector offices at all levels, including the Ministry of Women and Social Affairs (MoWSA), and the Ministry of Labour and Skills.

V. Guiding Principles for Youth-Friendly Services at Workplaces

The following principles are critical to the implementation of this national standard and MSP for adolescents and youth at workplaces:

- **Rights-based Approach** – to protect, promote and fulfil their rights to information and healthcare.
- **MCC** – Motivated, Compassionate and Caring service providers.
- **Comprehensive and Integrated Care** – along with support with referral services.
- **High-level Quality Practice** – Compliance with accepted ethical standards.
- **Equity and Inclusion** – with a gender-transformative approach.
- **YFS** – Youth-friendly quality health services.
- **Accountability**

In addition, there is a need to:

- Define a comprehensive package of health services to be provided to adolescents and youth from specified Service Delivery Points (SDPs).
- Provide quality health services through "youth-friendly health services" during routine working hours and off-service hours convenient to adolescents and youth.
- Improve services through training and maintaining staff skills in YFS delivery.
- Develop mechanisms for supportive supervision and on-going capacity building.
- Recognize the diversity of youth and align segment interventions by age, sex, schooling, marital and socioeconomic status, and disability and vulnerability conditions.
- Recognize the socioeconomic and cultural environment of adolescent RH.
- Address the needs of youth through a holistic approach.
- Collaborate with relevant partners from the public, private and non-profit sectors.
- Understand that gender considerations are fundamental to adolescents and youth as they are important determinants of access to social services and opportunities.

SWOT Analysis

Strengths and Opportunities	Challenges/ Threats
• Commitment at the national level • Physical facilities are already there • The workplaces are already providing minimal services • National document already developed • National and regional Legislations for work forces are in place • MOH is willing to take the overall leadership and coordination role • IPDC owns the program • CSR - Issue of providing SRH service by investors • Respective RHBs, Zones, Woredas • and City administrations had been part of the document development process	• Financial shortage • Impact of emergency situations: (eg. Covid pandemic, conflict and climate change) • Difficulty of Coordinating Multiple actors • Shortage of Supply & Financing

Stakeholder Analysis

Governmental Stakeholders:

- MOH and its sector offices
- IPDC, Workplace service/facilities
- Service providers at work places,
- Other ministries and their sector offices

Implementing and development partners

- Development partners, donors,

Other Stakeholders

- Service users (Young people, Community Based Organizations
- Academic institutions, professional associations,
- Training providers, SRH communicators and advocates
- Media institutions; Community members

Future potential partners for the implementation of the program

Stakeholder	**current engagement**	**Future engagement**		
		Planning	Resource mobilization	Implementation/ Coordination
MOH and Its Sector Offices				
Different Ministries and				

Their Sector Offices				
RHBs and their sector Offices				
IPDC				
Donors and Implementing Partners				
Other interested stakeholders				

Section II: Goal, Objective and Outcome

This document specifies the minimum service standards of health services to be provided at health service delivery points for adolescents and youth at workplaces, by improving the quality, access, and utilization of appropriate and comprehensive health services.

I. Goal and Objectives of the MSP

Goal:

The goal of this Minimum Service Package is to improve the health status of adolescents and youth at workplaces in Ethiopia.

Strategic Objectives:

- To enhance the health literacy of adolescents and youth at workplaces.
- To increase access to comprehensive health services.
- To improve utilization of quality health services.
- To contribute to better productivity through investing in health.

II. Expected Outcome

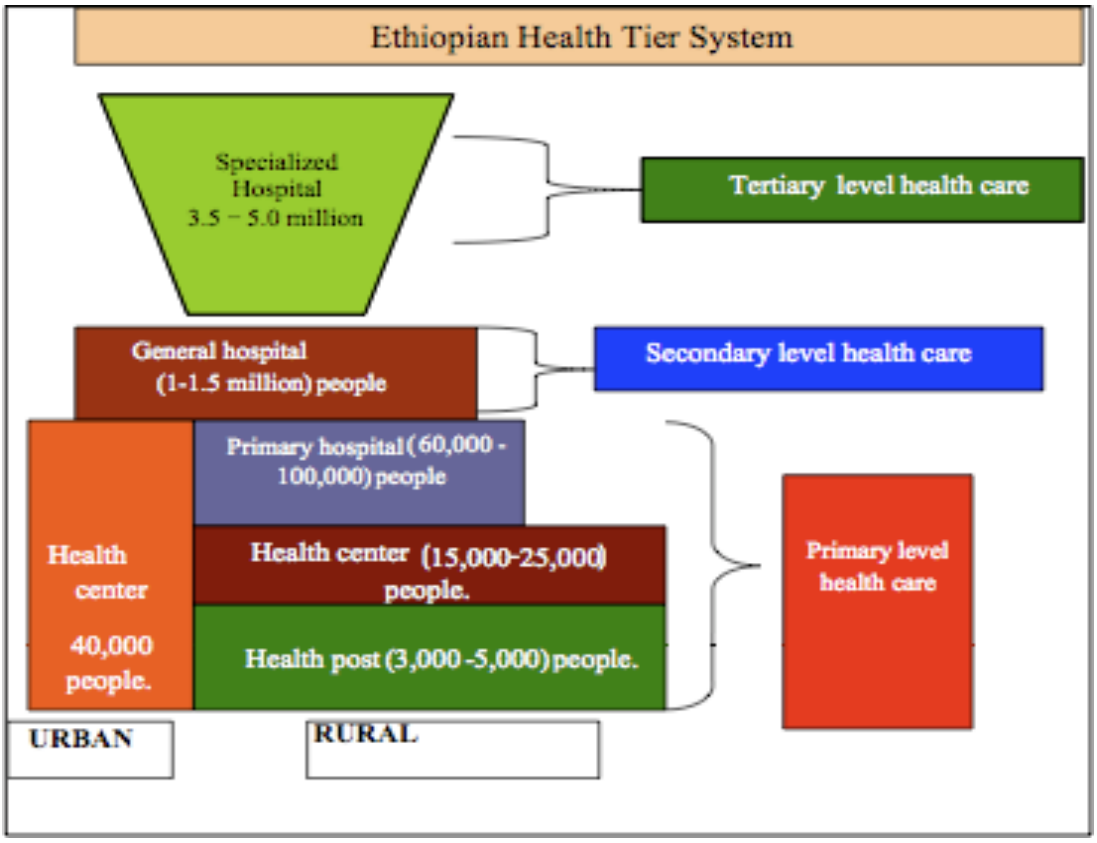
The implementation and operationalization of this Minimum Service Package are "to achieve quality and friendly adolescent and youth health services at workplaces."

Hence, the following outcomes are expected:

- H**armonized SRH/GBV** service **standards** with other health Facilities
- **Improved/integrated SRH & GBV** with other health services
- **Increased access** to quality, comprehensive health information, services, products

Section III: The Ethiopian Health System

I. Functional Health System



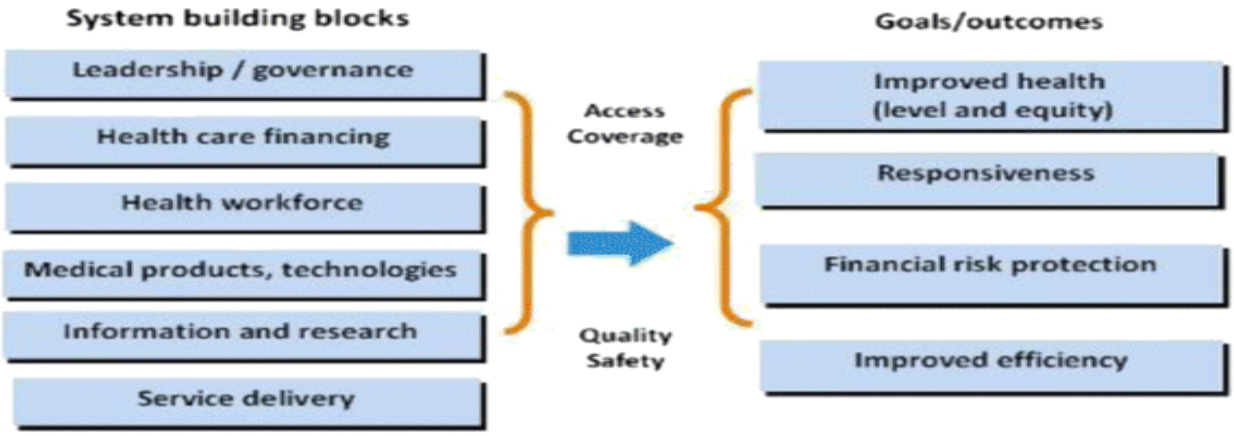
The chart above depicts the three-tier structure of the Ethiopian health system.

The primary care level of Ethiopia's healthcare system is established at the local district level (or 'Woreda' level in Amharic) and includes a primary hospital, local health centres, and rural health posts. The secondary and tertiary levels are comprised of general and specialized hospitals, and the coverage of each extends to larger portions of the population. The management, coordination, and distribution of technical support in each and every level are the responsibility of Woreda/District Health Offices and Regional Health Bureaus, whereas policy and significant decision making are in the hands of the Federal Ministry of Health. (23)

According to the Ethiopian health tier system, the primary care level serves the following groups: a health post for every 3,000 to 5,000 people; a health centre for 25,000 to 40,000 people (25,000 at rural and 40,000 at urban levels); and primary hospitals serve 60,000 to 100,000 populations. The secondary level healthcare system includes general hospitals and each level serves one million to 1.5 million people. The tertiary level healthcare systems include specialized hospitals where each of them serves 3.5 million to five million people.

However, there are segments of the population – including adolescents and youth at workplaces – that cannot be covered within the three-tier system. Hence, this document is developed to address the needs of these segments of the society.

The WHO Health System Building Blocks



The WHO Health Systems Framework (24)

1. **Service Delivery –** Good service delivery is comprised of ***quality, access, safety and coverage.***
2. **Health Workforce (HRH) –** A well-performing workforce consists of ***human resources*** management, skills and policies.
3. **Health Information System –** A well-performing system ensures the production, analysis, dissemination and use of ***timely*** and ***reliable*** information.
4. **Medical Products, Vaccines and Technologies –** Procurement/supply programs need to ensure ***equitable access, assured quality*** and ***cost-effective use***.
5. **Financing –** A good health financing system raises ***adequate funds*** for health, ***protects people*** from financial catastrophe, allocates resources, and purchases goods and services in ways that ***improve quality, equity, and efficiency***.
6. **Leadership and Governance –** Effective leadership and governance ensure the existence of ***strategic policy frameworks***, effective ***oversight*** and coalition building, provision of appropriate ***incentives***, and attention to ***system design***, and ***accountability***.

Section IV: Health Literacy

Social and behaviour change (SBC) is a collaborative and transformative process that empowers individuals, households and communities, and improves knowledge through shifting norms and perceptions, and modifying structures and policies to facilitate positive collective and individual behavioural changes.

Currently, available approaches for SBC for AYH Services include:

1. Capacity building trainings
2. Peer education
3. Health education
4. Use of digital technology for adolescent and youth health services

I. Capacity Building Training for YFS Providers

Capacity building trainings will be provided to health service providers and supervisors at workplaces. Adolescents and youth at workplaces and managers of business firms will be given orientations proportional to the gaps in their knowledge identified during preliminary needs assessments. These trainings are provided so that healthcare providers are technically competent to offer health promotion, prevention, treatment, and care relevant to each adolescent and youth's level of maturity and their social circumstances.

Providers should have interpersonal and communication skills, be non-judgmental and considerate, treat all young people with equal care and respect, and provide information and support that enable adolescents and youth to freely decide on the right choices for his or her unique needs. Service providers who are trained on AYH should be able to respond to the needs of adolescents and youth, address their fears, respect their concerns, and provide the services within an environment that suits their preferences.

II. Peer Education

Peer education for adolescents and the youth works best when it is participatory and involves them in discussions and activities whereby they share information and experiences with each other. It creates a relaxed environment for them to ask questions without fear of being judged and/or teased even on subjects that are considered taboo by the society. Hence, it is essential to establish a peer education system that could fill the information gap among adolescents and youth at workplaces.

Peer educators who engage in this system should undergo a series of trainings so that they are equipped with effective communication and knowledge transfer skills. Moreover, peer education should not necessarily be a one-on-one interaction; it can be done in groups, either with one or more peer educators and several learners, or with a group of co-learners. “Who an educator is,” and “who a learner is” may change in the course of a session depending upon what is being discussed or taught. The whole relationship may be created as a reciprocal arrangement, with each participant teaching and the other, in return, being taught something else. Another possibility is that once the learner masters whatever is being taught, she/he will then become a peer educator in their turn.

Youth dialogue provides an opportunity to raise awareness among adolescents and youth at workplaces on the importance and benefits of a comprehensive AYH education. It will also help gain the support of managers/leaders on these key issues while encouraging people, including adolescents and youth themselves, to discuss their concerns and come up with solutions together.

Creating these opportunities for open and honest discussion and dialogue around comprehensive AYH issues is important in: building consensus; getting support; engaging community members and workplace decision makers; and creating more spaces for sharing concerns about comprehensive AYH education.

III. Health Education

Information, Education and Communication (IEC), Behavioural Change Communication (BCC), and Social and Behavioural Change Communication (SBCC) are powerful tools proved for bringing social change and development. These strategies are research-based consultative processes designed for addressing knowledge, attitudes and practices to bring positive changes in the behaviours and attitudes of adolescents and the youth. They define the needs of adolescents and youth, create awareness, promote health education, and guide them on how to exercise their health rights.

Information, Education and Communication is one of the strategies to spread awareness using different communication channels that target audiences to achieve desired positive results. It is a strategy that involves sharing information through broadcast or print media such as posters, flyers, leaflets, brochures, booklets, radio broadcast or TV spots, or interpersonal communication in a manner appropriate to the target group’s culture and values. It is intended to instil positive knowledge for appropriate behaviour in the community which will promote preventive health measures and development.

IV. Use of Digital Technology for Adolescent and Youth Health

Healthcare is increasingly being delivered through digital channels such as the internet, mobile phone messaging, social media platforms, apps, voice, video messaging, and telemedicine. This trend has been facilitated by the proliferation of mobile technology and rapid advances in artificial intelligence. Digital communication channels have great potential to enhance the delivery of healthcare information to adolescents and youth as they offer wide coverage and allow targeted messaging to particular groups or individuals. Such kinds of technologies should be introduced and promoted to adolescents and youth at workplaces to increase access and utilization of available health services.

Section V:
Standards and Service Packages of Youth-Friendly Services

Service Standards

Standard 1: Adolescent and Youth Health Literacy – implies the cognitive and social skills that determine the motivation and ability of adolescents and youth to gain access to, understand, and use information in ways that promote and maintain good health. Healthcare delivery outlets ensure that adolescents and youth are knowledgeable about their own health, know how to protect themselves from health problems, and know where and when to obtain health services.

Standard 2: Comprehensive Service Package – Appropriate healthcare services that cater to the health needs of adolescents and youth are available and accessible at all time. The services provided are well aligned with the standards and the minimum service package included in this guideline.

Standard 3: Health Facility Characteristics – All service outlets must have an adolescent- and youth-friendly environment – convenient operating hours, a welcoming and clean environment, and one that maintains privacy and confidentiality. It should be equipped with the necessary medicines, supplies, and technology needed to ensure effective service provision to adolescents and youth, including young people with disabilities.

Standard 4: Provider Competency – Service providers in all service delivery outlets provide the services with technical competency as per the national protocol and guidelines to the various adolescent and youth health problems. Both healthcare providers and support staff respect, protect and meet adolescent and youth rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude, and respect.

Standard 5: Adolescent and Youth Participation – Adolescents and youth are involved in the planning, implementation, and monitoring and evaluation of healthcare information and service provision, and in decisions regarding their own care.

Standard 6: Community Support – Health facilities implement systems to ensure parents, guardians, community members and organizations recognize the value of providing health services to adolescents and youth, and support provision and service utilization.

Standard 7: Equity and Non-discrimination – Health facilities provide quality

services to all adolescents and youth irrespective of their ability to pay, age, and disability

Status, sex, marital status, education, ethnic origin, creed or other socio-demographic characteristics

Standard 8: Data and Quality Improvement – AYH data is collected, analysed, distributed and used regularly. Likewise, the data quality of AYH services should be assured by data quality assurance mechanisms.

Standard 9: Inter-sectoral Collaboration – Every sector implicitly contributes to adolescent and youth health through the sector's core business. General quality improvements in healthcare should benefit adolescents and youth – adequately addressing adolescent- and youth-specific concerns (such as concerns about accessibility and acceptability). As social protection sectors implement policies and interventions to address the needs of vulnerable families, adolescents and youth benefit as well.

Nature of the organizations included as workplace:

Organizations that have a significant number of employees such as 100 employees are included in the definition of "Workplace" and they are abiding by this document.

Category of the workplaces:

In order to propose what type of facility has to exist in which workplace to provide the service packages, the workplaces has to be categorized. Hence, For the purpose of this program, workplaces categorized based on their number of employees.

Each of the workplaces will be evaluated by the health regulatory sector of MOH in regard to the national standard. All will be assessed according to the four Ps (Premise, person, product, and place). Then they will be categorized in to three major categories with sub-categories.

Category I -

Those workplaces having **100 – 1,000 employees**: they are required to:

- Have an agreement with a nearby health facility to provide the services packages specified in this document to their employees OR
- Have their own Primary clinic in their premises

Category II

Those workplaces with more than 1,000 but less than 25,000 employees: they are required to have **medium /higher clinic** inside their compound based on their sub-category (See Sub Category 2.1 & 2.2)

Sub Category 2.1

Those workplaces with more than 1,000 but less than 10,000 employees: they are required to have medium clinic within the premise of their company/organization.

Sub Category 2.2

Those workplaces with more than 10,000 but less than 15,000 employees: they are required to have HIGHER clinic within the premise of their company/organization.

Category III

Those workplaces with more than 15,000 up to 50,000 employees: they are required to have Health Centres or Hospitals within the premise of their company/organization (See sub Category 3.1 and 3.2).

Sub Category 3.1

Those workplaces with more than 15,000 but less than 25,000employees: they are required to have a Health Centre within the premise of their company/organization.

Sub Category 3.2

Those workplaces with more than 25,000 employees: they are required to have either of the following whichever is feasible /convenient for them within the premise of their company/organization

- One Health Centre for every 25,000 employee
- A primary Hospital for every 1.000.000 employee

Standards of the workplace facilities:

The standard of the health facilities and the services provided will be according to the national standard set for any other governmental, private or Not-for-profit facilities.

Premises – will be according to the national standard to each level of health facility

Personnel - The requirements of man power to the workplace facilities is as per the national standard (refer to national standards for different health facilities)

Properly trained professionals and graduates from a recognized higher institutions

Capacity building - Training on the areas of the Minimum service package included in this document has to provide to the service providers as per the recommended standard

Providing training to the service providers shall be the joint responsibility of the workplace facility, the nearest catchment PHCU (with in the same Woreda), the Woreda Health Office,

Products - Supplies and commodities - the nearest catchment PHCU / Woreda has to provide supplies and commodities the same way it provides to its catchment facilities

These facilities will also have the advantage of getting commodities and supplies directly from EPSA like other health facilities provided that they fulfil the pre-requisites and reach a bilateral agreement.

The Minimum Service Packages

The MSP delivery for adolescents and youth at workplaces is categorized into seven packages as follows:

I. Information and Counselling on Adolescent and Youth Health Issues
II. SRH Services
    1. Comprehensive HIV Testing, Counselling, Treatment, Care, and Support.
    2. Testing Services for HIV (Voluntary Counselling and Testing).
    3. STI Screening, Management, and Follow-up.
    4. Testing Service for Pregnancy, Ante-natal and Post-natal Care, including PMTCT.
    5. Comprehensive Abortion Care.
    6. Contraception and Family Planning Services.
    7. Condom Promotion and Provision (both female and male condoms).
III. Nutritional Screening and Counselling
IV. Psycho-social Support Services
    1. Counselling and Psycho-social Support on Substance Abuse.
    2. Mental Health and Psycho-social Support.
V. Injuries and Non-communicable Diseases
    1. Prevention and Management of Injuries.
    2. Diagnosis, Treatment, Prevention, and Control of Non-communicable Diseases.

VI. Gender-based Violence (GBV)

VII. COVID-19 and Other Epidemics: Prevention, Control, and Management

I. Information and Counselling on Adolescent and Youth Health Issues

Service Objective: To equip adolescents and youth with quality health information and counselling services on different health issues to attain sustainable behavioural change.

Health facilities should provide to adolescents and youth tailored and age-appropriate promotional services on themes including:

- Physical, physiological, psycho-social, and/or emotional changes;
- Available services at service delivery points including referrals and procedures;
- Risks associated with early and unprotected/unsafe sexual intercourse including STIs and HIV/AIDS;
- Menstrual hygiene management (MHM) and personal hygiene and sanitation;
- Contraception and family planning services;
- Promotion of condom use (both female and male);
- Harmful traditional practices (HTPs) such as early marriage, marriage through abduction, etc.;
- Risks of early pregnancy including fistula;
- Prevention of cervical cancer;
- Pregnancy testing, focused ante-natal care, delivery, post-natal care, and comprehensive abortion care (CAC) services;
- Substance abuse and mental health;
- Nutrition, injuries and other non-communicable chronic diseases (NCDs);
- Gender-based violence;
- Prevention and control measures for COVID-19 and other epidemics.

Hence, focused counselling services have to be provided on the following topics:

Counselling on SRH and Other Health Issues – Adequate resource materials that cover topics related to growth and development, puberty myths and misconceptions, safe sex and contraception, unwanted pregnancy and unsafe abortions, menstrual disorders,

anaemia, sexual abuse, Reproductive Tract Infections (RTIs)/STIs, injuries, mental health, immunization, and other issues must be available to providers to address common health concerns of adolescents and youth at workplaces.

Counselling on Reversible Contraceptives – Provide counselling services on the benefits, side effects and characteristics of oral contraceptive pills (OCPs), depotmedroxyprogesterone acetate (DMPA), implants, condoms (female and male), and Intrauterine Device (IUD) insertion as per the national guidelines. Dual protection is to be an integral part of contraceptive counselling. Workplace adolescents and youth must have information and access to methods that provide dual protection.

Counselling on Emergency Contraceptive Pills – Every opportunity must be utilized to emphasize safe sex practices and risk reduction counselling. Apart from regular contraception methods, information and counselling on emergency contraceptivepills (ECPs) must be provided.

Counselling on Menstrual Disorders – Menstrual disorders are common among adolescent and youth girls. Service providers must be able to manage these problems in the following manner: Providing counselling for menstrual problems and hygiene, and referrals for any investigations and puberty-related problems.

Service Providers	Types of Services	Methods of Service Delivery
Trained Counsellors, Volunteers, Nurses, HOs, Physicians, etc....	Physical, physiological, and psycho-social changes occur during the time of adolescence and youth. Information and counselling services on early sexual initiation, contraception and condom use, HTPs like early marriage, Fistula, Cervical Cancer Prevention, MHM, CAC, ANC including PMTCT, STIs including HIV/AIDS, Substance Use, Nutrition, Mental Health, NCD, Injuries, Gender-Based Violence, etc.... Refer to the next level as appropriate.	Printed and electronic SBCC materials, health education through mini-media, coffee ceremonies, individual and group counselling, peer to peerdiscussions, signboards in thehealth facility.

II. SRH Services

1. Comprehensive HIV Testing, Counselling, Treatment,Care, and Support

Service Objective: To ensure adolescents and youth at workplaces know their HIV status by offering HIV testing and counselling services so that they protect themselves,

their partners, and others from HIV/AIDS and related risks.

Service Characteristics of Comprehensive HIV Testing and Counselling Care (CHTC) for Adolescent- and Youth-friendly Services at Workplaces

- Privacy shall be respected in all situations involving HIV counselling and testing.
- Test results shall not be disclosed to third parties unless for the clear benefit of tests.
- No adolescent and youth shall be discriminated against because of their HIV status.
- Peer education, a peer support system, and interpersonal communication skills among adolescents and youth shall be promoted at the health centre.
- Abstinence, faithfulness, and condom use must be promoted, and condoms provided.
- Education materials that focus on adolescent and youth issues should be made available.
- Providers and counsellors should be trained on YFS and how to be youth-friendly.
- "Youth-friendly" services should be provided in a safe, non-threatening environment.
- Providers and counsellors should be non-judgmental, and use language easilyunderstood by adolescents and youth.
- Respect the dignity and confidentiality of adolescents and youth.
- The service should be accessible to adolescents and youth with disabilities as well.

2. Testing Services for HIV (Voluntary Counselling andTesting – VCT Services)

Service Objective: To ensure that adolescents and youth at workplaces know their HIV status voluntarily so that they protect themselves, their partners and others from HIV/AIDS and related risks.

Voluntary counselling and testing services are the gateway to prevention and care for HIV/AIDS so that sexually active adolescents and youth are communicated for pre-test counselling to get voluntary testing services. Voluntary Counselling and Testing (VCT) sites need to facilitate access to antiretroviral therapy (ART) if required.

Post-Rape Services: These are services provided to sexual violence survivors (post-rape care) and physical and emotional violence services.

Post-Rape STI/HIV Services:
The following represents post-rape STI/HIV care services that must be in place:

- Rapid HIV testing with referral to care and treatment as appropriate.
- HIV post-exposure prophylaxis (PEP) or service linkage – if within 72 hours.
- STI screening/testing and treatment; referral when necessary for care and treatment.

Referral to a Social Protection Centre:

- Referral for psycho-social support and legal service provision.

Service Providers	Types of Services	Methods of Service Delivery
Trained Counsellor/Health Professionals on CHTC	Pre-test Information, Testing, Treatment and Care and Support, Post-test Counselling, Condom Demonstration and Provision, and Referral	Printed and Electronic SBCC Materials, Mini-media, One-to-One and Group Counselling

3. STI Screening, Management, and Follow-up

Service Objective: To ensure that adolescents and youth have adequate access to STI services including information, diagnosis, and treatment.

Treatment of Common STIs

Adolescents and youth are more vulnerable to genital infections on account of biological and social factors. Adolescent and youth girls may find it difficult to negotiate condom use with their partners. The following elements of quality of care deserve special attention:

- **Privacy and Confidentiality** – Complete audio and visual privacy must be maintained during the client-provider interaction. Although this applies to all interactions, it is crucial in ensuring maximum privacy and confidentiality while managing STIs.

- **Treatment Compliance** – It is important to emphasize compliance with the drug regimen prescribed for each adolescent and youth. Noncompliance will lead to treatment failure. This also includes counselling on personal hygiene and safe sex during and after treatment.

- **Partner Management** – As per national guidelines, partner management should constitute an integral component of services. Adolescents and youth should be informed about the importance of treatment for their partners in order to prevent reinfections.

- **Follow-up Visits and Referrals for Treatment Failures** – Adolescents and youth should be counselled to adhere to the schedule of follow-up visits. In case they do not respond to therapy, they are to be referred to higher levels.

Sexual Violence (Post-rape Care): The following represents the minimum package of post-rape care services:

- Counselling (other than for HIV counselling and testing);
- Provision of clinical services for STI screening/testing and treatment;
- Rapid HIV testing with referral to care and treatment as appropriate;
- Referral to legal and social protection.

Service Provider	Types of Services	Methods of Service Delivery
Trained Health Professionals: Nurses, HOs, Laboratory Technicians, and Physicians, etc....	Carry out a physical examination and provide counselling, appropriate treatment based on thetreatment guideline for STIs. Plus: Laboratory investigation, culture sensitivity test, partner notification and treatment, and feedback.	Facility-based service, SBCC materials, on-site and to take, individual counselling, provide therequired treatment.

4. Testing Services for Pregnancy, PMTCT, ANC, Delivery and PNC Care

Service Objective: To ensure that adolescents and youth have access to testing services for pregnancy and ante-natal care (including PMTCT).

Characteristics of Providers for Youth-friendly Pregnancy Testing, ANC, PMTCT:

- Service providers should be trained on ANC, PMTCT, delivery, and PNC services and need to have the skills on how to be youth-friendly, and how to care for young people.
- Provide youth-friendly services in a safe, non-threatening environment as most clients are first-time mothers and may be nervous about physical and pelvic examinations.
- Providers should be able to explain every step of the procedures during ANC,

PMTCT, etc.
- Providers should respect the dignity and confidentiality of adolescents and youth.

Focused Care during the Ante-natal Period

Pregnant adolescents and youth access the service more conveniently at dedicated timings. It is generally considered that ante-natal care should start early, preferably in the first trimester. Evidence shows that adolescents either do not seek care or that care is often delayed and infrequent. The ANC protocol for pregnant adolescents and youth

Does not differ from the protocol for other pregnant women However, the following issues need to be reiterated:

- **Nutritional Counselling:** there is an increased risk of nutritional deficiencies asadolescents and youth enter pregnancy with an existing nutritional deficiency.
- **Couple's Counselling**
- **ANC Follow-up**
- Conduct and/or refer for **Institutional Delivery**
- **Post-partum Contraceptive Counselling**
- **Referral**: should be made for complications during pregnancy.

Prevention of Mother-to-Child Transmission (PMTCT) of HIV, Hepatitis B Virus (HBV), and Syphilis

HIV, Syphilis and HBV Testing for Pregnant Mothers

Ideally, access to PMTCT is to be an integral component of focused ANC services. Adolescents and youth are to be counselled about the risk of HIV infections during pregnancy, and must be encouraged to undergo testing and therapy to prevent infection transmission to the foetus/new-born. Adolescents are to be referred to appropriate facilities in their catchment for access to ART. Early testing and counselling services for HIV, syphilis and HBV during pregnancy enable pregnant adolescent and young girls living with HIV to benefit from HIV prophylactic and therapeutic services.

Types of Providers	Types of Services	Methods of Service Delivery
Health Officers, Midwives, Clinical Nurses, Physicians, Public Health Nurses, Laboratory Technicians.	Pregnancy testing, haemoglobin, blood type, RHfactor. HIV testing, testing for syphilis, testing for HBV. General physical and pelvic examination, administer antibiotics and IV fluids, anti-hypertensives for those who need them. On-couch counselling including for PMTCT Services.	Facility-based service, SBCC materials, (educational materials that focus on youth issues) in a health facility, or off-site to provide individual counselling, and the required clinical care.

5. Comprehensive Abortion Care

Service Objective: To ensure all adolescents and youth at workplaces receive standard, consistent, and safe termination of pregnancy, and post-abortion care services within the legal framework and as per the national guideline.

Early and Safe Termination of Pregnancy and Management of Post-abortion Complications

All health facilities in Ethiopia are required by the law of the land to be fully equipped for the provision of early and safe abortion services to adolescents and youth within the legal framework. However, evidence suggests that younger adolescents are more likely to delay seeking termination of pregnancy: Hence, such clients need to be managed as per the Guidelines for Management of Common Obstetric Complications. Post-abortion contraceptive counselling is to be an integral component of abortion services.

Service Eligibility for Safe Abortion Care:

- The pregnancy is a result of rape or incest; or
- The continuation of the pregnancy endangers the life of the mother, or where the birth of the child is a risk to the life/health of the mother; or
- The foetus has an incurable and serious deformity; or
- The pregnant woman, owing to a physical or mental deficiency she suffers from, or from being that she is underage, or that she is physically as well as mentally unfit to bring up the child.

For further details, please refer to the **Technical and Procedural Guidelines for Safe Abortion Services (MoH: 2014).**

Types of Providers/ Healthcare Personnel Available/ Required	Types of Services	Methods of Service Delivery
HOs, Midwives, Clinical Nurses, Public Health Nurses and Physicians, Laboratory Technicians/Technologists	Counselling, manual vacuum aspiration (MVA) for up to 12 completed weeks ofpregnancy; Medical abortion for up to nine completed weeks of pregnancy, administer antibiotics and IV fluids (if necessary), post-abortion FP counselling and service.	Facility and outreach-based prevention intervention; printed and electronic IEC/SBCC materials; individual and group counselling; provide the required clinical and surgical care in the health facility.

6. Contraceptive and Family Planning Services

Service Objective: To enable adolescents and youth to have access to a range of contraceptive information and methods.

Range of Services and Activities to be offered – The following services and activities are offered at different levels of the national healthcare delivery system:

- Contraceptive and FP counselling;
- Provision of contraceptive methods (emergency contraceptive, short-term and long-term methods);
- Counselling and referral for infertility management;
- Counselling and linkage to other SRH services including for sexual dysfunction;
- Referral and follow-up.

Contraception and FP Counselling

Counselling should be an interactive process between the service provider and the client. Healthcare professionals/service providers should have basic skills in counselling techniques and should provide adequate information, along with a balanced and updated counselling service to assist clients in making informed and voluntary decisions. In caseswhereby clients have additional needs, service providers need to link the client to the next level of Service Delivery Point (SDP). Similarly, service providers working in different units across a health facility should be able to counsel clients for contraceptive and family planning services to avoid any missed opportunities.

Provision of Contraceptive Methods for Adolescents and Youth at Workplaces

The following contraceptives and FP methods (among the contraceptive mix available in Ethiopia) should be available and provided to ***adolescents and youth at workplaces***:

- Male (and female) condoms;
- Emergency contraceptive pills;
- Progestin-only pills, and combined oral contraceptive pills;
- Injectable contraceptives;
- Implants of different types; and
- Intrauterine contraceptive device (IUCDs).

While respecting clients' rights and supporting full, free, and informed choice, ensuring method-mix is central to quality contraception and FP services. The safety of the method

also needs to be weighed, along with the benefits of preventing unintended pregnancies.

Type of Providers/ Health Personnel Available/ Required	Types of Service	Service Delivery Method
Trained Providers and Counsellors (Medical Doctors, Health Officers, and Nurses, etc....) on contraceptive technology and counselling.	Long-acting reversible contraceptive (LARC) method (Implant and IUCD, including removal services); Combined Oral Contraceptive Pills (COC) ; Progestin-only Pills; Emergency Contraceptive Pills (ECPs); Injectables; Male and Female Condoms; FP Counselling, includingPost-partum FP Methods; Education; Screeningand Treatment of STIs and HIV; Referral Linkages; and Pregnancy Testing.	Facility-based Service, Outreach, SBCC (educational materials that focus on adolescent and youth health issues) on-site and off-site, individual and group counselling and testing.

7. Condom Promotion and Provision (Female and Male Condoms)

Service Objective: To ensure that adolescents and youth at workplaces have access to quality condoms (both male and female condoms) to protect themselves and their partners from HIV/AIDS, unintended pregnancy, and other STIs.

In general, knowledge of condoms and their role in preventing HIV/STI transmission is limited among adolescents and youth. STIs are a co-factor for HIV transmission and useful markers for unprotected sex; however, knowledge about other STIs is even much more limited than that of HIV.

To empower adolescents and youth at workplaces to make healthy transitions to adulthood, and to decrease risks and vulnerability, the following strategies need to be adopted:

- Provide clear, tailored and age-appropriate messages;
- Provide information and skills that help them to protect themselves from HIV infection and unwanted pregnancy;
- Counsel on delaying sexual debut if not sexually active (abstinence), and on limiting the number of sexual partners (faithfulness);
- Counsel and provide dual protection (consistent use of condoms and contraception);
- Counsel adolescents and young women about their health;

- Engage adolescents and youth in evaluating their risks;
- Provide counselling and VCT services to young married couples so that young married girls know their own, as well as their husbands' HIV status;
- Strengthen linkages to referral facilities that provide services for GBV cases; and
- Provide counselling and referrals to the next level of service for medical and psychological support.

Types of Providers/ Health Personnel Available/ Required	**Types of Services**	**Methods of Service Delivery**
Trained Counsellor (adult,youth), and Health Professionals	Counselling, STI Screening and Testing, Condom Demonstration and Provision	Provision of IEC materials and condoms, face to face discussions, using models

III. Nutritional Screening and Counselling

Service Objective: To improve access to a range of comprehensive nutritional information and services to improve nutritional status and prevent inter-generational malnutrition.

Adolescents and youth always should have continuous physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and preferences for an active and healthy life.

Nutrition Security – demands the utilization of food to generate optimal nutritional status, well-being, productivity, and longevity. Hence, food security alone is insufficient to ensure nutrition security. Several other complementary factors relating to how the food is utilized must also be in place if all adolescents and youth must enjoy a healthy and active life resulting from proper nutrition. Thus, access to clean water, a hygienic environment, and adequate healthcare services are central components of attaining nutrition security.

Many adolescents and youth suffer from a range of nutritional deficiencies, including micro-nutrient deficiencies such as iodine, calcium, iron, folic acid, and other vitamin deficiencies, mainly due to intakes below recommended values.

Nutrition and Dietary Habits during Adolescence and Youth

Adolescence and youth are a period of rapid physical growth, with a corresponding increase in nutritional requirements to support increases in body mass and brain development.

Hence, health facilities need to provide screening for anaemia by offering routine haemoglobin estimation. For pregnant adolescents and youth, the national guidelines need to be adhered to for haemoglobin testing as part of the ANC service. For non-pregnant adolescents and youth, treatment is to be given in the form of iron therapy. Health service providers are expected to provide information on a balanced diet. Worm infestations also have to be treated.

The daily intake of nutritional requirements increases/varies in line with the following factors:

- Age, gender, pregnancy, breastfeeding, post-natal period, physical exercise, infection with parasitic diseases, and in areas where micro-nutrient deficiency exists.

Common Nutritional Problems among Adolescents and Youth:

- **Under Nutrition** – results from the consumption of an inadequate quantity and quality of food (that is, less than the daily requirement) over an extended time period. This is very common among economically challenged persons with limited knowledge and skills on nutrition, which ultimately leads to chronic infections such as tuberculosis, parasitic infestations, and inter-generational malnutrition.

- **Micro-nutrient Deficiency** – results from a relative or absolute lack of a nutrient, such as iron deficiency anaemia. More than one-third of adolescents and young girls in Ethiopia suffer from nutritional anaemia. (Deficiency means a severelack that might have a pathological effect).

- **Over Nutrition –** is a result of the consumption, over an extended period, of unbalanced and excessive quantities of food, especially starches, sugar and fat.

- **Increased Needs Related to Heavy Physical Work** – such as working in farmlands, loading and unloading, maintenance, and store management where daily nutritional requirements increase.

- **Iron Deficiency Anaemia** – can occur due to decreased intake of the nutrient, or parasitic infestations such as a hookworm infestation. Iron deficiency anaemia can be prevented by nutrition counselling, deworming, or treated with iron and

Iron foliate medications depending on individual cases. However, if there is severe anaemia, it may need treatment with a blood transfusion.

- **Iodine Deficiency** – Iodine deficiency leads to goitre due to hypothyroidism that causes mental retardation and complicates pregnancy with abortion. Although iodine is a micro-nutrient that the body needs in small quantities, the need for iodine increases during adolescence and youth. Iodine deficiency can be prevented by using iodized salt or taking iodine pills during pregnancy and breastfeeding.

Health Service Providers	Nutrition Services	Methods of Service Delivery
Health Officers, Midwives, Nurses, Physicians.	Nutrition screening, assessment, and intervention counselling (Promotion of a healthy lifestyle, personal and environmental hygiene, food sanitation, and physical activity); and referral for further care and Support.	Health facility and outreach-based services, Printed and electronic IE/SBCC materials, counselling, and Clinical care.

IV. Psycho-social Support Services

1. Counselling and Psycho-social Support on SubstanceAbuse

Service Objective: To ensure that adolescents and youth lead a substance-free life through taking measures that prevent drug use at the individual and community level

The use of substances such as alcohol and tobacco has become one of the rising major public health and socioeconomic problems worldwide. The rapid economic, social, and cultural transition that most countries in Sub-Saharan Africa are now experiencing creates a favourable condition for increased and socially disruptive use of drugs and alcohol.

As in many developing countries, substance misuse is becoming a growing problem in Ethiopia, where alcohol and khat are the most frequent substances of abuse. Studies indicate that substance use among Ethiopian adolescents and youth is considerably rising, with college and university students being at the highest risk. Even if substance use has become a common problem among university students in Ethiopia, only scant information is available about its magnitude and factors contributing to its use in this segment of the population.

Service Providers	Types of Services	Methods of Service Delivery
Trained Counsellor (adult, youth, health professionals), Psychiatric Nurses.	Prevention through health education; Treatment; Recovery (rehabilitation); And Referral.	SBCC, Counselling (Individual, family, and Group), local media.

2. Mental health and Psycho-social Support

Service Objective: To ensure that all adolescents and youth have access to appropriate information, counselling, diagnosis, treatment, and follow-up services on mental healthcare as per their needs.

According to the World Health Organization (WHO), mental health is “a state of well-being in which an individual can realize his or her abilities, interact positively with

Others, cope with the stressors of life and study, work productively and fruitfully, and contribute to his/her family and community." It should be noted that the definition does not refer exclusively to the absence of "mental illness," but also addresses the concept of "mental wellness."

Mental illnesses which are associated with a high burden due to GBV, economic problems, disability, and mortality are common in Ethiopia, where they constitute an important, but largely unrecognized barrier to achieving the SDG goals. Despite the existence of affordable and effective treatments, less than one in ten severely affected persons receive the treatment they need.

Mental health is an integral component of any efficient, well-functioning structure of healthcare. The core components of mental health strategy take into account accessibility, the need to protect human rights, efficiency and sustainability, and community involvement and participation.

According to the WHO, "there is no health without mental health." It should also be noted that mental health is relevant to many of the health-related strategic development goals (SDGs). As per WHO recommendation and successful experiences of many developing countries, the National Mental Health Strategy of Ethiopia mandates that mental health be integrated into the primary healthcare system. It also ensures that those who require services have access to treatment as close to their home as possible, and in the least restrictive environment. Hence, in keeping with the overall health services development plan, the strategy promotes a decentralized approach in which mental health services are available at different levels of health facilities from tertiary facilities down to health centres.

A critical requirement for mental health promotion is to have information, increase trained skilled workers and quality mental health services, nurture self-confidence to access available services, and promote a community support system.

Service Providers	Types of Services	Methods of Service Delivery
Psychiatrists and Psychologists, Nurse, Trained MD, HOs, Clinical Nurses.	Mental health information, sensitization, health education (HE), counselling, psycho-socialsupport, and referral.	Facility-based health information, sensitization, and awareness creation activities, counselling, management, psycho-social support, follow-up and Referral.

V. Injuries and Non-Communicable Diseases

1. Prevention and Management of Injuries

Service Objective: To ensure that all adolescents and youth at workplaces obtain preventive and promotive services, as well as diagnosis, treatment and rehabilitation care for injuries and complications that arise from injuries.

Injury is defined as physical damage resulting from exposure to sudden energy that exceeds the threshold limit of human physiological tolerance.

Burden of Injuries in Ethiopia
Injuries in general – like drowning, falls, fire, heat and hot substances, mechanical forces – And road traffic accidents in particular are a growing national concern in Ethiopia. The overall age-standardized mortality from all injuries in Ethiopia was 69.4 per 100,000 persons in 2017.

Service Providers	Injury Management Services	Methods of Service Delivery
Physicians, Health Officers, Nurses, First Aid Care Providers	Promote workplace safety through outreach programs; Emergency care (first aid services until referral); Sensitization/Counselling; Psycho-social Support; Management of minor injuries; Screening and management of injured patients for mental health problems; Follow up (rehabilitation); Referral for psycho-social support and other supports.	Facility-based services based on treatment protocols (management of minor, major injuries, and mental disorders); SBCC materials, awareness creation, personal protection equipment (PPE), injury control, and prevention training; Outreach activity; Manage cases of mental illnesses, follow-up, and referral.

2. Prevention, Diagnosis and Treatment of Non-Communicable Diseases (NCDs)

Service Objective: To prevent the occurrence of NCDs during adolescence and youth and prevent premature death in adulthood through the promotion of a healthy lifestyle.

2.1 Risk Factors for NCDs – Risk factors associated with increased or decreased occurrence of NCDs:

Behavioural Risk Factors – They can be eliminated or reduced through healthy lifestyles or behavioural changes. Behavioural risk factors include:

- Tobacco smoking and excessive alcohol consumption;
- Unhealthy diet and physical inactivity;
- Insufficient vaccination;
- Unprotected sexual activity.

Biological Risk Factors – They develop from behavioural risk factors sustained over time, and may be influenced by a combination of genetic, lifestyle, and other factors such as:

- Raised Blood Pressure;
- Raised Blood Sugar;
- Raised Blood Lipids.

Overweight/Obesity – is affected by:

- Age – 81% of all deaths from stroke occur in ages 75 and over.
- Sex – Pregnancy and Oral Contraceptive Pills (OCPs) increase a woman's chances of breast cancer.
- Early menarche, late menopause, and late first childbirth have been shown to increase the risk of breast cancer.

Environmental and Occupational Risk Factors – Some diseases may result entirely from an individual's genetic make-up; many others arise from the interaction between genetic make-up and environmental factors such as:

- Pollution, smoke, coal tars, radiation, altitude, water.
- Industrial chemicals – Asbestos, radioactive substances.
- Herbicides, pesticides, insecticides, etc.

Infectious Risk Factors – Highly prevalent in developing countries Examples include:

- Hepatitis B and C – Liver cancer;
- Human Papilloma Virus – Cervical cancer;
- HIV;
- Kaposi's sarcoma and other opportunistic malignancies.

Early Life Factors – It is hypothesized that disease in future adults is "programmed" during foetal life and infancy. This is called the latency model that emphasizes the role of early environments on subsequent life trajectories. Abuse and neglect, childhood

Infections, low birth weight, maternal health and peri-natal events appear to exert effects that are independent of environmental risk factors in adults, or may be amplified by other risk factors. (20)

Psycho-social Factors – These are social determinants of health ("societal risk conditions") rather than individual risk. They are the economic, social, and psychological conditions under which people live that determine their health. Examples: Resilience and emotional well-being or stress; sense of control; and social support or exclusion.

2.2 Common NCDs in Adolescents and Youth

Non-communicable diseases (NCDs) include:

- Cardiovascular diseases (like heart attacks and stroke);
- Cancers and diabetes mellitus;
- Chronic respiratory diseases (chronic obstructive pulmonary disease and asthma).

It is estimated that cancer kills over 7.9 million people every year globally, constituting close to 13% of total deaths worldwide. While communicable diseases still remain the leading killers in many developing countries, the incidence of, and mortality from, non-communicable diseases is rising rapidly. Breast and cervical cancers are the leading cancers among women in developing countries, with estimated annual new cases of 882,900 and 444,500 respectively. More than 324,300 and 230,400 women die from these cancers every year, respectively. (21)

In Ethiopia, cancer accounts for about 5.8% of the total national mortality. Although population-based data are very limited, it is estimated that the annual incidence of cancer is around 60,960 cases and the annual mortality is over 44,000. The most prevalent cancers in Ethiopia among the adult population are breast cancer (30.2%), cervical cancer (13.4%) and colo-rectal cancer (5.7%). About two-thirds of reported annual cancer deaths occur among women. (22)

Reproductive Organ Cancers (ROCs) – Limited available data on the national prevalence of reproductive organ cancers (ROCs) in Ethiopia estimates that breast and cervical cancers in women, and penile and prostate cancers in men are the most prevalent ones.

Prevention and Screening for Reproductive Organ Cancers

Contraceptive and family planning services offer a unique opportunity to screen for cervical cancer and to teach the client to perform self-examinations for breast cancer.

Where health facilities exist, women should be encouraged to get an annual Pap smear, or visual inspection of the cervix using acetic acid (VIA) or Lugol's Iodine Solution (VILI). Health workers should educate women and their families about reproductive organ cancers (ROCs) and the benefits of screening. Women found to have ROC should receive treatment either in the same facility or be referred as urgently as possible.

HPV – Nearly 100% of cervical cancers are attributed to a persistent human papillomavirus (HPV) infection. Most of the factors that increase the persistence of HPV infection and development of cervical cancer – early sexual debut, teenage pregnancy, multi-parity, co-infection with other sexually transmitted infections (STIs) such as HIV, herpes simplex virus (HSV) type 2 and *Chlamydia trachomatis* – are potentially preventable. (WHO, 2007)

Another method of preventing cervical cancer is providing HPV vaccines for girls and boys at ages between nine and 14 years, which has been proven to offer the best protection from cervical cancer in their later age. Chemotherapy services, again with limited capacity, are also available in government and private health facilities. With the on-going scale-up of specialty trainings, the surgical treatment of ROCs is expected to improve markedly.

Pelvic Organ Prolapses (POP) – It is one of the common gynaecologic problems that usually become symptomatic later in life. Although the exact prevalence in Ethiopia is unknown, it is expected to be among the highest in the world due to the presence of multiple risk factors: Early marriage and child birth, high fertility, high proportion of home delivery, high incidence of obstructed labour, high prevalence of malnutrition, and engagement in heavy physical work. With that understanding, the current RH strategyof Ethiopia primarily aims to clear the backlog by identifying women with POP, and linking them to treatment sites. In parallel, preventive actions will be promoted by integrating with other RH schemes.

Service Providers	Types of Service	Methods of Service Delivery
Trained providers and counsellors (Midwives, Health Officers and Nurses, and Physicians, Gynaecologists).	Promotion of physical activity, healthy diet, cessation of tobacco, alcohol, and khat use, etc.… Counselling on healthy living for patients with NCDs such asdiabetes. Screening for hypertension and diabetes mellitus. Prevention, diagnosis, and treatment of STIs and HPV vaccination to reduce risks for cervical cancer. Screening patients with NCDs for common mental health Problems/disorders.	Facility-based Service; Community outreach (schools) to provide SBCC on NCDs and their modifiable risk factors; Different media such as mass media; Management, follow up and referral of mental

	Referral service for individuals screened for common NCDs. Provide follow-up care for patients with NCDs including drug refills.	Health problems.

VI. Gender-Based Violence (GBV)

Service Objective: To ensure adolescents and youth have adequate access to information on GBV, assessment, diagnosis, treatment, psycho-social and legal support, and rehabilitation through follow-up counselling with all forms of gender-based violence.

1. Violence

Violence includes emotional, social, or economic force, coercion or pressure, as well as physical harm. It can be overt, in the form of a physical assault or harassment, deception and other forms of psychological, emotional, or social pressure. It takes place within a variety of settings, including at home, the workplace, schools, and the community. In many cases, it begins in childhood, adolescence and young age.

Violence may be physical, sexual, economic, emotional, and psychological, occurring in or outside the family, including sexual exploitation, sexual abuse, sexual harassment, female genital mutilation, and other harmful traditional practices.

Incident Type of Violence: We need to use consistent words/definitions to enable proper data collection, tracking of incident data, monitoring, and evaluation. The following types of GBV are characterized as incident types:

Attempted Rape – An act of non-consensual sexual intercourse (the invasion of any body part of the victim with a sexual organ, by force, or coercion)

Rape – Any such vaginal or anal penetration is considered rape; efforts to rape someone which do not result in penetration are considered attempted rape.

Rape or attempted rape may include:

- Rape of adolescents and youth;
- Rape of a minor (male or female), including incest;
- Gang rape, if there is more than one assailant;
- Male rape, sometimes known as sodomy.

Sexual Abuse – refers to other non-consensual sexual acts, not including rape or attempted rape. Sexual abuse includes acts performed on a minor – even if the child has

given consent, sexual activity with a minor is sexual abuse as she/he is considered unable to give informed consent.

Sexual Exploitation – Sexual exploitation includes sexual coercion and manipulation by a person in a position of power who uses that power to engage in sexual acts with a person who does not have power. Examples include:

- Humanitarian worker requiring sex in exchange for assistance/privilege;
- A teacher requiring sex in exchange for grades or admission;
- A soldier or security worker requiring sex in exchange for safe passage;
- Workplace managers/supervisors asking for sex in exchange for some favour.

Trafficking for Sex or Labour – Trafficking, as defined by the International Organization for Migration (IOM), occurs when "a migrant is illicitly engaged (recruited, kidnapped, sold, etc.), or moved either within or across borders… Intermediaries during any part of this process obtain economic or other profit using deception, coercion, and/or other forms of exploitation under conditions that violate fundamental human rights of migrants."

Women and girls are at primary risk of trafficking for forced prostitution, and marriage.

Other Gender-based Violence – This includes physical, mental, emotional, or social abuse directed against a person because of his/her gender role in a society or culture.

2. Management of Sexual Violence in Adolescents and Youth at Workplaces

Health facilities that provide services for the management of sexual abuse, especially for adolescents and youth girls, should create access to emergency contraception pills, compressive abortion care (CAC), prophylaxis against STIs, and Post Exposure Prophylaxis (PEP) for HIV along with psycho-social counselling, follow up and referral tosocial and legal services.

Sexual Violence (Post-rape Care): the minimum package of post-rape care services should always begin with an assessment of the client's specific needs. The following services must be in place at each service delivery point at workplaces:

- Provision of clinical services
- Rapid HIV testing, care, treatment, and referral to appropriate service
- Post-exposure prophylaxis (PEP) for HIV or service linkage – if within the first 72

hours
- STI screening/testing and syndromic management
- Emergency contraception and counselling if a person reached in the first 120 hours

For both sexual violence and physical and/or emotional violence:
- Longer-term psycho-social support (for example: individual/group counselling),
- Legal counsel, police, child protection services, or referral

Service Providers	Types of Services	Methods of Service Delivery
Health care providers and counsellors trained inthe management of gender-based violence (Medical Doctors, Health Officers, Nurses, Midwives, Social Workers, Psychiatry Nurses, etc...)	History taking and examination; Testing for pregnancy, STI/HIV; Treatment including first aid, TAT, Hepatitis B vaccination, ECP, PEP; Psycho-social support counselling, documenting evidence, and support to access legal service. Screen for mental illness, substance use disorders, and refer to specialty facilities.	Printed and electronic IEC/SBCC materials, psychotherapy and physiotherapy, rehabilitation, physical injury treatment, follow up, and referral.

VII. COVID-19 and Other Epidemics at Workplaces: Prevention, Control, and Management

Service Objective: To ensure adolescents and youth have access to information and service on the prevention and control of emerging epidemics including COVID-19.

Although the elderly and those with pre-existing health conditions are known to be the most vulnerable, COVID-19 affects all segments of the population including adolescents and youth who are also at risk of contracting and transmitting the coronavirus.

COVID-19 has become a pandemic due to widespread community transmission across countries and communities. It is transmitted through droplets (coughing) and unprotected close personal contact with an infected person (touching, shaking hands, touching eyes, nose and mouth). Anyone with COVID-19, including adolescents and youth, can become seriously ill or die at any age. The different control and prevention measures should be seriously practiced at workplaces.

1. Activities to Engage into Control COVID-19 Pandemic

Principles to follow during the COVID-19 era at workplaces:

Protect the safety and well-being of adolescents and youth, and others at workplaces.

Interrupt the impact of the virus in the workplace by using protection mechanisms.

Maintain essential AYH services including COVID-19 prevention.

Shield adolescents and youth in workplaces from socioeconomic shocks.

MCC (Motivated, Compassionate, and Caring): avoid stigma and discrimination that may arise from healthcare providers, other work colleagues, and the community.

To minimize the impact of COVID-19 and other epidemics at workplaces, implement the following activities:

- **Health Education** – Educate the workforce at workplaces on COVID-19: Avoid touching eyes, nose, and mouth with unwashed hands; Keep physical distance; Maintain hand hygiene and throw used tissues and clothing in the bin or trash can; Cover mouth and nose with a tissue or use the inside of a flexed arm when sneezing or coughing; Practice a healthy lifestyle including adequate rest while maintaining good nutrition with moderate amounts of vitamin C, D, and E.
- **Physical Distancing** – Avoid gatherings to ensure physical distancing at workplaces.
- **Hand Hygiene and Sanitization** – Enhance hand hygiene in workplaces by installing hand washing facilities with soap and water.
- **Using Face Masks** – Cover nose and mouth with a mask. Avail face masks.
- **Open Facilities Full Time**, and establish a proper queue control system.
- **Vaccination** – Vaccinate all adolescents and youth at workplaces.

2. Activities to Engage into Control Other Communicable Diseases

- Reporting of increasing caseloads of malaria in different parts of the country, as the rainy season continues.
- On-going response to other disease outbreaks like cholera and measles.
- Response to the consequences of floods.

Service Providers	Types of Services	Methods of Service Delivery
Trained Counsellor And All Health Professionals.	Information and counselling on prevention and control measures of COVID-19 and other outbreaks, screening, management, care, and support; Vaccination, and referral for further care and Treatment.	Printed and electronic IEC/SBCC Materials; PPE and hygiene and sanitation practicing materials like soap and water, and washbasins; mini-media; and group counselling; Community education.

Section VI: Outreach Services

The primary purpose of community health outreach programs is to offer services to educate residents on what resources are available to help them take control of their health. Public health outreach programs can make a difference through education on, and screening for, potential health concerns.

Mobile health outreach services help to close the divide between advantaged and disadvantaged communities. These services can help to close the gap and improve the quality of life in these areas.

Workplace site visits are provided by health workers, and sometimes by nearby Health Offices. There is a need to make these services more regular and productive. The outreach services could also be used as a mechanism for demand generation for adolescent- and youth-friendly service delivery points. During outreach services, working environments, status of workers, exposures to hazards and chemicals could be assessed well, and interventions provided. The outreach service will also focus on residences of the workers if they live in close proximity to their workplaces.

Periodic Health Education Activities and Co-curricular Activities

Health education and health promotion activities for adolescents and youth are to be organized in industrial parks, mega-projects, and development corridors. The service provider, in cooperation with these sectors, can conduct health education sessions on health-related issues to increase awareness about adolescent and youth health issues and availability of adolescent and youth health services.

Periodic Health Check-ups

In collaboration with the Industrial Park Development Corporation (IPDC) and other relevant partners, periodic health check-ups can be organized for adolescents and youth at workplaces.

Section VII: Corporate Social Responsibility (CSR)

Corporate social responsibility (CSR) is fast becoming a benchmark in the business world. Companies are not just expected to stimulate the economy and provide products and services to the community — they are also expected to "do good" as well.

From environmentally sustainable and ethical labour practices to volunteering and philanthropy, businesses of today need to show both the public and their employees that they are positively contributing to society.

Trends in Corporate Social Responsibility – The ways companies give back to society vary and often reflect the issues that matter most to their investors and consumers. In the last few years, ethical practices and sustainability have risen to the forefront of CSR. Globally, 72% of companies publicly report their CSR efforts. (23)

Hence, investment companies (workplaces) in Ethiopia need to provide such services strictly following the four basic steps to CSR success:

- **Understand Stakeholders** – Who their customers are; who their staff are; what is important to each of them; what social and environmental issues have affected them; what issues they care about;
- **Keep the Values of Their Customers in Mind** – When making business decisions, businesses need to consider possibilities to address a CSR issue that is important to their stakeholders.
- **Keep Up the Talk –** They need to understand what issues matter to them most: What can businesses do to give back to the community; what can they do better.
- **Show Accountability –** Businesses need to report their CSR initiatives — the good or the bad.

Section VIII: Monitoring and Evaluation ofthe Services

I. Performance Tracking Systems

Measuring performance against set targets in the YFS program is crucial to generating essential information, tracking progress of the implementation, and achieving results. Also, process monitoring will allow for corrective and preventive actions and also for planning and coordination. Monitoring and evaluation of quality services will rely on routine and periodic data sources, which will be collected for several categories and levels of indicators. The indicators for monitoring and evaluation of a quality program are built into the framework of four core sequential domains: Inputs/Processes, Outputs, Outcomes, and Impact**.**

II. Integrated Supportive Supervision and Program Monitoring

Supervision will be essential at and between various levels of the health system. Frequent and regular joint supportive supervisions will be conducted to help identify problems early on and take immediate remedial actions using integrated supervisory mechanisms and checklists.

The MoH, through the AYH case team, will organize a bi-annual joint supportive supervision in collaboration with the workplaces and Regional Health Bureau (RHBs). A bi-annual progress review meeting to assess against targets the progress of YFS implementation in workplaces will also be conducted among different stakeholders including the MoH, IPDC and RHBs.

The meetings will, therefore, serve to assess SRH program outputs/outcomes as a key accountability mechanism to assess implementation.

III. Review Meeting

Conducting regular review meetings in collaboration with RHBs, Zonal health departments, Woreda health offices and health facilities at all levels. The MoH and other federal sectors like IPDC are also included.

IV. Performance Measurement Methods

1. Continuous (Routine) Data Collection

- **Health Management Information Systems (HMIS)**: HMIS and DHIS2 provide routine monthly information on AYH service utilization at workplaces.
- **Patient Records**: provide more detailed information on YFS services provided.
- **Record Review**: helps to assess quality of documentation and adherence to standards of care.
- **Client Questionnaires**: structured questionnaires can provide information about client priorities for care, and experiences of care.
- **Client Interviews and Focus Group Discussions:** help to gather and review qualitative/quantitative information about clients' priorities for care, experiences of care, and future care-seeking intentions.
- **Observations**: help to assess provider performance and adherence to standards of care.

Reporting and recording

The reporting mechanism should follow the standard DHIS2 and HMIS reporting of the Ministry of Health and regional health bureaus.

- Reporting and recording of services provided will be done Using the national standard reporting format
- Reporting will be to the nearest catchment PHCU (with in the same Woreda)
- Supportive supervisions will be conducted using the check list of the nearest catchment PHCU (with in the same Woreda)
- Supervisions shall be conducted jointly in an integrated manner. Supervision team will be composed of experts from the nearest catchment PHCU (with in the same Woreda), IPDC, the workplace (service provider/head of health facility)
- The workplace facility has to participate in Review meetings organized by the nearest catchment PHCU (with in the same Woreda), zone and region

2. Population-based Health Surveys

The Ethiopian Demographic and Health Survey (EDHS) provide information on YFS coverage, service-seeking behaviour, and patient self-reported practices and experiences of care at workplaces.

3. Periodic Data Collection

- **Client Exit Interviews**: assess experience of care and user satisfaction.
- **Provider Interviews**: assess provider knowledge, self-reported practice and training.
- **Simulations of Care**: assess provider competence and skills for discrete tasks.

4. Planning and Reporting

There should be common planning for all health activities of adolescents and youth at workplaces from both sides; that is from the workplaces and the respective government bodies within the catchment of the workplace. Plans on activities should be aligned in the same way as any other health SDP within the catchment. Joint planning, reporting, supervision and capacity building trainings have to be in place.

Leadership, Integration and Coordination

Leadership:

Overall Leadership - The overall leadership and implementation of the program is to be held by MOH

Human Resources

At the national level:

- The technical aspect will be led by the assigned Senior National SRH and AYH Advisor who will coordinate the activities of regional focal persons, development partners, donors, IPDC, and other sector organizations

At Regional level

- There will also be leadership and service Integration at the regional level who will in-turn cascade the implementation to the lower levels

Integration

Integration at national level:

- The MCH directorate with the FP/AYH/SRH desk will coordinator the implementation at federal level

- A senior advisor will be assigned to coordinate the activities of regions, donors, IPDC, and other development partners

- IPDC, and other sector organizations and decision makers at the federal and regional level

Integration at regional level

- Regional HB will coordinate the implementations of the program in their respective regions
- Cascade the implementation and follow up to the lower administrative levels
- Report to the national level

Roles and responsibilities:

- MOH – implement the program and oversees the overall implementation of the program at the National and Regional level
- The assigned National Advisor – follows the implementation of the program, conducts RM, ISS, Mentoring, reporting, resource mobilization
- Regional HBs - follow the implementation of the program, conducts Review Meetings, ISS, Mentoring, reporting, resource mobilization - oversees implementation at their respective level
- IPDC – facilitate the implementation of the program in collaboration with sector organizations and partners
- Implementing partners, donors, and other development partners – provide financial, technical and other supports as required for the implementation of the program at all levels

Implementation Arrangement/Guide

The implementation arrangement for the MSP document requires joint collaborative efforts with and by the workplace/industrial park, the health sector, partners, and the engagement of young people as well. Therefore, there needs to materialize an establishment of a coordinating body, working in collaboration with development and implementing partners, determining the duties and responsibilities of different stakeholders such as the MoH, IPDC, RHB, development partners, donors, implementing partners, and other stakeholders.

Hence, once the document is finalized and launched for implementation, the following activities need to be undertaken:

- **Dissemination** – The document has to be disseminated to all relevant government bodies, and other stakeholders working in the sector.
- **Assignment of Human Resources for Health (HRH)** – The effective implementation of the project requires highly qualified and experienced personnel to be deployed at the national and regional levels including assignment of Senior National Advisor
- **Joint planning exercise**–need concerted efforts of stakeholders
- **MOU preparation** –signed between MOH and IPDC, DP/IP
- **Technical teams** – incorporating the MSP activities as part of the existing National TWGs
- **Resource mobilization** – Advocating for government at all levels to allocate adequate finance,
- **Monitoring, Evaluation & Learning**- Conducting regular follow up and scale up of best practices

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