NATIONAL ADOLESCENTS AND YOUTH HEALTH STRATEGY

(2021-2025)







FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA
MINISTRY OF HEALTH

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MINISTRY OF HEALTH - ETHIOPIA
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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

Foreword

Adolescents and youth comprise 33% of Ethiopia's population which has a great implication on the social, economic, and political agenda of the country and positively contribute to the country's development if investments are made towards the attainment of their health potential. To realize this goal, the Ministry of Health has been developing and implementing two consecutive strategies in line with the rolling health sector development plan. To this end, the third National Adolescent and Youth Health Strategy would bring out Ethiopia's commitment to transforming the health and wellbeing of the adolescents and youth through a coordinated effort with regional health bureau and partners to rapidly improve their health status in Ethiopia.

The Ministry of Health recognizes the provision of high-quality health information and services to adolescents and youth that requires a multi-sectoral approach. Therefore, government sectors, agencies, industrial corporations, donors, implementing partners, associations, youth-led organizations, and other stakeholders' engagement including young people themselves are pivotal to attain the Health Sector Transformation Plan II (HSTP II) as well as meeting the Sustainable Development Goals (SDGs) by 2030. The National Adolescent and Youth Health Strategy (2021-2025) is intended to provide programmatic guidance to pertinent stakeholders in meeting the need of young people beyond the reproductive health issues to include other key health conditions affecting them. Several issues are included in the strategy such as adolescent nutrition, substance use, mental health, non-communicable diseases, injuries, gender-based violence, early/ child marriage, female genital mutilation/cutting (FGM/C) are considered.

Furthermore, the strategy gave due attention to inclusivity reach vulnerable groups such as adolescents and youth living with HIV, adolescents with disability, and youth in humanitarian settings aiming to reach and serve adolescents and youth information and services. With the geographical and socio-economic disparities, lower socioeconomic strata and those living in remote settings should be reached to address inequity in accessing youth friendly health services is also bold in the strategy which requires targeted programs to act on. Ensuring meaningful youth engagement across all programmatic interventions would be vital to bring robust insights for better programming and health outcomes as well.

Finally, on behalf of the Federal Ministry of Health, I would like to invite all stakeholders to work and collaborate with the ministry to achieve the overall goal and objectives of strategy during the implementation period.

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Acknowledgments

With the intention of the multifaceted changes of Adolescent and Youth Health (AYH) requires a clear understanding of their status and issues. There is also a need for an integrated approach that is not just problem-oriented but one that provides for mitigation of risk factors and puts in place a shield for early detection and prevention of AYH challenges. In this regard, the five-year National AYH Strategy will provide guidance to regional health bureaus and partners working on the AYH program on how to best respond to the health needs of adolescents and youth. The National AYH Strategy was developed using programmatic evidence and research gathered at the national and global levels from a variety of credible and well-recognized sources.

The Federal Ministry of Health, thus, gratefully acknowledges the leadership of the Adolescent and Youth health team of the Maternal, Child Health, and Nutrition Directorate, under whose leadership this document was developed. The inputs from AYH health experts invited from different regional and city administration health bureaus and youth representatives who have spent time and knowledge during the developing this strategy are also appreciated.

In addition, the Federal Ministry of Health would like to extend its sincere gratitude to the core team members including the TWG members who dedicated their time and expertise to reviewing, editing, and finalizing the National Adolescent and Youth Health Strategy, taking into account all comments and suggestions received at all levels of consultation meetings. The Ministry would also like to pass its gratitude to the following designated partner organizations for their technical contribution in the course of developing this strategy; Pathfinder International, Packard Foundation, Engender Health, CORHA, MSIE, UNFPA, Amref Health Africa, USAID, UNICEF, WHO, FGAE, CARE Ethiopia, DSW, EMWA, PSI, YNSD, VSO, UNESCO, TaYA, and Plan International. Special thanks goes to Packard Foundation, PIE, UNFPA, CORHA, UNICEF, Amref Health Africa, DSW, EMWA, and Plan international for their both technical and financial contributions during the development process of the strategy.

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Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASFR	Age-Specific Fertility Rate
AYFHS	Adolescent and Youth Friendly Health Service
AYH	Adolescent and Youth Health
AYRH	Adolescent and Youth Reproductive Health
BCC	Behavioral Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BMI	Body Mass Index
CAC	Comprehensive Abortion Care
CBA	Cost-Benefit Analysis
CBHI	Community Based Health Insurance
CBO	Community-Based Organization
CPD	Continuous Professional Development
CPR	Contraceptive Prevalence Rate
CSA	Central Statistics Agency
CSO	Civil Society Organization
DHIS	District Health Information System
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis, Tetanus
EDHS	Ethiopian Demographic Health Survey
EHW	Education for Health and Wellbeing
ESPA	Ethiopian Service Provision Assessment
FBO	Faith-Based Organization
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
FP	Family Planning
GBV	Gender-Based Violence
SS	Smart Start
GYSI	Girls, Youth, and Social Inclusion
HCG	Human Chorionic Gonadotropin
HEEADSSS	Home, Education/employment, Activities/Eating, Drugs, Sexual, Safety and Suicide
HEP	Health Extension Program
HEW	Health Extension Worker
HIT	Health Information Technology
HIV	Human Immune Virus
HMIS	Health Information Management System
HPV	Human Papilloma Virus
HSTP	Health Sector Transformation Plan
HTP	Harmful Traditional Practice
ICT	Information Communication Technology
IDA	Iron Deficiency Anemia
IDP	Internally Displaced People
IEC	Information Education Communication
IPDC	Industrial Parks Development Corporation

IRT	Integrated Refresher Training
LBW	Low Birth Weight
mCPR	Modern Contraceptive Prevalence Rate
MHM	Menstrual Hygiene Management
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MoE	Ministry of Education
MOH	Ministry of Health
MOSHE	Ministry of Science and Higher Education
MoWCY	Ministry of Women Children and Youth
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHA	National Health Account
NTD	Neglected Tropical Diseases
OVC	Orphan and Vulnerable Children
PAC	Post Abortion Care
PEP	Post Exposure Prophylaxis
PHCU	Primary Health Care Unit
PMA	Performance Monitoring for Action
PNC	Postnatal Care
PPMED	Policy Plan Monitoring and Evaluation Directorate
PWD	Persons with Disabilities
RAC	Research Advisory Council
RHB	Regional Health Bureau
RMNCAYH-N	Reproductive, Maternal, Newborn, Child, Adolescent, and Youth Health-Nutrition
SARA	Service Availability and Readiness Assessment
SBCC	Social and Behavioral Change Communication
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SLOT	Strength, Limitations, Opportunities, and Threats
SNNPR	Southern Nations Nationalities and Peoples' Region
SPA+	Service Provision Assessment plus
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TVET	Technical and Vocational Education Training
UN	United Nations
UNICEF	United Nations Children's Fund
VMMC	Voluntary Medical Male Circumcision
WDA	Women Development Army
WHO	World Health Organization
WoHO	Woreda Health Office
YAC	Youth Advisory Council
ZHD	Zonal Health Department

Executive Summary

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

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

However, besides limitation in scope, the first AYSRH strategy was challenged by lack of multi-sectoral collaboration, low stakeholder and youth involvement, inadequate resources, and persistent social and cultural barriers to AYSRH. The main limitation of the strategy was that it only considered adolescents and youths having a sexual and reproductive health problem neglecting other health issues like nutrition, mental health, injuries, communicable and non-communicable illnesses. As a result, adolescents and youth continue to face challenges to their health and development. Thus, the need for a comprehensive adolescent and youth health responsive strategy was imperative resulting in the development of the second adolescent and youth health strategy that has been implemented from 2016 to 2020.

The second Adolescent and youth health strategy (2016 to 2020) that was a preceding for the current AYH strategy, was developed after thorough preparation and was informed by far-reaching situational analysis of the trends in mortality, morbidity, and health system response to adolescent and youth health and development in Ethiopia. The situational analysis showed the development and health of adolescents in Ethiopia are determined by broad-ranging health and health-related behavioral conditions. The second strategy goes beyond SRH and HIV and addressed other health conditions such as nutrition, mental health, substance use, non-communicable diseases, intentional and unintentional injuries, various forms of violence, and risks and vulnerabilities associated with disability, identified by the then situational analysis.

Even though a lot has been achieved through implementing the second AYH strategy over the last 5 years showing an improvement in adolescent and youth health. The second strategic document lacks giving equal emphasis for early adolescents, lacks meaningful youth engagement, benefiting from innovations and technology for better access and utilization, quality of service delivery and equity remained as a gap making a requirement for the revision to address these and other related gaps. The current strategy will continue to ensure their due consideration while consolidating on the achievements of the recently ending adolescent and youth health strategy.

The strategic framework is built on a set of key guiding principles. It aims to contribute to the improvement of the health of adolescents and youth through the development and strengthening of an integrated

health sector response and the implementation of effective health promotion, prevention, and care programs. It employs 7 impact indicators to be achieved by 2025:

- Reducing overall mortality by 15%
- Reduce pregnancy-related mortality rate from 0.39 to 0.29 for age group 15 to 19
- Reduce pregnancy-related mortality rate from 64 to 48 for age group 20 to 24
- Reduce teenage pregnancy rate from 12.5 to 7
- Raise median age at first sex from 16.4 to 17 years
- Raise median age at first marriage from 17.8 to 18 years
- Reduce HIV prevalence among 15 to 24 years from 0.34% to 0.1%

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

- Enhance health literacy among adolescents and youths.
- Improve equitable access to adolescent and youth health services.
- Improve the quality of adolescent and youth health services.
- Strengthen leadership and accountability.

The framework also employs eight strategic priorities of positive health development; adolescent and youth development and engagement in health; expansion of adolescent and youth health service packages and service delivery outlets; mainstreaming continuous quality improvement in all AYH service settings, enhancing adolescent and youth health competent health workforce, strengthening and scaling up adolescent and youth health financing, strengthening adolescent and youth health information management as well as enhancing multi-sectoral approach, programing and regulation.

The strategy also considers seven impact and thirty-seven outcome indicators by key strategic priority areas and conditions. Its respective implementation strategies, performance targets, and priority interventions accompany each of these strategic priority areas. It outlines the implementation arrangement and service delivery strategies based on the life cycle approach aligned with the HSTP's II strategic lines of Population Oriented Outreach/Schedulable Services, Family Oriented Household Services, and Individual Oriented Clinical Services.

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

The overall cost of implementing the strategy is estimated at ETB 2,755,539,628.32 for the coming five years. This overall cost reflects for adolescent and youth health of different expenses.

This strategic plan requires the collective efforts and commitment for program planning, implementation, monitoring, and evaluation across the health delivery system including health care providers as well as sector organizations, partner organizations, bilateral organizations, UN agencies, and other stakeholders.

1. Introduction

Adolescents and youth are described as important phase of life in the stages of human development. The World Health Organization (WHO) defines 'adolescence' as a transitional age between 10-19 years and 'youth' between ages 15-24 years. These two overlapping age categories are often combined into 10-24 and are labeled as 'young people. Adolescents and youth constitute a wide age range with diverse interests, problems, and capacities that require further disaggregation for targeted and successful interventions. Adolescence and Youth is a period in which an individual undergoes enormous physical and psychological changes in social expectations and perceptions.

Globally, there are over 1.8 billion adolescents and youth aged 10-24 years, 90 percent of whom live in developing countries[1]. In Africa, 32% of the population belongs to the age group of 10-24 years[2-3]. In Ethiopia, adolescents and youth of the age group 10-24 years account for 33 percent of the total population and over three-quarters of them live in rural areas[4].

As the single largest and yet dynamic section of the population, adolescents and youth have the potential to contribute to growth and development. Young people are being referred to as the "torchbearers" of the 2030 SDG agenda[5]. The African Union's Agenda 2063 has a pivotal role to play both as beneficiaries of actions and policies a collective partner[6]. Indeed, the 2030 agenda calls for the development and activation of sound, evidence-based youth policies and actions to ensure its full realization[7]. A strategic response is vital to address their physical, social, and mental development needs thereby harnessing the critical demographic dividend expectations. Meeting their diverse and dynamic needs of health, education, economic empowerment, and participation call for broader investment in health infrastructure, socio-cultural and economic domains.

A critical, overarching reason to invest in the health of adolescents and youth is that it is adolescents and youth's fundamental rights to life, development needs, and fulfillment of the highest achievable standards of health through access to health services. In addition, the investment in adolescent and youth health will bring a triple health dividend for adolescents now for their future adult lives and the next generation health and wellbeing are engines of change in the drive to create healthier, more sustainable societies.[8]

The World Program of Action for Youth was adopted in 1995, many UN Member States have increased efforts to develop and implement robust youth policies affecting youth across the 15 priority areas. The area includes health, HIV/AIDS, substance abuse, girls and young women, education, employment, hunger and poverty, environment, juvenile justice, leisure-time activities, full and effective participation of youth in the life of society and decision-making, globalization, information and communication technologies, armed conflict, and intergenerational issues[9].

To address these key adolescent and youth health issues, the government of Ethiopia has taken several measures through its youth policy, the Health Sector Development Program I-IV, the Health sector transformation plan I-II, the National Adolescent and Youth Reproductive Health Strategy (AYRH) in 2006, Adolescent and Youth Health Strategy 2016-2020, and many other responses. As a result, encouraging outcomes have been achieved such as improved youth responsive health facilities, improved adolescent and youth awareness, improved utilization of health services, reduced unsafe abortion and its complication, age disaggregation of routine service data, etc.

However, adolescents and youth are still facing multiple challenges starting from the emerging health threats, preventable causes of morbidity and mortality. As a result, this strategy is developed through a consultative process involving stakeholders including sector ministries, regional health bureaus, and adolescents and youth.

2. Situational Analysis

The ministry of health implemented two strategies related to adolescents and youth before the current strategy. The AYRH strategy (2006-2015) and the AYH (2016-2020) ended recently. From the implementation of these strategies, the ministry of health and its partners have gained ample experience. However, generally generating age disaggregated data and documentation and sharing of evidence and lessons learned is poorly captured. This strategic planning document (2021 to 2025) gathered most of the situational analysis from national reports and health and health-related indicators from MOH, recent EDHS report, and adolescent health service barrier assessment (AHSBA), this situational analysis was developed to construct interventions for implementing this strategic document (2021-2025). In this situational analysis, key accomplishments in specific focus areas and key challenges of the currently ending strategy are highlighted to serve the development of strategic initiatives and interventions of the current strategy.

Major Health Concerns

2.1 Adolescent and Youth Mortality

According to the data from the institution of health metrics and evaluation, the overall mortality rate of adolescents and youth 10-24 years of any cause has declined during the last couple of decades. Similarly, evidence from the Ethiopian demographic and health survey (Figure 1) reveal that the all-cause mortality rate per 1000 population decreased for both genders: for 15 to 19 years' females (4.89 in 2000 and 2.22 in 2016) and the corresponding rate for males of the same age group (4.27 in 2011 and 2.86 in 2016). However, the male mortality rate among 15-24 age groups has been steadily increasing from 2000 to 2011, though there is a sharp decline in 2016 across all AY age groups. The relative increase in all-cause mortality for males against their female counterparts might be due to exposure to road traffic accidents, injuries, and other interpersonal violence[11]. In urban areas, there were 2.4 male deaths and 1.9 female deaths per 1,000 populations in the previous seven years. In rural areas, there were 3.2 male deaths and 2.4 female deaths per 1,000 populations[10].

Female mortality 15-19 years dropped by more than half from about 4.89 deaths per 1000 population in 2000 to 2.2 deaths per 1,000 populations in 2016[10-11]. The risk of mortality in females was found to increase as they enter the reproductive age because of pregnancy-related health problems such as unsafe abortion, pregnancy, and birth complications. Pregnancy-related mortality is 0.39 per 1,000 women for age 15-19 years and 0.64 per 1,000 women for age 20-24 years, which translates to MMR of 293 and 320 per 100,000 live births according to the 2016 EDHS. The figure below summarizes the progress of reducing mortality among adolescents and youth in Ethiopia.

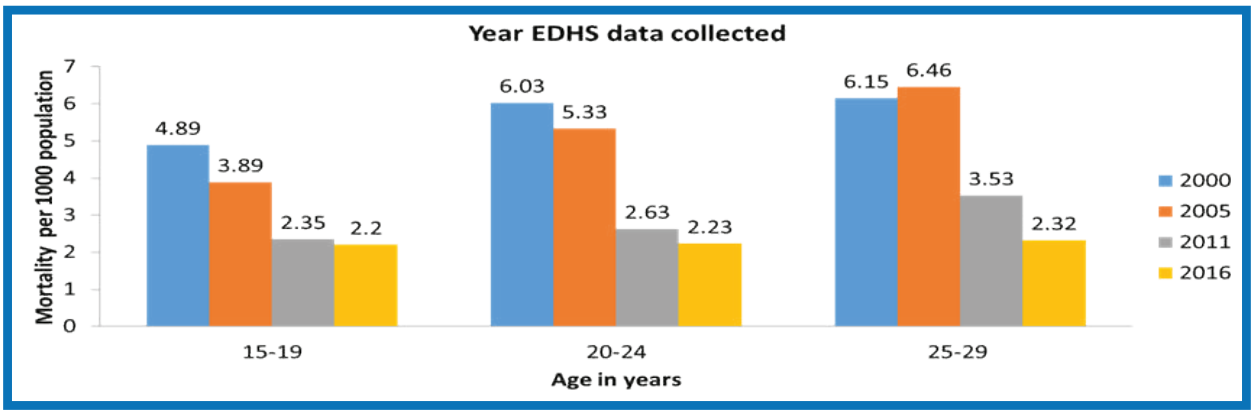

FIgure1: Female mortality rates in the age category of 15-29 years for 0-6 years before each EDHS survey, 2000, 2005, 2011 and 2016

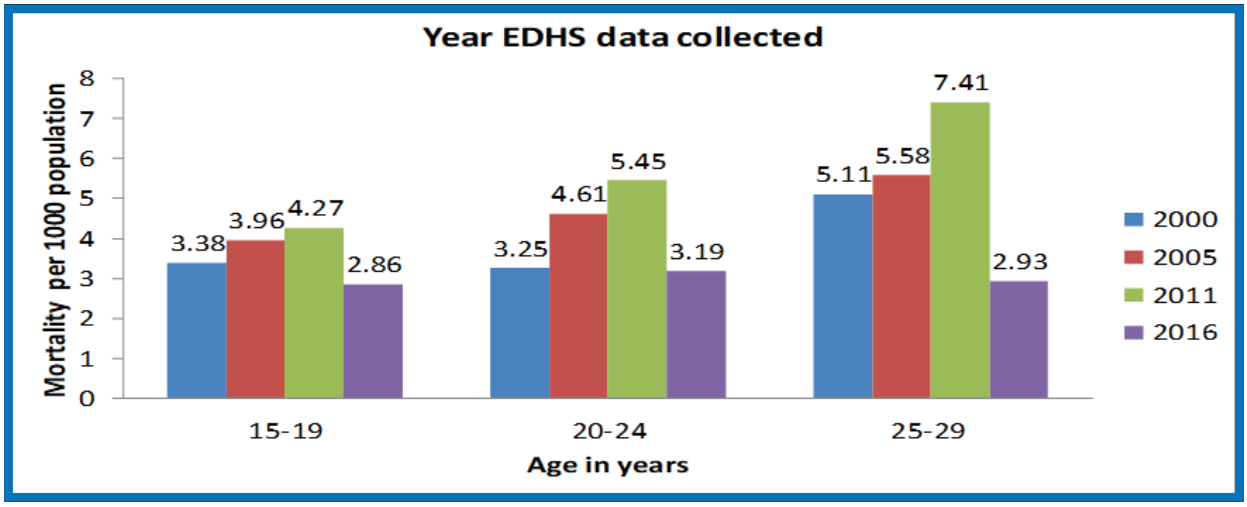

Figure 2: Male mortality rates in the age category of 15-29 years for 0-6 years before each EDHS survey, 2000, 2005, 2011 and 2016

2.2 Adolescent and Youth Morbidity

2.2.1 SRH Timeline as a cause

Adolescent and youth morbidity in connection to early engagement in sexual activity has been detrimental. According to the PMA survey result from 2019, the median age at first sex is at 16.4years and the median age for first marriage is 17.8 years for rural girls which are lower compared to adolescent girls in urban areas[12]. The finding has further documented that the first contraceptive use occurs at least seven years after having the first sexual intercourse in the rural community.

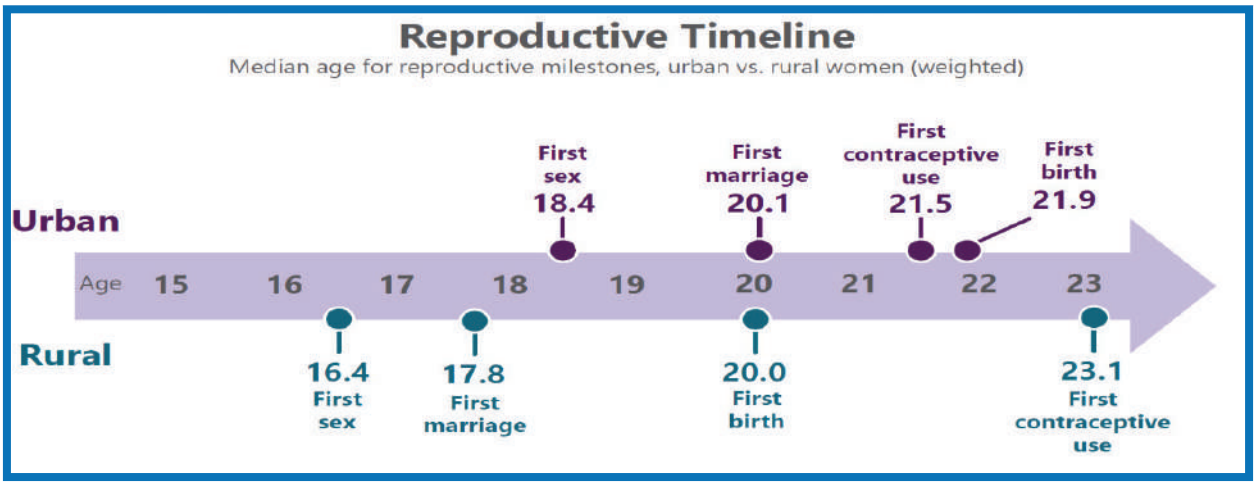

Figure 3:. Median Age at Reproductive Events

In Ethiopia, there has been a uniform decline in the Age-Specific-Fertility-Rate (ASFR). In 2019, the ASFR for the age group 15-19 years is 72 births per 1,000 women and peaks to 202 births per 1,000 women in the age group of 25-29 years and then drops to 14 births per 1,000 women in the age group of 45-49 years. The adolescent and youth fertility rate also varies across the regions of Ethiopia. According to the EDHS 2016, the adolescent fertility rate for the age group 15-19 years is highest in Afar at 152 births per 1,000 women and lowest in Addis Ababa at 13 births per 1,000 women. ASFRs are lower in urban areas compared to rural areas among women in all age groups. On average, rural women have 1.3 more children than urban women (4.5 versus 3.2 children), the disparity between urban and rural has narrowed over the last 3 years[12].

2.2.2 Contraceptive Use and Adolescents and Youth

Modern contraceptive use among adolescents and youth has increased over the last two decades. The modern contraceptive prevalence rate (mCPR) is higher among sexually active unmarried youth than married youth. Non-married women tend to use more contraceptives as compared to married young women up to the age of 24 years. According to the 2019 mini- EDHS, only 36.4% of young women aged 15-19 years use modern contraceptives. This is mainly because of the religious and cultural influence on married adolescents and youth to prove their fertility than delaying childbearing immediately after marriage (EDHS 2016). Teenage pregnancy and motherhood are increasing from 12% in 2011 to 13% in 2016. The unmet need for contraception remains high at 23.4 % for urban youth of the same age group (EDHS2016). Regarding the method mix, the injectable is the common method in both married and unmarried adolescents and youth. However, the male condom is the 2nd commonest method used by unmarried adolescents and implants are the 2nd commonest method used among married adolescents and youth. About 14% of unmarred adolescent and youth also uses emergency contraceptive as a modern contraceptive method. The adolescent age group of 15-19 years has higher unmet needs than the youth age group of 20-24 years. This indicates that adolescents and youth have more barriers to access contraceptives, which calls for more attention to ensure access and friendliness of the service provision.

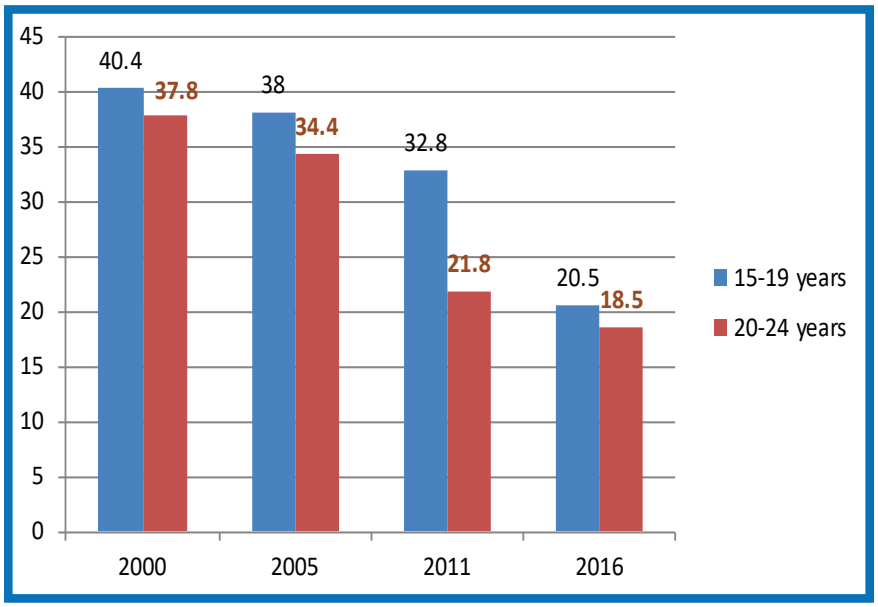

Figure 4: Unmet need for family planning among Adolescent and Youth by year – (EDHS 2000, 2005, 2011, and 2016)

2.2.3 HIV/AIDS and STIs Among Adolescents and Youth

According to the EDHS 2016 report, comprehensive knowledge of HIV among adolescents and youth, especially among rural females is very low. As compared to urban males, 16% of rural females and 38% of rural males had comprehensive HIV knowledge, which is much lower as compared to adolescents and youth in urban settings where 39% of females and 48% of males have comprehensive knowledge. The report shows that 5.4% of sexually active urban females and 3.2% of sexually active rural women had a sexually transmitted infection (STI) in the last year. A total of 15,000 (9,000 females and 6,000 males) new HIV infections are estimated in 2019, about 67% of the new infections are occurring in the age group below 30 years. Of these 20% are from the age group 20 to 24. The national HIV prevalence among young people (15-24) is low (0.34%) as compared with adult prevalence (0.93%). On a similar note, the prevalence of HIV is 0.3 among women which is higher than a 0.1% prevalence for adolescents and youth aged 15-24 years old. The prevalence of HIV among adolescent women is 0.4 compared to almost 0% for men counterparts. Gambella and Addis Ababa are the regions that have the highest HIV prevalence in the general population, which also represent the highest HIV prevalence among young people 15-24, 1.93% in Gambella, and 1.79% in Addis Ababa indicating the ongoing spread of HIV in the population[11].

2.2.4 Child Marriage and Teenage Pregnancy

Elimination of child marriage by 2030 is targeted in Sustainable Development Goal 5.3 (SDG5.3), and child marriage is illegal in Ethiopia as stated in the revised criminal and family laws of Ethiopia (2005) which set the minimum age of marriage for women as 18 years. Despite such legal provisions, child marriage remains high in Ethiopia. According to UNICEF (2018), the prevalence of child marriage in Ethiopia is 40% and varies across regions. Fewer than 10 percent of young women were married in childhood in Addis Ababa compared to 50 percent or more in Afar, Benishangul Gumuz, and Somali regions.

Although the legal age of marriage in Ethiopia is 18 years, 14.1% of girls married by age 15, and 40.3% by age 18. In Ethiopia, most teenage pregnancies occur within marriage[11]. Nationally, 13% of the married teenager's age group 15-19 have already begun childbearing. Teenage childbearing is more common in

rural areas where 15% of teens give birth to a child before age 18 years with wide variation between regions. The pastoral settings of Afar and Somali have the highest teenage birth estimated at 23% and 19%, respectively while Addis Ababa is the lowest with only 3% of teens giving birth to a child before age 18 years (EDHS 2016).

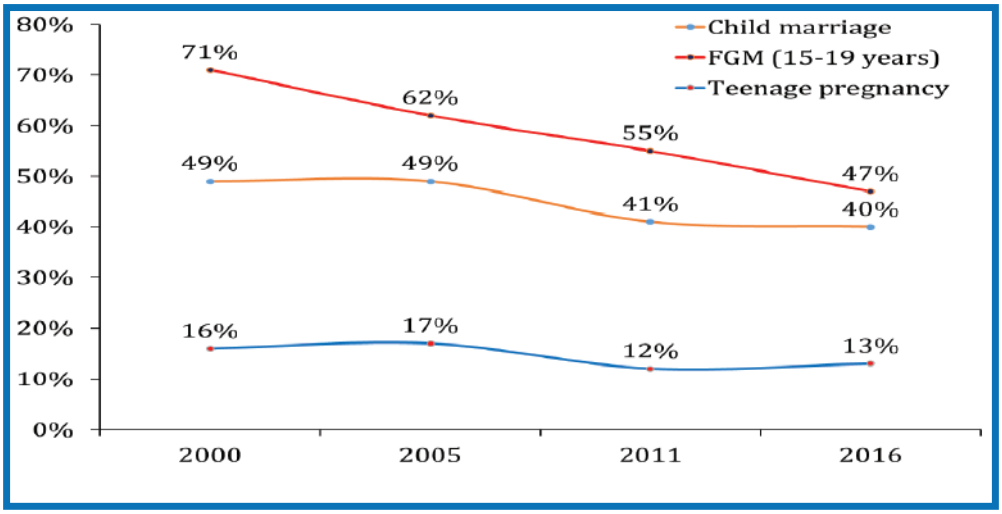

Figure 5: Proportion of child marriage, FGM & teenage pregnancy by years

Despite the government's commitment and development partners' engagement to end child marriage and FGM/C in the last two decades, the recent EDHS data has shown that there was insignificant decline in the prevalence of teenage pregnancy between 2000 and 2016 (a decline from 16% to 13%) which means about 400,000 pregnancies occur before the age of 18 years. Seventy-five percent of the pregnancies occur in rural areas, where access and utilization of obstetric services are limited, and the risk of obstructed labor is higher. Teenage pregnancy has serious consequences that are the leading cause of death among girls aged 15–19 years. Pregnant teenage girls face higher risks of eclampsia, puerperal endometritis, systemic infection, and unsafe abortion. Teenage pregnancy is an obstacle for girls' future education, job opportunities, and various socio-political engagement. Unmarried pregnant teenagers are affected by stigma, rejection, or violence by partners, and peers. Girls who become pregnant before the age of 18 years are more likely to experience violence within a marriage or partnership. Babies of teenagers face higher risks of low birth weight, preterm delivery, and other neonatal morbidity and mortality.

2.2.5 Adolescent and Youth Nutrition

The age of Adolescence and youth is a crucial period in terms of physical growth and significance to nutrition. It is the second window of opportunity for investment in adolescent and youth nutrition when lifelong health and nutrition behaviors are formed, which can also affect future generations[13]. Adolescents should take diversified and healthy diets for their growth and development which contain more fruit and vegetables, whole grains, and smaller amounts of fat, oil, and sugar. Adequate water and mineral intake are also required. Multi-sectoral collaboration is required to ensure optimum nutrition for adolescents and youth. There are three types of malnutrition in general: undernutrition, overnutrition/overweight, and micronutrient deficiency. Factors that affect adolescent nutrition span across generations starting from childhood to death implicating on adolescents and youth.

Adolescent malnutrition is an important public health problem particularly for girls and boys because of its faster growth than at any time in their life. Young girls who grow poorly become stunted and are more likely to give birth to low-birth-weight infants. If those infants are girls, they are likely to continue the cycle by being stunted in adulthood. Adolescent pregnancy heightens the risk of low birth weight and the difficulty of breaking the cycle.

However, malnutrition affects a large portion of the adolescent and youth population in Ethiopia. According to the EDHS 2016, men are generally thinner than women showing a national average of 32.3% prevalence (BMI <18.5) against 22.4% for women. This figure is much high for adolescent boys aged 15-19 years of age (59%) than adolescent girls (29%). On the other hand, the prevalence of underweight is also very high among rural adolescents (31%) compared to their urban counterparts (17%).

Furthermore, the prevalence of anemia for 15 - 19 years' females was 24.8% in 2005 and 19.9% in 2016; and among 20 - 24 years of age females, it was 23.3% in 2005 and 23.8% in 2016. Severe anemia during pregnancy is associated with increased maternal mortality. Poor nutritional status in pregnancy and pre-pregnancy is linked to poor birth outcomes including obstructed labor, premature or low-birthweight (LBW) babies, stillbirth, birth defects, postpartum hemorrhage, and subsequent linear growth (EDHS 2011).

Deep-rooted poverty, illiteracy, infections like intestinal helminthiasis, malaria, HIV, and cultural taboos are among the major factors of malnutrition in adolescents, especially in girls. An adequate well-balanced diet is the foundation of child survival, health, and development. Well-nourished children are more likely to be healthy, productive, and ready to learn.

The pooled prevalence of overweight and obesity among children and adolescents in Ethiopia is substantially high (11.3%) and becoming an emerging nutrition-linked problem. The study shows Female, high family socioeconomic status, learning in private school, physical inactivity and sweet nutrient preference, and less use of fruits/vegetables were significantly associated with overweight. Interventions should be placed to address malnutrition, micronutrient deficiencies, and diet-related chronic illnesses. Nutrition screening and counseling; micronutrient supplementations; promotion of healthy behaviors and healthy lifestyles; delayed early marriage and teenage pregnancy and service integration with family planning and others are recommended.

2.2.6 Maternal Health Service Utilization among Adolescents and Youth

Though Ethiopia has improved the expansion of access to several maternal health services in the last decades, service utilization remains a major problem. While more pregnant adolescent girls and women visit health facilities during pregnancy, institutional delivery and postnatal care follow-up are limited. As compared to previous years, data from 2019 shows encouraging changes. Nonetheless, given overall limited maternal health service utilization, improved maternal health for adolescents and youth remains to be a challenge in Ethiopia. Mini EDHS (2019) report revealed that 26.6% of adolescents do not have any antenatal care visit while 72.8% had at least one visit and only 36.4% had 4 antenatal care visits showing a high dropout. In addition, only 34.5% of adolescents had a postnatal check during the first two days after birth.

2.2.7 Substance Use and Mental Health

The most common addictive substances used by adolescents and youth in Ethiopia are cigarettes, alcohol, and khat. According to the EDHS 2016 report, 36.8 % of adolescent girls and 43.3 % of adolescent boys aged 15-19 years consume alcohol. The national prevalence of Khat consumption among adolescents and youth is 51%; higher among males (56.5%) than females (36.6%). In connection to such substance use, mental illness is the leading non-communicable disorder among adolescents and youth in Ethiopia. With the prevalence ranging from 12-25%, mental illnesses make the highest burden of non-communicable disorders in the health sector. Cyber addiction is also currently evolving as a main public health problem, particularly among adolescents and youth due to the rapid advancement of information technology and the Internet becoming public health concern.

Evidence indicates that about 75% of mental disorders in adulthood have their onset in adolescent and youth, particularly among those 12 – 24 years of age. In Ethiopia, mental illness in children and adolescents is estimated to be between 17% and 23%, with lower prevalence in rural settings. Studies indicate that substance use among Ethiopian adolescents and youth are considerably rising. Of the young segment of the Ethiopian population, college and university students are at the highest risk of substance use. Joining university often leads to new opportunities, independence from family control, self-decision making, and peer pressures to use alcohol or other drugs[14]. Studies done in different universities and colleges in the country show that khat chewing ranges between 14.1% in Addis Ababa University to 33.1% in Jimma University. Alcohol drinking and cigarette smoking are the cases where a third of university students from Axum, Debre Markos, Addis Ababa, and Jimma universities.

2.2.8 Non-Communicable Diseases and Injuries

Studies indicate that NCDs is an emerging epidemic in Ethiopia and other low and middle-income countries because of the increasing urbanization and the related changes in lifestyle and dietary habits. In Ethiopia, Non-communicable diseases (NCDs) are recognized as emerging public health problems which accounts for 30% of deaths in 2014. In a study conducted among working adults in Addis Ababa, the prevalence of diabetes mellitus was 6.5% and the prevalence of hypertension was 19.1% with a higher proportion among males 22%.

Injuries are among the leading causes of death and disability among adolescents and youth with unintentional injuries such as road traffic injuries, physical fight, and burns-being the most common. As per the national AYH baseline statistic report, road traffic injuries account for a prevalence rate of 31.5% among all trauma patients in Ethiopia, which is also estimated to reach 58.3% in southern nations, nationalities, and peoples (SNNPR) regions. Physical fight, often associated with substance use and other behaviors, is common among younger adolescents, and more among boys than girls leading to severe injuries. In Ethiopia, injuries due to Road Traffic Accidents (RTA) account for 22.9% of the mortality or injury among adolescents and youth (15-29), the prevalence of RTAs is 2.7% (3.2% male and 2% female) and that of non-RTAs is 2.4% (3% male and 1.6% female).

2.2.9 Gender-Based Violence & Harmful Traditional Practices

Evidence reveals that GBV is an outstanding problem in Ethiopia. Studies conducted in northwestern Ethiopia indicated that the prevalence of GBV (physical and/or sexual) among high school girls is 57.3%[15]. GBV is so common that 60.3% of married young women believe that a husband is justified for beating his

wife. There is poor awareness about the existing legal framework. More than half (53%) of married adolescent women aged 15-19 do not know the existence of a law that protects women from GBV in Ethiopia, similar for the older age groups (EDHS, 2005, 2011). According to EDHS 2016, the Experience of violence among women aged 15 to 49 is 23% physical violence, 10% sexual violence, about one-quarter of women who had experienced physical or sexual violence have sought help.

Due to socio-cultural and economic factors, women have limited space for decision-making autonomy, lack of control over resources, have limited participation in socio-economic practices, and experience child and early forced marriage, and this poor service utilization has exposed them to poor sexual and reproductive health outcomes. Young girls with disabilities are also suffering from GBV, including sexual violence as they are viewed as "defenseless and live under poor protection" (Samrawit[7] et al 2019). Hence, disability and poverty can also exacerbate vulnerability to GBV.

Similarly, the prevalence of FGM in Somali and Afar is almost universal 91% & 99%, giving the national prevalence rate of 65% among women of 15-49 years[16]. The promising part is that the national prevalence of FGM in children aged 0-14 years has declined to 16%, but far from ending. The prevalence of FGM in aged 15-19 years has also declined from 71% in 2000 to 47% in 2016. The practice is likely to persist unless new approaches to intervention are implemented. It is recommended that a comprehensive response that couples community empowerment with strong enforcement of legislation is administered to effectively end FGM in Ethiopia by 2025, in alignment with the national plan against Harmful Traditional Practices.

3. Key Priority Issues from the Consultative Meeting as an input for Adolescent and Youth Health Strategy 2021-2025

There were key priority issues derived from the consultative meeting used as an input for adolescent and youth strategy 2021-2025 development. As part of the strategic plan review, the ministry of health, regional health bureaus, and non-governmental organizations hosted a one-week review meeting. After presenting the regional AYH performance and Adolescents Health Service Barrier Assessment (AHSBA) report findings, the experts worked out and discussed to identify the critical issues of Adolescent and youth health specific to each age group of 10-14, 15-19, and 20-24 years. This context-specific analysis by a group used a problem rating tool to help to identify the key health problem per each age group.

The criteria for rating were: 1) The magnitude of the problem, 2) the severity of the problem, and 3) the feasibility of interventions by the health sector. From two days of problem identification and prioritization exercise the expert team has identified the top three health issues that includes:

- For age 10-14 years: Micronutrient deficiency, Communicable disease, and GBVs,
- For age 15-19 years: are teenage pregnancy, unsafe abortion and HIV and,
- For the age group 20-14 years: HIV, unsafe abortion, and unintended pregnancy

In addition, the experts identified specific contexts for each age group. In school, out school, pastoralist, agrarian, in humanitarian crisis settings, industrial parks, and others like an institutionalized orphan adolescent and youth need were identified as the most disadvantaged groups. This analysis calls for age and context-specific strategies for the identified problems.

4. Strength Limitation Opportunities Threats (SLOT) Analysis

While implementing adolescent and youth health programs over the last two decades, important accomplishments and useful lessons have been recorded. In this section, highlights of strengths, limitations, opportunities, and threats to the new strategic plan are analyzed about established experiences to date.

The situational analysis revealed that most adolescents and youth of Ethiopia lack good and sound information in line with unprotected sex, sedentary lifestyle, harmful consumption of alcohol, tobacco, and drugs, poor diet, and misuse of information and communication technology (ICT). The availability of data, particularly gender and age-disaggregated data, is still a limitation. The source availability for adolescent and youth health programs remains a major challenge.

The main strengths identified during the analysis include the existence of a health extension program and physical access to Health Infrastructure, partnership and collaboration with the stakeholders, and availability of youth friendly health service. The main limitations are weak coordination, weak service provision, limited awareness of the service, and weak community engagement. Finally, adolescents and youth are demanding representation in decision-making bodies.

Table 1: Slot Analysis

SLOT ANALYSIS	
Strengths	**Limitations**
• Establishment of AYH structure eg at national level • National government focus on AYH (Availability of national strategies and guidelines on adolescent and youth health) • Available AYH technical working group • Available national strategic planning • Increasing primary health service coverage • Physical access to Health Infrastructure • Availability of AYH corners at health facilities. • Availability of one-stop centers • Program-specific monitoring and evaluation • Availability of learning districts in selected regions (Oromia, Amhara, and AA) • Improve involving partnership and collaboration with the Stakeholders • Existence of AYH forum • Establishment of AYH Digital and e-learning platforms • AYH service initiatives in Industrial Parks Development Corporation (IPDC) and mega projects.	• low focus on AYH including advocacy at sub-national levels • Very Low budget allocation • Limited implementation of youth engagement guidelines • Low quality of AYH service at all service outlets • Relatively negative attitudes of health systems towards adolescent and youth SRH • Low commitment and limited capacity on AYH service provision at all levels. • Weak linkage and referral among other sectors providing AYH service • The Health Extension program inadequately address the AYH • Limited cascading of AYH structure to the lower-level structure, or low regional commitments • Inadequate HMIS for AYH • Limited tailored of IEC/ e-learning/ social media platforms. • Low attention for the vulnerable and adolescent and youth with special needs. • Low Community engagement (parent, religious leaders, boys, and men) for AYH • Lack of functional AYH coordination platforms and HR structure at a lower level of the health system (Region, Zone, woreda, and PHCUs) • Low awareness of society on HTP • Limited multisectoral collaboration and coordination • Limited access due to service fee (HCG test, STI treatment, card fee...)

Opportunities	Threats
• Government/political will to invest in young people • Conducive Policy Environment • Favorable global momentum on adolescent and youth health through SDGs • Existing of community health program • Existence of School health program framework • Government commitment to job creation and adolescent and youth economic empowerment • Increased health-seeking behavior of adolescent and youth • Urbanization such as convenience for literacy, job opportunity, information access • Globalization such as access to technology-based information • Expansion of infrastructure and communication technology development and use (Mobile, internet, FM) • Increased school enrollment • A Large number of the youth population • Conducive laws on CSO	• Public health emergencies and Global Covid-19 pandemic. • Instability and security problem • Increased population explosion that needs more demand. • Urbanization making relative vulnerability to sexual promiscuity risk, street children, trafficking, the risk to addiction, and substance • Increasing emerging nutritional problems including malnutrition and obesity • Unemployment, internal/external displacement. • Weak law enforcement on HTPs/GBV

The main identified strength and limitations within the health system and the external factors of opportunity and threat require a thorough understating of the focus area for improving the health outcome of adolescents and youth in the coming five years by carefully crafting the strategic approaches, interventions, and key activities. Hence, the ministry of health and partners will consider these during implementing the strategy.

5. Stakeholder Analysis

Stakeholder analysis is a crucial part of the effective and efficient implementation of the national adolescents and youth health strategy in the coming five years. The health and wellbeing of young people cannot be addressed only by the health sector. Thus, diversified stakeholders, their needs and roles are required and summarized in the table below

Table 2: Stakeholder Analysis

Stakeholders	Behaviors required	Their Needs	Possible responses
Line ministries (MoE, MoWCY, IDPC (Industrial Development Park corporation) commission, and agencies	Ensure the inclusion of adolescents and youth health into their policies (AYH in all policies), Creating a conducive environment for health-promoting schools and AYH in development corridors	Awareness and advocacy on the importance of investing in AYH for better academic performances, economic growth, and disease prevention that occur during adolescent and adulthood	Create health promoting schools Ensure AYH services are provided in the development corridors as per the national standards Advocacy and coordination to curve preventable causes of mortality and morbidity among youth
NGOs, CSO, and professional associations	Joint planning, Participation, and support in the implementation of the strategy. Design and implement targeted youth-focused projects/ programs that address the young people specific need	Guidance, conducive policy	-Proactively engage in Program designing and implementation -Identify Innovation and digital technology and introduce timely -Advocacy for age-appropriate health information and services

Development Partners	-Engage in planning, Allocate budget for supporting identified gaps in AYH program -Provide technical assistance through sharing oversee experiences	-Well-functioning Monitoring and evaluation system -Well planned activities and a clear financial system	-Support in capacity building on leadership -Support youth organizations with budget allocation -Bring Youth innovation and advocacy
Political leaders and parliament	Policy development that supports better health outcomes of youth Influences for budget allocation for youth programming	Support policy implementation for equity where most at risk and marginalized youth are addressed through the policy	Evidenced and data Measurable programs / M&E system
Trained Health professionals	Basic knowledge on domains of adolescents and youth health and development to provide AYH-friendly health services for young people in need. Updated information, knowledge, motivation, technology	Policy, strategy, guideline, job aids, training, and mentorship support	Provide quality health information and services for young people, Engage in the community health system, identify youth in need and provide services, Work with line sectors/ schools, youth centers, and industrial parks
Community	Understand youth has a special need for their health and well being	Information and education on adolescent health and development parenting skill	Acknowledge the health needs of the young people and support in the advocacy, identification, and referral system. The community has a role to protect young people from an ill-health condition
Youth associations young people themselves	Participation, engagement Ownership Service utilization Healthy lifestyle	Access to quality health information, education, and services when they need	Engage in health programming during planning, implementation, and M&E. Advocate in the prevention of HTPs and unhealthy lifestyles

6. Strategic Framework

The Strategic Framework is based on an integrated and comprehensive adolescent and youth health care package that comprises health promotion, preventive, curative, and rehabilitative interventions across all levels of care. The package promotes focus on consolidating gains from the previous strategic document implementation. It holds on to key basic principles of program planning, implementation, and monitoring and evaluation at all levels and stages

6.1 Key Guiding Principles

- **Right based approach:** Promotes and advances the right to decision making, choice of health services, confidentiality, privacy, and respect to gender equality.
- **Compassionate, respectful and competent human resource:** Promotion of compassionate, respectful, and competent health care providers at all levels of the health system that provide quality adolescent and youth health services.
- **Adolescent and youth engagement:** The strategy encourages meaningful adolescent and youth engagement at all levels of the health system in planning, implementation, and monitoring of youth programs and to play active decision-making in their health matters.
- **Equity and inclusion:** The strategy focuses on a health system that responds effectively and comprehensive care, to the specific needs of adolescents and youth including gender, disability, and underserved youth population.
- **Affordability:** Health services to adolescents and youth must be affordable and avoid financial barriers to access youth health services. This strategy promotes the achievement of the UHC where all adolescents and youth receive health services without financial constraints.
- **Partnerships:** We value the synergistic action and collaboration with different actors including education, agriculture, youth organizations, social welfare, non-governmental organization, and

Medias to enhance the health and wellbeing of adolescents and youth.

- **Innovations:** The strategy promotes investment for testing and scaling up new technology, products, and models to improve the health of adolescents and youth.

6.2 Vision

- Healthy, productive, and empowered Ethiopian adolescent and youth

6.3 Mission Statement:

- To promote health, wellbeing, and development of adolescents and youth through increased access to equitable and comprehensive youth responsive health system in partnership with young people, community, and stakeholders

6.4 Goal

By 2025, attain full health and well-being of adolescents and youth through ensuring equitable access and utilization of comprehensive health services.

6.5 Strategic Objectives

I. Enhance health literacy among adolescent and youth

II. Improve equitable access to adolescent and youth health services

III. Improve the quality of adolescent and youth health services

IV. Strengthen leadership and accountability

6.6 Strategic Priorities

1. Positive youth health development
2. Adolescent and youth leadership and engagement in health
3. Expanding Adolescent and youth health service package and delivery outlets (Youth centers, education settings, universities, Industrial parks, etc.)
4. Mainstream Continues Quality improvement in all Service delivery settings
5. Enhance Adolescent and youth health competent workforce
6. Strengthen and scale up of financing for adolescent and youth health
7. Strengthen Adolescent and youth health information management
8. Enhance Multi-Sectoral approach, programming, and regulation

6.7 Conceptual Framework of the Strategy

Table 3: Conceptual Framework of the Strategy

<table>
<tr><td colspan="4">Vision: Healthy, Productive and Empowered Ethiopian Adolescent and Youth</td></tr>
<tr><td colspan="4">Goal: By 2025, attain full health and well-being of adolescent and youth through ensuring equitable access and utilization of comprehensive health services.</td></tr>
<tr><td>Enhance health literacy among adolescent and youth</td><td>Improve equitable access to adolescent and youth health services</td><td>Improve quality of adolescent and youth health services</td><td>Strengthen leadership and accountability</td></tr>
<tr><td>SP1: Positive youth health development</td><td rowspan="2">SP3: Expanding Adolescent and youth health service package and delivery outlets (Youth centers, education settings, universities, Industrial parks etc.)</td><td>SP4: Mainstream Continues Quality improvement in all Service delivery settings</td><td>SP6: Strengthen and scale up of financing for adolescent and youth health</td></tr>
<tr><td rowspan="2">SP2: Adolescent and youth leadership and engagement in health</td><td rowspan="2">SP5: Enhance Adolescent and youth health competent workforce</td><td>SP7: Strengthen Adolescent and youth Health information management</td></tr>
<tr><td>SP8: Enhance multi-sectoral approach, programming and Regulation</td></tr>
</table>

As depicted in the framework above, the national AYH strategy entails four interlinked strategic objectives that lead to the achievements of the desired targets and outcomes by 2025 and the realization of the HSTP II goals. Under all the strategic objectives a total of eight priority areas are identified. For each priority area, a list of potential interventions and sub-activities are identified with a timeline of the implementation period. The targets and monitoring frameworks to measure these objectives are listed out separately.

7. Key Interventions Per Each Strategic Priority

7.1 SO1: Enhance Health Literacy among Adolescents and Youth:

7.1.1 Positive Youth Health Development:

It is an approach that engages adolescent and youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's assets, and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership capability. The following are some of the key interventions included under this strategic priority.

- Structural and organizational level interventions: Health facility-based targeted interventions, Health-promoting schools, e-health, m-health, and hotline interventions.
- Promoting life skill education using the 6 Cs at Community and interpersonal level interventions: The 6 Cs are adolescent and youth competence, confidence, connection, character and caring, and contribution) parenting, or caregiver interventions
- Evaluation of SBCC on AYH and redesign for the improved behavioral outcome
- Addressing gender and social inclusion

7.1.2 Adolescent and Youth Leadership and Engagement

It is an inclusive, intentional, and mutually respectful partnership between adolescents and adults, whereby power is shared, respective contributions are valued, and young people's ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, strategies, policies and funding mechanisms that affect their lives, communities and countries, and the wider world. The power of adolescents and youth is one of the most underused resources for achieving global health and

development goals. It requires a shift away from viewing adolescents solely as passive beneficiaries of services, and towards considering them as powerful agents of change. Cognizant of this, the following are the key indicative interventions:

- Create a functional structure for adolescents and youth leadership and engagement in their health.
- Enhancing adolescents and youth capacity in terms of health rights and responsibility
- Support sustainable adolescent and youth involvement

7.2 SO2: Improve Equitable Access to Adolescent and Youth Health Services

Expand adolescent and youth health service packages and delivery outlets (youth centers, education settings, universities, industrial parks, etc.):

As described in the situation analysis, the health needs of adolescents and youth are beyond sexual and reproductive health and HIV. It includes non-communicable diseases comprising nutrition, cardiovascular diseases, diabetes, mental health issues, psychosocial health issues, substance use, and injuries that include various interpersonal like gender-based violence. The AYH service package should address those major health concerns of the adolescent & youth. In addition, growing mega project sites like industrial parks, and out-of-school youth centers require a functional health service provision, which needs to address youth health, especially SRH issues. Those service outlets should have sufficient supply and appropriate stock of health workers, with the competencies and skill mix to match the health needs of the adolescent and youth population. To realize this strategic priority, the key priority actions will be:

- Strengthen service-delivery platforms that maximize coverage (School, youth centers, industrial parks, etc)
- Ensure access and provision of minimal adolescent and youth health services package
- AYH Service for special need groups (including highly vulnerable young people like street children, and orphans)
- Integrate and enhance implementation of existing innovative approaches

7.3 SO3: Improve the Quality of Adolescent and Youth Services

7.3.1 Quality Service Delivery and Service Delivery Platforms that Optimize Coverage:

Poor quality of care still contributes to a significant number of young people deferring from using adolescents and youth health services. Quality does not come automatically; it requires planning and should be an identified priority of universal health coverage, along with access, coverage, and financial protection. Mainstreaming quality into the health systems is fundamental. The key intervention is, therefore:-

- Mainstream continuous Quality improvement in AYH service outlets including health post level

7.3.2 Adolescent and Youth Competent Workforce

Responding to adolescents' uniqueness requires providers to develop competencies (knowledge, skills, and attitudes) in better understanding adolescent and youth development and in adopting a different communication style tailored to an adolescent's and youth's age and stage of development. Providers need to be competent in applying in clinical practice the laws and policies that promote, protect, and fulfill adolescents' rights in health care. The particularities of management of adolescents and youth with specific conditions need to be known to ensure effective care.

- Define core competencies in adolescent health and development in line with global standards for Adolescent Health and Development for Primary Care Providers
- Build adolescent and youth competent workforce

7.4 SO4: Strengthen Leadership and Accountability

7.4.1 Adolescent and Youth Healthcare Financing:

Strengthening the financial sources for adolescent and youth health services will break the financial gap to access the essential adolescent and youth services. It will also ensure the sustainability of the AYH program.

- Strengthen and scale up financing of the AYH program activities.
- Financial risk protection for adolescent and youth health
- Promote the inclusion of adolescent health in the national health account and other existing accounting schemes of MOH.

7.4.2 Adolescent and Youth Health Management Information System & Evidence-Based Decision-Making

Improving data demand, information culture, knowledge management, learning, and capacity to change data into meaningful information and use of it for action will be a priority at all levels with special attention to service delivery points.

- Ensure the inclusion of core AYH indicators into the HMIS reports, and disaggregation of data by age [10-14, 15-19, and 20-24] and sex.
- Strengthen knowledge management, evidence, and learning

7.4.3 Multisectoral approach and programming with other sectors for AYH:

The overall health and wellbeing of adolescents and youth cannot be achieved with the sole responsibility of the health sector. Coordinated, multisectoral programming and response to achieve the desired goals and objectives.- sectoral actions across different areas are vital while keeping adolescents and youth at the

center of an intervention. The following are the key interventions

- Multisectoral approach interventions to AYH service access
- Strengthening school health program with MOE
- Programming with Ministry of Women, and Social Affairs
- Programming AYH with Industrial Park Development Corporation and Development Corridors
- Programming of AYH at TVETS and Higher Educational Institutions (HEI)
- Adolescent and youth health interventions in humanitarian and fragile settings
- Coordination and collaboration on AYH intervention at all levels

8. Implementation Arrangement

The life cycle approach and giving due attention to social determinants that affect adolescent and youth health behavior is the central focus for service delivery. Hence, interventions are designed to build protective factors, defend negative behaviors and promote positive norms. In addition, the existing health care delivery structure addresses the full range of adolescent and youth health and health-related conditions and maximizes access and utilization to strengthen the paradigm shift in adolescent and youth health.

The implementation of this strategy requires the availability of skilled professionals, adequate supplies, commodities, and equipment, proper information management systems, sound governance and management, a sustainable financing mechanism, and appropriate service delivery outlets. Moreover, new service delivery outlets including industrial parks and megaproject sites need infrastructure arrangements. Adolescent and youth health services selected indicators need to be integrated into the planning and reporting system (HMIS) for routine evaluation and monitoring including in the new service provision outlet. As a result, the following specifications for implementation are proposed.

8.1 Service Delivery Modalities

AYH services include a broad list of infectious diseases including HIV/AIDS, SRH health problems, and non-communicable diseases including malnutrition, mental and psychosocial disorders, substance use disorders, injury, and violence including GBV management services. This strategy employs health promotion, disease prevention, and management as key approaches to be delivered through different service delivery outlets. The key implementation modalities recommended for AYH services include family-oriented house-to-house services by HEWs; population-oriented outreach services delivered by health workers through routine/regular, outreach or scheduled program campaigns; and individual-oriented clinical services that address individual specific clinical services. This strategy recommends facility-based AYH services to be provided through either a separate space / or mainstreamed with other existing health services in all service delivery outlets. The separate space approach will be strengthened to be a referral

unit as well as a center for quality assurance hubs to other services that are not available in the clinic/ corner. Services need to be accessible to provide 24/7 service for AY at their convenience: including Saturday clinics and off-school services.

While the primary health care unit will be responsible to provide the major AYH services, this strategy will also emphasize the expansion of AYH services through the health extension program, school health interventions, youth centers, private clinics, workplace clinics, humanitarian and fragile settings, out of school platforms, workplace institutions, hotline/helpline telephone services, and other innovative service platforms. The strategy also promotes the use of electronic media including social platforms and digital health applications beyond the existing mainstream media.

The strategy supports access to and provision of high-quality and affordable adolescent and youth-friendly AYH services at all levels of health service provision.

8.2 Human Resources and Infrastructure

To provide quality adolescent and youth health service package in health facilities, youth centers, industrial parks, and other outlets across the country, fulfilling the required human resources and infrastructure arrangement is a critical step.

Cognizant of the limited competency of health workers on adolescent and youth-friendly health service provision, the strategy recommends building the capacity of health workers in all health facilities to be AYH competent. To ensure health care workers have basic competency in adolescent health, the ministry of health shall engage with the ministry of science and higher education on curriculum review to ensure adolescents' health and development are incorporated for pre-service health students. For the health workers providing services for adolescents, competency gaps must be addressed through on-demand in-service training, continuous professional development, catchment-based clinical mentorships, and other innovative modalities.

The major resistance and stigma for AYH service start at the entry of a health compound and an overall AYH orientation for all health workers is critical.

The health system governance structure: woreda health office, zonal health office, regional health bureau, and national ministry need to establish or strengthen an accountable coordinating structure for the overall implementation and monitoring of the AYH program.

Furthermore, this strategy is recommending the expansion of AYH service through school health, youth centers, industrial parks, and humanitarian and fragile settings. However, some do not have the infrastructure, and others do not have a trained human resource to provide AY-friendly health services. To address this gap, an evidence-based structure that includes staffing patterns and service linkage with the primary health care units for supplies, service packages, mentorship, and data management needs to be developed and implemented among relevant sector ministries, agencies, and line bureau.

The table below summarizes the minimum requirement which will be revised as required based on regular assessments of workload and infrastructure.

8.3 Recommended Requirements for the Provision Of AYFH Services

Table 4: Human resource and infrastructure requirements

Service delivery outlet	Human resource needed	Infrastructure	Remark
Health facilities	• Trained AYH service provider/focal	Examination room that ensures privacy	Health facility staff are provided orientation to avoid barriers
Other Service Outlets (Youth center, Workplace, school health, humanitarian…)	• AYH trained service provider	A clinic with basic equipment	The clinic should be linked with nearby PHCU for logistics, mentorship, and technical support
Woreda/Zone	• AYH focal/	NA	Follows optimum AYH service delivery at PHCU level
National and Regional level	• AYH Coordination Unit	NA	Coordinates implementation of AYH strategy at all levels

8.4 Supplies, Equipment, and Drugs

The ministry of health and its structure will ensure continuous logistics arrangements to these service outlets. For other service outlets outside of the healthcare system, logistics and supply will be linked to the nearby PHCU and they will be managed according to existing national guidelines; whereby the PHCU will incorporate the drugs, supplies, and equipment needs of all the public AYH service outlets in their forecasting plans and fulfill distribution accordingly. The private facilities will access supplies and logistics directly from EPSA as per the private-public mix guideline.

9. Program Budget and Financing

As cost is one of the barriers for adolescent and youth service utilization, the services will be provided at an affordable cost, through service waiver, health insurance, subsidized fee, and other innovative financing schemes. Considering adolescents' financial limitations, the government promotes community health insurance to make sure cost barriers are addressed. All stakeholders including government, private sectors should mobilize resources from the community, private sector, and NGOs which may strengthen the implementation of the AYH program.

The overall cost of implementing the strategy is calculated using Onehealth of tool which provides an estimate of ETB 2,755,539,628.32 (two billion seven hundred fifty-five million five hundred thirty-nine thousand six hundred twenty eight and 32/100 birr only) for the five-year period. These program costs are further grouped into

- Program specific human resource cost: ETB 1,444,320,000
- Infrastructure and equipment: ETB 303,900,000.00
- Training cost: ETB 454,929,448.32
- Supervision cost: ETB 140,400,000.00
- Monitoring and evaluation: ETB 31,050,000.00
- Media and communication: ETB 85,012,500.00
- Advocacy: ETB 74,010,000.00
- General program management: ETB 142,710,000.00 and for other activities an amount of ETB 79,207,680.00

9.1 Costing

Table 5: Costing

Costing						
Program costing summary	2021	2022	2023	2024	2025	TOTAL
Programme-Specific Human Resources	283,680,000	284,400,000	290,160,000	293,040,000	293,040,000.00	1,444,320,000.00
Training	11,700,240	135,734,539	123,291,605	112,377,149	71,825,915.52	454,929,448.32
Supervision	15,600,000	31,200,000	31,200,000	31,200,000	31,200,000.00	140,400,000.00
Monitoring and Evaluation	-	-	1,050,000	6,000,000	24,000,000.00	31,050,000.00
Infrastructure and Equipment	-	60,540,000	60,825,000	91,035,000	91,500,000.00	303,900,000.00
Communication, Media & Outreach	3,841,500	65,901,000	6,138,000	4,566,000	4,566,000.00	85,012,500.00
Advocacy	2,100,000	17,460,000	20,400,000	15,000,000	19,050,000.00	74,010,000.00
General Programme Management	17,400,000	26,700,000	29,760,000	34,350,000	34,500,000.00	142,710,000.00
Other	10,500,000	14,700,000	16,500,000	17,857,680	19,650,000.00	79,207,680.00
Total	**344,821,740**	**636,635,539**	**579,324,605**	**605,425,829**	**589,331,915.52**	**2,755,539,628.32**

10. Monitoring and Evaluation

Monitoring and evaluation of the AYH strategy will rely on various systems and data sources (routine and periodic), supported and maintained by numerous stakeholders. A comprehensive list of key performance indicators from the strategic document will be integrated within routine data collection mechanisms such as DHIS II, the MNCH scorecard, and associated monitoring tools. This strategy learns from the past and the current ongoing particle for better programming. Additionally, the AYH is backed through continuous monitoring, evaluation, research, and outcome harvesting of the changes and paying attention to building capacity to increase participation and adopt both proven and innovative youth systems. The following will be the key areas the strategy will focus in adding to the routine means like monitoring, review meeting, and supervision.

10.1 Health Information Management System

The strategy will follow the existing digital approaches in monitoring and sharing digital data, which is the district health information management system (DHIS). The health facilities and the various services outlets will gather information based on the system developed and the indicators agreed upon. Then all data will be reported to DHIS2. The strategy will be open to using any new innovative solution that can be integrated into the existing health system to enhance the community to health facility level information management. Most importantly, information that will not be captured through HMIS will be tracked through building a national database system integrated from various sources including joint and regular supervision checklist, and performance review meetings, and training databases. Hence, looking for any innovative solutions in this arena will be highly recommended.

10.2 Young People Engagement in Data Demand and Use

Building the capacity of various partners, adolescent, and youth, youth-led and youth-serving organizations including the local government sector offices will involve in collecting, synthesizing, disseminating, and utilizing data for decision making. Moreover, MOH will coordinate utilization and alignment of data from various organizations that work with adolescent and youth health information management systems.

10.3 Performance Measurement Strategy

To assess the progress made across the strategic objectives, AYH monitoring, and evaluation will be participatory. The Major indicators are aligned with the HTSP II and RH Strategy. Age and sex-disaggregated service data will be collected through the DHIS 2 system. Moreover, efforts will be made to ensure AYH-focused evidence is captured through population-based surveys such as DHS, SARA, and PMA 2020, and studies that provide data on services, such as the SPA+ and other AYH specific period surveys. The MOH with its stakeholders will routinely use the evidence generated to track progress, inform programming, and mobilize resources. The strategy will set the tone by conducting a baseline assessment and will evaluate the end of the project to track the key progress of the strategy.

10.4 Learning and Research

Various learning and research platforms such as RAC, TWG, Academia, professional associations, and other structures will play a pivotal role in the production of evidence for policy decisions and programming. Young people and youth-led organizations will be involved in the research agenda identification, research implementation, and learning forums. Invest and implement a knowledge management platform with data analytics capabilities that will complement content generated from traditional data capturing tools. Strengthening the AYH technical working group will organize and take part in different national, regional, and global youth forums, symposia and promote research publications to share lessons learned and best practices.


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ANNEXES

Annex – I: Monitoring and Evaluation Matrix Outcome and Impact Indicators

The impact, outcome targets will be realized by the strong intervention in the ground and targeted the below process, output, and outcome targets during the project lifetime.

Table 6: Impact & outcome targets for the AYH during the implementation period

#	Indicator	Type	Baseline	2021	2022	2023	2024	2025
1	The mortality rate from all causes, age 10-24 (per 1,000 population)	impact (core)	2.71			2.5		2.3
2	Pregnancy-related mortality rate per 1000 women age 15-19	impact (core)	0.39			0.34		0.29
3	Pregnancy-related mortality rate per 1000 women age 20-24	impact (core)	0.64			0.56		0.48
4	Teenage pregnancy rate (%)	impact (core)	12.5			10		7
5	Median age at first sex (Female)	impact (core)	16.4			16.7		17
6	Median age at first marriage (Female)	impact (core)	17.8			17.9		18
7	HIV prevalence among 15-24 (%)	impact (core)	0.34			0.1		0.1
8	Contraceptive Prevalence Rate (CPR) among married adolescent women (15-19) (%)	Outcome	36.5			42.5		44.5
9	Contraceptive Prevalence Rate (CPR) among married young women (20-24) (%)	Outcome	52.5			58.5		64
10	Contraceptive Prevalence Rate (CPR) among unmarried adolescent women (15-19) (%)	Outcome	57.5			63		70
11	Contraceptive Prevalence Rate (CPR) among unmarried young women (20-24) (%)	Outcome	47			52		57
12	unmet need for modern contraceptives among married 15-19 years (%)	Outcome	20.5			15		10
13	unmet need for modern contraceptives among married 20-24 years (%)	outcome	18.5			10		10
14	The proportion of pregnant adolescents (<20) who had 1 antenatal care visit (ANC 1) during the current pregnancy.	outcome	77.3			81		85
15	The proportion of pregnant adolescents (<20) who received antenatal care four or more times (ANC 4+) during the current pregnancy.	outcome	36.4			52.4		68
16	The proportion of pregnant adolescents (<20) who received antenatal care four or more times (ANC 8+) during the current pregnancy.	outcome	1.3			6		10
17	Adolescent (<20) health facility delivery (%)	outcome	53.6			67		81

#	Indicator	Type	Baseline	2021	2022	2023	2024	2025
18	PNC 24 hours stay adolescent age <20 (%)	outcome	30.5			33.5		37
19	Immediate Post Natal Care (≤2 days) coverage among pregnant women age15-24 (%)	Outcome	34.5			75		90
20	Condom use at last higher-risk sex among unmarried/non-cohabiting adolescent male 15-19(%)	Outcome	26			32		40
21	Condom use at last higher-risk sex among unmarried/non-cohabiting adolescent female 15-19 (%)	Outcome	10.2			12		15
22	Condom use at last higher-risk sex among unmarried/non-cohabiting youth male 20-24 (%)	Outcome	19			28		40
23	Condom use at last higher-risk sex among unmarried/non-cohabiting youth female 20-24 (%)	Outcome	5.7			8		10
24	comprehensive knowledge of HIV AIDS among adolescents of 15-24 (%)	Outcome	38			46		55
25	Ever been tested and received the result for HIV female 15-19 years	Outcome	22.4			31		40
26	Ever been tested and received the results for HIV males 15-19 years	Outcome	18.2			25		35
27	Ever been tested and received the results for HIV females 20-24 years	Outcome	48.4			52		55
28	Ever been tested and received the results for HIV males 20-24 years	outcome	43.7			52		55
29	Percentage of women reporting a sexually transmitted infection, genital discharge, or a genital sore or ulcer in the last 12 months among women who ever had sexual intercourse 15-19 (%)	outcome	2.5			2		1.5
30	Percentage of women reporting a sexually transmitted infection, genital discharge, or a genital sore or ulcer in the last 12 months among women who ever had sexual intercourse 20-24 (%)	outcome	3.7			3		2.5
32	Percentage of men reporting a sexually transmitted infection, genital discharge, or a genital sore or ulcer in the 12 months among men who ever had sexual intercourse male 15-19 (%)	outcome	3.6			3		2.5
31	Percentage of men reporting a sexually transmitted infection, genital discharge, or a genital sore or ulcer in the 12 months among men who ever had sexual intercourse (%) 20-24 (%)	outcome	3			2.5		2
32	The proportion of girls 14 years old who have received the second dose of the Human papillomavirus vaccine (%)	Outcome	95%			96		98

#	Indicator	Type	Baseline	2021	2022	2023	2024	2025
33	The proportion of adolescent females who currently smoke cigarettes (15- 19)	Outcome	0.0			0		0
34	The proportion of adolescent males who currently smoke cigarettes (15-29)	Outcome	0.4			0.35		0.3
35	The proportion of adolescent females who currently smoke cigarettes (20-24)	Outcome	1.0			2.50%		2.30%
36	The proportion of adolescent males who currently smoke cigarettes (20-24)	outcome	2.7			0.9		0.8
37	Percentage of adolescent's females 15-19 who had one alcoholic during at least one or more days during the past 30 days	outcome	26.9			23		20
38	Percentage of adolescent's males 15-19 who had one alcoholic during at least one or more days during the past 30 days	outcome	35.5			32.5		30
39	Percentage of female youth 20-24 who had one alcoholic during at least on one or more days during the past 30 days	outcome	30.2			27		25
40	Percentage of male youth 20-24 who had one alcoholic during at least on one or more days during the past 30 days	outcome	43			40		35
41	Percentage of adolescent's females 15-19 who had chewed Khat at least on one or more days during the past 30	outcome	6.6			5		4.5
42	Percentage of adolescent's males 15-19 who had chewed Khat at least on one or more days during the past 30	outcome	12.8			10		8
43	Percentage of female youth 15-24 who had chewed Khat at least on one or more days during the past 30	outcome	8.8			6		5
44	Percentage of male youths 15-24 who had chewed Khat at least on one or more days during the past 30	outcome	20.9			17		15
45	percentage of adolescent females (15-19) involved in Road Traffic Accidents over the past 12 months	outcome	3.4					3
46	percentage of adolescents and youth females (20-24) involved in Road Traffic Accidents over the past 12 months	outcome	2.6					2
47	percentage of adolescent males (15-19) affected in Road Traffic Accidents over the past 12 months	outcome	8.9					6
48	percentage of adolescents and youth males (20-24) involved in Road Traffic Accidents over the past 12 months	outcome	9.4					7
49	% of adolescent females (15-19) who encountered non-traffic accidents	outcome	10.2					7

#	Indicator	Type	Baseline	2021	2022	2023	2024	2025
50	% of adolescent & youth females(20-24) who encountered non-traffic accidents	outcome	9.6					6
51	% Of adolescents & boys (15-19) who encountered non-traffic accidents	outcome	21.2					15
52	% of adolescents & youth boys (20-24) who encountered non-traffic accidents	outcome	26.1			23		20
53	Percentage of adolescents& girls (15-19) who have any form of anemia (%)	outcome	19.9			17		15
54	Percentage of females aged 20-24 who have any form of anemia (%)	outcome	24.2			20		18
55	The proportion of adolescent and youth girls who are underweight-BMI<18.5 (15-19) (%)	outcome	29			25		20
56	The proportion of adolescent and underweight youth boys (15-19) (%)	outcome	59			50		40

ANNEXES

Annex – II: Strategic Priorities, Key Interventions, and Activities

Table 7: Slot Analysis

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
1. Positive youth health development	Structural and organizational level interventions: Health-promoting schools, e-health, m health and hotline interventions.	Skill-based health education including Education for health and wellbeing (EHW)	Ensure or support the implementation of life skill-based education including EHW	Schools	54303	1.37%	30%
			Orientation of schoolteachers on school Health including vision screening	Teachers	543,030	NA	30%
			Support school to sensitize paren students (PTS) associations	Schools	54,303	NA	30%
		E-health and m-health interventions (web-based learning, active video games, text messaging, mobile phone or tablet software programming)	Design web-based and or mobile-based AYH training	eLearning martial	lump sum	N/A	2
			Provide web basedtweb-based AYH training for health care providers at different settings (eLearning)	HW	135,484	N/A	80%
			Design and provide age-appropriate messages to Adolescents and youth by applications	AY	Mobile penetration (AY)	N/A	20%
			Production and dissemination of appropriate media spot messages at least five per year	Spot Messages	100% of AY	N/A	40
			Production and dissemination of appropriate text messages (through mobile SMS)	Text message	22.7mill		60
		Revise HEP package/IRT and integrate AYH information and education	Develop and support the integration of AYH information and education in the IRT for HEWs	Workshop	One		100%
		Capacity building to teachers and families on age appropriate AYH information	Develop /adapt the material on AYH for teachers and parents	Training manual	1		1

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
			Giving training for teachers and families (teachers-parents association) on AYH to increase their awareness	Training/ Orientation	100%	N/A	40%
		Develop AYH core messages and integrate them into 952 and other hotlines	Develop or update a training guide (including core messages) focused on call center counselors on AYH including for married adolescents	Guideline	AYH call centers/ counselors	N/A	1
			Provide training for call center counselors on AYH	Training	Counselors	N/A	300 (100%)
			Develop AYH core messages and integrate them into 952 and other hotlines	Text message	22.7 million		60%
	Promoting the 6 Cs at Community and interpersonal level interventions: The 6 Cs are adolescent and youth competence, confidence, connection, character and caring, and contribution) parenting, or caregiver interventions	Enhance parent to adolescent open discussion on health issues	Develop parental engagement guidelines (AYH, Nutrition, mental health, injury, MHM)	Guideline	Parents, teachers, HEWs, Counselors	N/A	1
		Support the capacity building programs to teachers, parents, CBOs, media corporate, and local youth structures on adolescents and youth health concerns	Training of teachers/parents, youth association members, and HEWs on Parental engagement	Gatekeepers	678,515		81455
			Develop/adapt training material on AYH for CBOs, FBOs, media people, and opinion leaders	Training material	1	0	1
			Training and integrating local structures like CBO/Edirs/ FBOs/, media people, and opinion leaders on AYH for AYH health	Gatekeepers	NA	NA	6000
			Parent skills training, as appropriate, for managing behavioral disorders in adolescents	Gatekeepers	NA	NA	6000
			Training and technical support to local youth structures on AYH	Youth	175870		25%
			Training /orientation / parental awareness of nutritional values to adolescent girls	schools	54303	0	16291

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
			Training of Media professionals on AYH, at the national and regional level	Person	700	0	560
		Include innovative counseling approach for reaching adolescents including married adolescents for contraceptive uptake	Scale up the implementation of Roadmap for Integrating Smart Start in Ethiopia (RISE) program in 465 woredas	HF	250	0	465
			Married adolescents counseled using discussion guide through different service delivery approaches	Married adolescents	10000		500000
		Implement community-mobilization activities to provide adolescent-friendly spaces	Mapping of existing Adolescent and youth structures, including self-help groups at the community level	HPs	17,587	0	100%
			Establish youth coalitions to lead adolescent and youth health movement	number of youths	3,000	0	100%
			Support local youth structures to plan and implement AYH specific interventions	Youth Network	17,587	0	25%
			Support self-help groups on AY to conduct dialogues, community educations, and innovative intervention designs	self-help groups	17,587	0	10%
	Evaluation of SBCC on AYH and redesign for the improved behavioral outcome	Conduct assessments and mapping of health information materials and design SBCC strategies for vulnerable groups	Conduct formative research and mapping of existing health information materials including Poster, leaflet, flyer, billboard, comic book, transit ads -flip card, counseling card, job aid (health professionals) and produce a policy brief	Research	AY, stakeholders	0	3
			Develop/adopt SBCC strategy and materials based on the formative research	Document	AY, stakeholders	0	3
			Contextualize the SBCC strategy and materials for vulnerable youth groups	Document and materials	AY stakeholders		

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
		Engage media on adolescent and youth health to mainstream AYH in media work in building active, informed, and responsible young citizens	Signing a Memorandum of understanding and joint planning on mass media use with media institutions	Media institutions	70	0	15
			Support distribution and airing of media messages	message	700	0	420
		Develop and adopt a pocket Guide that includes self-care and Puberty education	Develop and adopt a pocket health Guide that includes self-care and Puberty education (body literacy)	Document	AY	0	1
			Provide and support individual level AYH counseling at the health facility level, including health posts				
	Addressing gender and social inclusion	Empower girls with age-appropriate life skills to improve health-seeking behavior	Design or update age-appropriate life skill training material for empowering girls including Girls, youth, and social inclusion (GYSI)	document	AY, HWs, Youth facilitators	0	1
			TOT training on GYSI and life skill training	person	678,515	0	15%
			Provide roll out training for HWs, teachers, and RH clubs	person	678,515	0	43134
			Support cascading of GYSI and life skill training	School, HPs	71890	0	20%
		Improve economic opportunities to keep girls in school	Training girls group leaders and cascading financial entrepreneurship	girl groups	17578	0	25%
			Linking girls' group to microfinance	girl groups	17578	0	25%
		Identify specific risks and barriers for girls and engage with boys and men to tackle gender inequality, discrimination, and violence against girls	Conduct barrier assessment on major gender inequality, discrimination, and GBV	Research	NA	0	3
			Prepare policy briefs and advocacy workshops based on evidence	Document	NA	0	3
			Sensitization of the health workers and health managers on gender inequality, discrimination, and violence against girls	Person	10,000	0	2340

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
		Support and strengthen menstrual Hygiene management	Design and develop a national MHM guide, including product standards	Document	NA	0	1
			Organize TOT training on MHM for schools, youth associations, and work sites	Schools, youth associations, worksites	5460	0	273
			Organize basic training on MHM for schools, youth associations, and work sites	Schools, youth associations, worksites	71881	0	64693
			Support schools to roll out of MHM to adolescents and youth as well as on parental engagement	Schools, youth associations, worksites	5460	0	20%
			Advocacy to ensure MHM products are tax exempted, encourage local production, improve wash facilities at school and workplaces	Workshop	NA	0	240
			Sensitization with industrial sectors on local production of MHM products at reasonable price	Workshop	NA	10	120
			Partnering and signing of MOU with industrial sectors on local production at reasonable price	Document	3	0	3
2. Adolescent and youth leadership and engagement	Create a functional structure for AYH leadership and engagement among adolescents and youth.	Establish Youth Advisory Council (YAC) to represent youth groups at all levels (from the Ministry of Health to the facilities)	Support the formation of a nonpartisan youth network: Youth Advisory Council	HC	3764		60%
			Support the development of a youth advisory council guide	Documents	HWs, AYC	0	1
			Provide life skills training to members of youth advisor counsel	person	37640		11292
			Regional level advocacy for the appointment of adolescents and youth from YAC to the board of directors of health care facilities	Workshop	13	0	13
			At the regional level, support the amendment of the health facility board of directors' guidelines to include adolescents and youth.	Advocacy workshop	13	0	13

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
			Youth-led and youth-focused organizations, as well as the Youth Advisory Council, meet with youth councils in all regions regularly.	Meeting	13	0	13
		Ensure the availability of feedback mechanisms for Adolescents and Youth on AYH.	Organize and conduct regular roundtable discussions among existing youth councils and associations	Meetings	2258.4	0	45168
			Establish a virtual/online feedback system	Document (Virtual)	NA	0	2
			Conduct 952 phone interviews regularly.	survey	AY	0	10
		Engage Adolescents in community work, such as health education and service provision	Health-care facilities encourage young people to volunteer in the community, including raising awareness and making service referrals.	HC	3764	0	60%
		Organize annual Adolescents and Youth Health Forum to discuss AYH issues	Organize annual national Adolescents and Youth Health Forum to discuss AYH issues at a national level	Forum	NA	2	5
			Organize annual regional Adolescents and Youth Health Forum to discuss AYH issues at the regional level	Forum	NA	0	60
		Ensure that adolescents and youth are involved in the development of monitoring and evaluation systems as well as accountability procedures.	Support adolescents and youth to participate in periodic (biannual) monitoring and evaluation activities	person	3764	0	45168
	Enhancing adolescents and youth capacity in terms of health rights and responsibility	Increase adolescents and youth legal awareness and literacy about their health rights and legal entitlements.	Provide sensitization on existing laws, procedures, and legal provisions for adolescent and youth	person	3764	0	112920
			Prepare booklets, radio, and television spots for adolescents and youth about existing laws, procedures, and legal provisions.	Spots, messages	700	0	420

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
		Train and mentor youth leaders to help them develop the skills they need to participate effectively in the governance and accountability process.	Adopt and revise the meaningful youth participation (MYP) training manual	Document	AY	1	1
			Training of adolescent and youth leaders on meaningful youth participation	person	37640	0	112920
	Support sustainable adolescent and youth involvement	Conduct and compile a list of adolescents and youth-led or serving organizations and programs in Ethiopia that address issues affecting adolescents and youth.	conduct mapping of existing youth-led organizations, create directories, and make them available including through web-based registration	Document	AY	0	2
			Inventorying and coordination of current youth participation programs, events, and initiatives	document	NA	0	2
		Capacity Building and strengthening of Adolescents and Youth, as well as Youth-Led and youth-focused organizations on Adolescents and Youth Health	Provide Training of adolescent and youth, and youth-led/serving oan organizations on MYP and positive role modeling for AYH	Persons	37640	0	112920
			Develop a national adolescent and youth internship participation guideline.	Document	3764	0	1
			Provide internship opportunities for youth participation within the ministry of health and other like-minded originations	Sensitization	770	0	57750
			Initiate youth-adult partnership where adults can provide a mentorship	document	NA	0	1
			Organize an annual adolescent and youth health development marketplace at the national and regional level where AYPs, YLOs, and YFOs can share their innovative ideas and tools for addressing AYH concerns.	Workshop	13		65

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
3. Expand Adolescent and youth health service packages and delivery outlets (Youth centers, education settings, universities, Industrial parks, etc.)	Strengthen service-delivery platforms that maximize coverage	Improve health-care facilities at all levels to provide integrated, adolescent-centered services (for example, train providers to do HEEDASS assessments).	Assess the quality of YFS service modalities (mainstreamed vs separate spaces)	document	NA	0	1
			Develop a national guide/ service packages/approaches to healthcare services for adolescents and youth in various identified service outlets with due attention to updating with SS approach of counseling.	Document	NA	0	1
			Sensitization and validation of the various AYH friendly services approach	Workshop	770	0	9240
			Promote the opening of new AYH service delivery outlets	delivery points	100	10	75
			Equip newly opened service delivery outlet with medical equipment and supplies	delivery points	100	10	75
			Production of mini-media management training manual	Document	NA	0	1
			Support schools and other clubs that have mini media	school	54303	0	10860
			media equipment and supplies to schools and other clubs				
			Provide student peer educators with short media management training.	person	54303	0	271515
			Sensitization of school community on AYH services	school	54303	0	54303
		Engage health extension workers in providing health education and services to adolescents, particularly those who are out of school	Ensure the integration of AYH into the HEWs package and IRT	Document	NA	0	1
			Training of HEWs on AYH				1
			Map and support Adolescent and youth networks /volunteers at the health post	HP	15758	0	9454.8
			Support adolescent and youth sensitization on referrals for in-service and outreach services.	person	2269152	0	20%

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
	Ensure access and provision of minimal adolescent and youth health services package	Integrate Nutritional program in AYH service delivery points	support the provision of deworming for adolescents and youth in schools	person	19 mill	NA	11,400,000
			support vision screening for adolescents and youth in schools				
			Support the provision of iron folate for adolescents and youth in school	person	9842954	NA	5,905,772
		Prevention, detection, and treatment of communicable diseases, including HIV/STIs SGBV and HTPs	Support AY friendly service infrastructure (renovation)	HC	3764	NA	752
			Provide outpatient service for adolescent and youth	Person	33 mill	NA	16.5mill
		Increase access to Comprehensive Abortion Care (CAC) and post-abortion family planning (FP) services.	Provide SAC service for adolescent and youth	Percent	25,000	43%	75%
			Provide PAC services for adolescent and youth	Percent	25,000	50%	90%
			Provide post-abortion family planning	Percent	25,000	43%	90%
		Increase access to comprehensive contraceptive services	Provide short-acting and long-acting contraceptive services	Percent	250,000	27%	80%
		Injury prevention and management (including road traffic accidents/ RTAs)	Provide emergency treatment, care, and support on personal injuries and RTAs, and GBV management	Percent	NA	50%	100%
		Prevention and treatment of Neglected Tropical Diseases (NTD)	Increase access to NTD prevention and treatment.	Percent	NA	NA	50
		Prevention, detection, treatment, and follow-up of non-communicable diseases	increase access to NCD detection, treatment, and follow-up	Percent	NA	7%	30%
		Improve mental health and Psychosocial health	Support expanding access to mental health prevention, treatment, and psychosocial support for vulnerable groups.	Percent	1.97	3%	15%
			Support the establishment of substance use rehabilitation centers	Regions	NA	3	13

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
		Support the reduction of drug and other substance use among AY	Expand access to counseling services and rehabilitation corners	facilities	NA	45%	80%
		Prevention of and response to harmful practices, such as female genital mutilation and early and forced marriage	Provide Deinfibulation service for FGM	percent	47%	40%	100%
			Support the establishment of a one-stop center	Site	Zones, Regions	10	83
			Training of HWs on the management of GBV survivors	Person	40,000	NA	2075
			Support and strengthen the establishment of the call centers at the regional level	Call center	NA	NA	12
		Pre-pregnancy, pregnancy, birth, and post-natal care as relevant to adolescents	Provide preconception counseling	Percent	62%	0%	50%
			Expand access to Antenatal Care service with special emphasis on teen pregnancy care	Percent	13%	73%	90%
			Provide access to a skilled birth attendant	Percent	13%	55.10%	90%
			Provide access to immediate post-natal family planning services		13	34.2	60%
			Provide access to post-natal care service		13	34.2	80
		Support Voluntary medical male circumcision (VMMC) regions with high HIV prevalence and lower circumcision practice	support voluntary male circumcision in Gambela and other pocket areas	percent	1 million	5%	60%
		Psychosocial support and related services on mental health and wellbeing including highly vulnerable AY	Mainstream mental health at PHCU				
		Routine vaccinations, e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella,	Support the provision of targeted immunization services for AY (including HPV, hepatitis B, TT, DPT…)	percent	8844716	NA	80%
		Support comprehensive and differentiated care and treatment of adolescents and youth living with, or exposed to, HIV	support/facilitate comprehensive and differentiated care and treatment to adolescents and youth living with or exposed to HIV	HCs	4186	NA	30%

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
	AYH Service for special need groups (including highly vulnerable young people)	Establish guidelines and standardize health service delivery packages for vulnerable groups	Develop targeted intervention guidelines to address AYH in industrial parks, IDPs, street AY, disabled, and HIV positive AY	Document	NA	0	1
			Orientation on the implementation of the guideline for Health care providers, managers, partners, and AY	Workshops	NA	0	780
		Ensure health service delivery to address adolescents and youth with special needs and vulnerable groups	Provide training to health service providers to address AY with special needs and vulnerable groups	Percent	NA	0	60%
		Strengthen referral linkages with nearby health facilities;	Prepare Service mapping and referral directory for special needs population	Document	NA	0	1
		SRH Service to married adolescents	Provide counseling to married adolescents	Persons	1 million	NA	90%
4. Quality Service delivery and service delivery platforms that optimize coverage	Mainstream continuous Quality improvement in AYH service outlets	Develop and/or revise national quality standards and monitoring systems (revising the minimum service packages).	Develop or revise national quality standards, indicators, and minimum service packages of AYH including updating on innovative approaches (counseling for married adolescents)	Document	5000	0	100%
		[Revision of the existing quality guidelines, if required) (in conformity with global and national standards for quality health care for adolescents	Develop an AYH certification mechanism for health facilities	Accreditation	3764	0	4,516
		Promote the implementation of AYH quality standards	Health workers and partners training and sensitization on national AYH quality standard	workshop	3764	0	22584
			Establish a recognition scheme (annual workshop) for high-performing healthcare facilities.	workshop	13	0	6500
			Prepare experience sharing twining between health facilities	Event	3764	0	11292
			Provide a means to encourage adolescent and youth engagement in providing feedback to facilities using new techniques such as IT and exit interviews.	document/ software	NA	0	1
			Referral of AY to access AYH services	Percent	NA	0	10%

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
5. Adolescent and youth competent workforce	Define core competencies in adolescent health and development in line with global standards for Adolescent Health and Development for Primary Care Providers	Revise/update in-service training materials on AYH for health workers	Conduct Consultative workshop to revise the in-service training materials, checklists, M&E tools including updating with SS innovative approaches	workshops	NA	0	3
			Print 1000 copy AYH in-service training guide	Copies	NA	0	1000
		Support preparation of integrated or standalone pre-service curriculums or preparation of training materials	Advocacy workshops with higher institutions	Advocacy w/shop	50	0	90%
			Consultative workshops on the development of pre-service training materials.	workshops	NA	0	2
		Update CPD training materials including revision of e-learning modules	Consultative workshop to update CPD training m material on AYH	workshops	NA	0	3
			Testing the e-learning training module and rolling out the digital platform	Training material	NA	0	1
	Build adolescent and youth competent workforce	Build provider capacities in adolescent and youth-centered approaches and the principles of confidentiality, safety, and security, respect, and non-discrimination across all sectors.	Provide master TOTs for all regions that can serve a pool of trainers	# of trainee			1
			cascade AYH training to 80% of health facilities (hospital, health center, and youth centers)	Health facility	100	45	?
		Build provider understanding of sexual violence issues and sensitivity to adolescent-specific gender and RH concerns	master training on GBV for health care providers for regions that can serve trainers pool	Master training			5
			Provide training for all one-stop centers to have at least one health care provider on SGBV	One-stop centers	100		?
		Build the capacity of health care providers to manage and provide AYFHS	Provide training on AYFHS to health care workers and HEWs	news	21,351		
		Ensure that teachers and other education personnel receive periodic, relevant, and structured orientations.	Development of AYH orientation materials for teachers through three consultative workshops.	workshops			3
			50% of primary and secondary school teachers (grade 5-12) will be oriented.	School teachers	100		?

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
		Organize catchment-based AYH mentorship	Conduct a consultative workshop to Include AYH mentorship into the RMNCAYH-N program.	workshops			1
			Integrate 50% of the youth centers to be included in the mentorship program.	Youth centers	100		?
6. Health care Financing	Strengthen and scale up financing of the AYH program activities.	Ensure government for allocation of budget for AYH program and leverage and mobilize resources for AYH programming from partners and donors (both local and international), including privates.	Conduct Advocacy on AYH-specific budget allocation.	workshops	NA	0	5
			Regions allocated budget for AYH implementation per annum	percent	NA	0	12
			Conduct Advocacy on AYH-specific resource mobilization.	workshops	NA	0	5
			Conduct resource mapping and partner alignment at all levels.	document	NA	0	5
			Develop AYH costed plan through the one-health tool	Document	NA	0	1
		Ensuring accountability of HCF management (auditing of revenue and expense, reimbursement, budget allocation and include adolescents in accountability) and utilization at all levels	Develop monitoring and accountability guidelines.	Guideline	NA	0	1
			Monitoring /tracking the proper financial utilization of the AYH program	report	NA	0	1
			costed AYH strategy using one health tool	document	NA	0	1
		Support capacity building on AYH program budgeting for the region, zone, and woreda decision-makers and managers and advocate for budget allocation on AYH program for decision-makers at all levels RHB, ZHD, and who	Conduct Consultative workshops with regions.	workshops	NA	0	5
			build the capacity of Youth/Youth associations on budgeting and financing for AYH programming	training	NA	0	1
			Engage on Woreda based planning and ensure costing of the AYH program in the plan	meeting	NA	0	5
			Participate in regional level AYH planning and budgeting.	Meeting	NA	0	5

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
	Financial risk protection for adolescent and youth health	Design and implement measures for adolescent financial risk protection (e.g. waivers, vouchers, and exemptions or reduced co-payments) and ensure that youth are covered by mandatory, prepaid, and pooled funding	Conduct Consultative workshops with regions.	workshops	NA	0	5
			Conduct consultative workshops on the integration of the AYH program into CBHI	workshops	NA	0	5
			Conduct Consultative workshop on service exemptions with public-private, NGOs health facilities.	workshops	NA	0	5
			conduct monitoring activities to health facilities to ensure implementation of pay exemption guideline	report	NA	0	1
	Promote the inclusion of adolescent health in the national health account and other existing accounting schemes of MOH.	Advocacy the inclusion of adolescent health in the national health account at the national level.	5 Advocacy workshop on specific AYH national health account.	workshops			5
			Monitor facilities to ensure that payment exemption guidelines are met.	visits			5
7. health management information system & evidence-based decision making	Ensure the inclusion of core AYH indicators into the HMIS reports, and disaggregation of data by age [10-14, 15-19, and 20-24] and sex.	Ensure and Strengthen the inclusion of core AYH indicators and their disaggregation by age sex and marginalized segment of the population at the national level into the HMIS reports,	Advocacy workshop on the inclusion of core AYH indicators and their disaggregation by age, sex, and marginalized segment of the population at the national level into the HMIS reports	workshops	NA	0	1
		Ensure that district and national reports address adolescents and youth {10–14, 15-19, 20-24 years}, including cause-specific utilization of services and quality of care.	Follow-up with PPMED integration of age disaggregated {10–14, 15-19, 20-24 years} data in the regular reporting.	workshops	NA	0	10
			Monitoring of the implementation of the monthly reporting tally sheet against age disaggregated {10–14, 15-19, 20-24 years} data for AYH at least at the district level.	Follow up	NA	0	20
		Ensure AYH indicators included in national surveys	Revise the standard AYH performance assessment tools and checklists.	document	NA	0	1

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
			Advocacy workshops for the inclusion of core AYH indicators into the HMIS reports, EDHS, SARA, SPA+, BEmONC, and NHA at the national level.	workshop	NA	0	2
			Ensure the inclusion of core AYH indicators on EDHS, SARA, SPA+, BEmONC, and NHA at the national level	report	NA	0	1
		Implement participatory monitoring approaches to engage adolescents themselves in designing monitoring and evaluation systems, to capture the user perspective (i.e. service quality and policy implementation), and to ensure that mechanisms are in place to hear the voices of young adolescents (10–14 years).	Support Youth associations and build their capacity	Training	NA	0	20
			Include youth association and organization biannually in planning, review meeting and experience sharing events at all levels by engaging adolescent and youth	review meeting	NA	0	10
			Conduct regular review meetings with youth associations and organizations.	review meeting	NA	0	5
			Conduct targeted supervisions and regular follow-ups at all levels.	Supervision	NA	0	5
			Conduct regular review meetings following program-specific supervision.	review meeting	NA	0	5
		Capacity building for health extension workers, HITs, health care providers, and other relevant staff on data collection, data quality, analysis, and use.	Conduct workshop to revise AYH standard performance assessment tools and checklists.	workshops	NA	0	2
			Conduct dissemination workshop on the revised performance assessment tools	workshops	NA	0	1
	Strengthen Knowledge management, evidence, and learning	Establish an AYH database (resource center) and update it regularly. {this an information source for youth health promotion}	Conducting training in collaboration with PPMED and HEP.	Training	NA	0	1
			Conduct mentorship at facilities on data collection, data quality, analysis, and use for health extension workers, HITs, and health care providers.	Mentorship	NA	0	60%
			Advocacy for the establishment of AYH database (resource center)	workshops	NA	0	1
			Development of database	Database	NA	0	1
			Professional Consultant	Consultant	NA	0	2

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
			consultative workshops	workshops	NA	0	3
			Testing the database	Testing database	NA	0	1
			dissemination workshop/event of the database	workshops	NA	0	1
		Establish AYH knowledge management Hub	orientation for the establishment of the AYH knowledge management hub	workshops	NA	0	1
			Development of knowledge management Hub	Knowledge Hub	NA	0	1
			Professional Consultant	consultant	NA	0	2
			SharePoint platform	Platform	NA	0	1
		Strengthen research and learning on the AYH program; develop technical briefs to Incorporate the research findings and recommendations in the annual AYH planning.	Identify top ten research agendas for AYH	research	NA	0	1
			Research at least two per year	research	NA	0	10
			Disseminate learning outputs to stakeholders and other adolescents and youth through available media	workshops	NA	0	1
			Capacity building and monitoring the use of generated local data and research findings in the AYH program at all levels	Dissemination event	NA	0	2
			Conduct technical briefs workshop to Incorporate the research findings and recommendations in the annual AYH planning.	Policy brief	NA	0	4
		Strengthen and scale-up up learning districts/zone and health facilities.	Conduct training on the use of generated local data and research findings on the AYH program at the national and regional levels.	Training	NA	0	10
		Organize regular experience-sharing events on innovative AYH programs.	conduct intensive mentorship at health facilities and documentation	Mentorship	NA	0	10%

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
		Establish and Strengthen the Centre of excellence of the AYH program in all regions.	Follow-up learning sites/districts	Follow-up	NA	0	10%
			Conduct training on AYH for learning f learning sites/districts		NA	0	10%
			Advocacy on provision 24/7 AYH services to learning sites/districts	learning districts	NA	0	10%
		Linkage of local Universities with RHBs and health facilities for evidence generation on AYH program in all regions.	Conduct Follow-up of the implementation of the AYH service at local Universities and health facilities.	Follow-up	NA	0	5
		Ensure leadership commitment for the use of AYH program data in planning, implementation, M& E	Conduct Advocacy workshop of leadership commitment for the use of AYH program data in planning, implementation, M& E.	workshops	NA	0	5
		Establish and revitalize the AYH research advisory council (RAC) at the federal and regional level to develop a comprehensive research plan and support to implement	Establish an AYH research advisory council (RAC) at all regions and city administration.	RAC	NA	0	12
		Conduct assessment on CBA at industrial parks	conduct assessment on CBA at selected industrial parks	Assessment	NA	0	5
		Engagement of Adolescent and Youth on AYH program designing, planning, budgeting, implantation, and M&E at all level	Include youth associations biannually in program designing, planning, budgeting, implementation, and M&E	workshops	NA	50	100%

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
8. Multisectoral approach and programming with other sectors for AYH	Multi sectoral approach intervention to AYH service access	Design multi-sectoral approach for AYH including gender responsiveness and Social Inclusiveness for AYH service in all programming	Design and develop a guide for implementing a multi-sectoral approach for AYH	Document	1	0	1
			Prepare validation workshop on the multi-sectoral guide with partners	Workshop	1	0	1
			Organize high-level GYSI training to decision-makers, managers, and parliamentarians	Person	50	0	50
	Programming with the education sector	Establish programs to improve the nutritional status of adolescent girls	Advocacy workshops of the school community on nutrition	Advocacy w/shop	NA	0	5
			Conduct sensitization workshops in primary and secondary school.	workshops	100		50
			Advocacy workshops on school feeding programs at a higher lev.	workshops	NA	0	5
			Increasing the coverage of WIFAS from 30% to 75%	number of girls	100	30	75
			Development of nutrition screening and counseling in school Material to teachers.	Schools	100	0	100
			Increasing the coverage of deworming in schools	Schools	100	70	100
			Teachers' orientation on nutrition screening and counseling	Teachers	100	0	100
			Nutrition Screening and counseling in primary and secondary school.	Schools	100	0	70
			Development of communication material on nutrition.	Material	NA	0	1
			Provide orientation for schools on deworming programs.	workshops	100	0	100%
			Develop spot message on nutrition for Radio/TV	No of message	NA	0	5
			Disseminate spot message on nutrition by Radio/TV	No of times	NA	0	300

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
		Plan and implement comprehensive education-sector responses to substance use. (Such as panel discussion, dramas, workshops, rallies)	High-level advocacy workshop on substance use	workshops	NA	0	5
			Synthesis of existing literature on substance use	Document	100	0	5
			one workshop on dissemination of evidence on substance use	workshops	100	0	1
			Advocacy on substance use, e (rule and regulation)	workshops	100	0	1
			Campaign against substance use, (rule and regulation)	Campaign	100	0	25
			Orientation for school peer educators on substance use	School	100	0	100
		Implement programs to prevent youth violence, prioritizing promising approaches and strategies used	Strengthen referral linkage between schools and health facilities for substance use victims in 20% of schools.	Schools	100	0	100
		Implement programs to prevent teenage pregnancy,	Development of communication material on substance use/abuse.	Material	1	0	1
			Develop spot message on teenage pregnancy for Radio/TV	No of message	1	0	5
		Implement national drug prevention programs in early and late adolescence	Disseminate spot message on teenage pregnancy by Radio/TV	No of times	NA	0	300
	Programming with Ministry of Women, Children, and Youth	Strengthen the capacity of AYH service providers at Youth Personality Development Centers	Orientation on youth violence for the school community	workshops	NA	0	10
			Conduct 5 advocacy workshops for high officials	workshops	100	0	100
			Provide training for school science teachers on the prevention of teenage pregnancy	Training	100		100
		Provide technical support for the implementation of costed Road map to end child marriage and FGM	Conduct 5 advocacy workshops for high officials	workshops	5	0	5
			Conduct 10 sensitization workshops on AYH service at all levels	workshops	0	0	10
			Provide training for youth centers service providers on AYH	Youth centers	1500	0	50%

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
		Provide technical support in the implementation of minimum AYH service package at the youth centers	Provide capacity building on CHCT, short-acting FP for youth centers	Youth centers	5	0	5
			capacity building for health care providers to ensure quality care services are provided to women and girls who are affected by child marriage and FGM/C	workshop	NA	0	5
		Strengthen the referral linkage between health facilities and Youth Personality Development Centers	Ensure that the services are effectively integrated and applied in the existing health service packages.	Health service package	1	0	1
	Programming AYH with Industrial Park Development Corporation	Strengthen the capacity of AYH service providers at industrial park clinics	Appropriate referrals and protection care are made to the child protection system.	Document	1	0	1
		Provide technical support in the implementation of minimum AYH service package at industrial parks	Integrate with catchment-based AYH mentorship ***guideline***	document	1	0	1
		Strengthen the referral linkage between health facilities and industrial parks	Capacity building for AYH service providers at the industrial park	Training	NA	0	5
		Develop tailored service standard packages for the industrial park clinics	Conduct bi-annual supportive supervision	Supervision	NA	0	10
	Programming of AYH at TVETS and Higher Educational Institutions (HEIs)	Provide IEC/BCC technical support to higher educational institutions including TVETs	Orientation/sensitization to providers at Higher education including TVETs	workshop	NA	0	5
			Cascade sensitization workshop on AYH service.	workshops	NA	0	10
		Provide technical support in the implementation of minimum AYH service package at higher educational Institutions including TVETs	Provide training for service providers on AYH	Training	100%	0	50%
			training on AYH	training	NA	0	5
			Conduct bi-annual supportive supervision.	Supervision	NA	0	10

Strategic priorities	Key interventions	Major activities	Sub Activity	Unit	Population in need	Baseline	Target 2025
			Integrate with catchment-based AYH mentorship	Document	NA	0	1
		Develop tailored service standard packages for clinics of higher educational institutions including TVETS	Conduct advocacy workshops with MOSHE, TVETs, higher educational institutions, and FMOH.	workshops	NA	0	5
	Adolescent and youth health interventions in humanitarian and fragile settings	Build humanitarian workers' and careers' capacities in adolescent and youth-centered approaches and the principles of confidentiality, safety and security, respect, and non-discrimination.	Revising the existing referral linkage.	Document	NA	0	2
			Capacity building for providers on AYH service and referral linkage.	training	NA	0	2
		Ensure that AYSRH service addressed in humanitarian and fragile settings through MISP	Advocacy for humanitarian setting providers	workshop	NA	0	5
			conduct advocacy workshop on AYH/SRH in humanitarian settings	workshop	NA	0	5
			develop an AYSRH toolkit in humanitarian settings	document	NA	0	1
		Strengthen the referral linkage between health facilities and clinics of humanitarian and fragile settings	Develop/revise monitoring tools addressing AYH/SRH service in humanitarian settings	document	NA	0	1
	Coordination and collaboration on AYH intervention at all levels	Strengthen alignment and coordination of implementing partners working on AYH with the public health system program	Establish/strengthen AYH technical working groups at the national, regional, and zonal level	working group	83	0	83
			Support and/or lobby Adolescent and youth focal person assignment at regional, zonal, and district level	Peers	853	0	853
			Strengthen the referral system for AYH services between health facilities and youth centers				


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Annex III – Action Plan

Table 8: Action Plan

Strategic priorities	Key interventions	Major activities	Sub Activity	2021	2022	2023	2024	2025
1. POSITIVE YOUTH HEALTH DEVELOPMENT	Structural and organizational level interventions: Health-promoting schools, e-health, health, and hotline interventions.	Skill-based health education including Education for health and wellbeing (EHW)	Ensure or support the implementation of life skill-based education including EHW	■	■	■	■	■
		E-health and m-health interventions (web-based learning, active video games, text messaging, mobile phone or tablet software programming)	Design web-based and or mobile-based AYH training	■				
			Provide web based AYH training for health care providers at different settings (eLearning)		■			
			Design and provide age-appropriate messages to Adolescents and youth by applications		■	■	■	■
			Production and dissemination of appropriate media spot messages at least five per year		■	■	■	■
			Production and dissemination of appropriate text messages (through mobile SMS)	■	■			
		Revise HEP package/IRT and integrate AYH information and education	Training on AYH for nonhealthy working (including teachers, parent-teachers association, CBOs, Edir, media people, local youth association, etc)			■	■	■
		Capacity building to teachers and families on age appropriate AYH information	Develop /adapt the material on AYH for teachers and parents	■	■			
			TOT and roll out training on life skills to school community and parents through PTS association	■	■			
		Develop AYH core messages and integrate them into 952 and other hotlines	Develop or update a training guide (including core messages) focused on call center counselors on AYH	■	■			
			Develop AYH core messages and integrate them into 952 and other hotlines	■	■			
	Promoting the 6 Cs at Community and interpersonal level interventions: The 6 Cs are adolescent and youth competence, confidence, connection, character and caring, and contribution) parenting, or caregiver interventions	Enhance parent to adolescent open discussion on health issues						

		Establish and strengthen community-support networks and structures for orphans, vulnerable children, and AY	Training /orientation / parental awareness of nutritional values to adolescent girls		■	■	■	
			Training of Media professionals on AYH, at the national and regional level		■	■		
			Establish and strengthen volunteer community support groups for OVCs and AY (sensitization)	■	■	■		
			Train community support networks on AYH to facilitate peer discussions	■	■	■		
			Support community networks to conduct regular peer dialogue on AYH	■	■	■		
		Implement community-mobilization activities to provide adolescent-friendly spaces	Mapping of existing Adolescent and youth structures, including self-help groups at the community level	■	■			
			Establish youth coalitions to lead adolescent and youth health movement	■	■	■		
			Support local youth structures to plan and implement AYH specific interventions	■	■	■	■	
			Support self-help groups on AY to conduct dialogues, community educations, and innovative intervention designs		■	■	■	
	Evaluation of SBCC on AYH and redesign for the improved behavioral outcome	Conduct assessments and mapping of health information materials and design SBCC strategies for vulnerable groups	Develop, adapt and design age-appropriate and gender-responsive SBCC materials (Poster, leaflet, billboard, comic book, counseling card, job aid…) and digitalize the SBCC resources		■	■	■	
		Engage media on adolescent and youth health to mainstream AYH in media work in building active, informed, and responsible young citizens	Develop communication guide on AYH for non-health workers (volunteers, mini media, WDA		■	■		
		Develop and adopt a pocket Guide that includes self-care and Puberty education(providers)	Workshop to develop AYH training material for non-health workers		■			
			Develop pocket guide development for adolescent and youth		■			
			Provide training of self-care implementation for 250 providers		■	■	■	

		Empower girls with age-appropriate life skills to improve health-seeking behavior			x	x	x	
		Improve economic opportunities to keep girls in school	Support training girls group leaders and cascading financial entrepreneurship					
		Identify specific risks and barriers for girls and engage with boys and men to tackle gender inequality, discrimination, and violence against girls	Prepare policy briefs and advocacy workshops based on evidence					
			Sensitization of the health workers and health managers					
	Addressing gender and social inclusion	Support and strengthen menstrual Hygiene management	Support the design and development of national MHM guide, including product standards					
			Organize TOT training on MHM for schools, youth associations, and work sites					
			Organize basic training on MHM for schools, youth associations, and work sites					
			Support schools to roll out of MHM to adolescents and youth as well as on parental engagement					
			Advocacy to ensure MHM products are tax exempted, encourage local production, improve wash facilities at school and workplaces					
			Sensitization with industrial sectors on local production at a reasonable price					
			Partnering and signing of MOU with industrial sectors on local production at reasonable price					
2. ADOLESCENT AND YOUTH LEADERSHIP AND ENGAGEMENT	Create a functional structure for AYH leadership and engagement among adolescents and youth.	Establish Youth Advisory Council (YAC) to represent youth groups at all levels (from the Ministry of Health to the facilities))	Support the formation of a nonpartisan youth network: Youth Advisory Council					
			Support the development of a youth advisory council guide					
			Provide life skills training to members of youth advisor counsel					

		Ensure the availability of feedback mechanisms for Adolescents and Youth on AYH.	Organize and conduct regular roundtable discussions among existing youth councils and associations	■	■	■	■	
			Establish a virtual/online feedback system	■	■			
			Conduct 952 phone interviews regularly.		■	■	■	■
		Engage Adolescents in community work, such as health education and service provision	Health-care facilities encourage young people to volunteer in the community, including raising awareness and making service referrals.	■	■	■	■	
		Organize annual Adolescents and Youth Health Forum to discuss AYH issues	Organize annual national Adolescents and Youth Health Forum to discuss AYH issues at a national level	■	■	■	■	■
		Ensure that adolescents and youth are involved in the development of monitoring and evaluation systems as well as accountability procedures.	Support adolescents and youth to participate in periodic (biannual) monitoring and evaluation activities	■	■	■	■	■
	Enhancing adolescents and youth capacity in terms of health rights and responsibility	Increase adolescents and youth legal awareness and literacy about their health rights and legal entitlements.	Prepare booklets, radio, and television spots for adolescents and youth about existing policies, laws, procedures, and legal provisions.		■	■		
		Train and mentor youth leaders to help them develop the skills they need to participate effectively in the governance and accountability process.	Adopt and revise the meaningful youth participation (MYP) training manual		■	■		
			Training of adolescent and youth leaders on meaningful youth participation		■	■	■	
	Support sustainable adolescent and youth involvement	Conduct and compile a list of adolescents and youth-led or serving organizations and programs in Ethiopia that address issues affecting adolescents and youth.	Make maps of existing youth-led or service-oriented organizations, create directories and make them available including through web-based registration		■	■	■	■
			Inventorying and coordination of current youth participation programs, events, and initiatives	■	■	■	■	■
		Capacity Building and strengthening of Adolescents and Youth, as well as Youth-Led and youth-focused organizations on Adolescents and Youth Health	Provide Training of adolescent and youth, and youth-led/serving an organization on MYP and positive role modeling for AYH	■	■	■	■	■

			Develop and update the national adolescent and youth internship participation guideline.			■		
			Provide internship opportunities for youth participation within the ministry of health and other likeminded originations	■	■	■	■	■
			Initiate youth-adult partnership where adults can provide a mentorship	■	■	■	■	■
			Organize an annual adolescent and youth health development marketplace at the national and regional level where AYPs, YLOs, and YFOsion can share their innovative ideas and tools for addressing AYH concerns.	■	■	■	■	■
3. Expand Adolescent and youth health service packages and delivery outlets (Youth centers, education settings, universities, Industrial parks, etc.)	Strengthen service-delivery platforms that maximize coverage	Improve health-care facilities at all levels to provide integrated, adolescent-centered services (for example, train providers to do HEADSSel assessments).	Develop a national guide, service packages/ innovative approaches for to adolescents and youth and providers	■	■	■	■	■
					■			
			Sensitization and validation of the various AYH friendly services approach		■	■	■	
			Support service delivery outlets for special groups Egg. The industrial park, HEIs, Youth centers	■	■	■	■	■
			Support schools and other clubs that have mini-media	■	■	■	■	■
			Develop guidelines for the tailored intervention of AYH at special settings (industrial parks, IDPs, street adolescent, and youth, HIV positive adolescent and youth	■	■	■	■	■
			Support Sensitization of school community on AYH	■	■	■	■	■

		Engage health extension workers in providing health education and services to adolescents, particularly those who are out of school	Ensure the inclusion of AYH into the HEWs package and IRT						
			Training of HEWs on AYH						
			Map and support Adolescent and youth networks / volunteers at the health post						
			Implant innovative pro that target younger adolescents to increase their health literacy (ACT with Her program)						
			Implement an innovative program that targets married rural adolescent girls to delay their first pregnancy (smart start) or Roadmap to integrate smart start in Ethiopia (RISE)						
	Ensure access and provision of minimal adolescent and youth health services package	Integrate Nutritional program in AYH service delivery points	support the provision of deworming for adolescents and youth in schools						
			Support the provision of iron folate for adolescents and youth in school						
		Prevention, detection, and treatment of communicable diseases, including HIV/STIs SGBV and HTPs	Revise inclusion of AYH specific service into MISP for humanitarian setting / develop AYH toolkit and implement						
			Provide outpatient service for adolescent and youth						
		Increase access to Comprehensive Abortion Care (CAC) and post-abortion family planning (FP) services.	Provide SAC service for adolescent and youth						
			Provide PAC services for adolescent and youth						
			Provide post-abortion family planning						
		Increase access to comprehensive contraceptive services	Provide short-acting contraceptive services						
			Provide long acting and reversible contraceptive services						
		Injury prevention and management (including road traffic accidents/ RTAs)	Provide emergency treatment, care, and support on personal injuries and RTAs, and GBV management						
		Prevention and treatment of Neglected Tropical Diseases (NTD)	Increase access to NTD prevention and treatment.						

		Prevention, detection, treatment, and follow-up of non-communicable diseases	increase access to NCD detection, treatment, and follow-up						
		Improve mental health and Psychosocial health	Support expanding access to mental health prevention, treatment, and psychosocial support for vulnerable groups.						
			Support the establishment of rehabilitation centers						
		Support the reduction of drug and other substance use among AY	Expand access to counseling services and rehabilitation corners						
		Prevention of and response to harmful practices, such as female genital mutilation and early and forced marriage	Provide DE infibulation service for FGM						
			Support the establishment of a one-stop center						
			Training of HWs on the management of GBV survivors						
			Support and strengthen the establishment of one call center at the regional level						
		Pre-pregnancy, pregnancy, birth, and post-natal care as relevant to adolescents	Provide preconception counseling						
			Expand access to Antenatal Care service with special emphasis on teen pregnancy care						
			Provide access to a skilled birth attendant						
			Provide access to immediate post-natal family planning services						
			Provide access to post-natal care service						
		Support Voluntary medical male circumcision (VMMC) regions with high HIV prevalence and lower circumcision practice	support voluntary male circumcision in high prevalent areas						
		Psychosocial support and related services on mental health and wellbeing including highly vulnerable AY	Mainstream mental health at PHCU						
		Routine vaccinations, e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella,	Support the provision of targeted immunization services for AY (including HPV, hepatitis B, DPT…)						
		Support comprehensive and differentiated care and treatment of adolescents and youth living with, or exposed to, HIV	support /facilitate comprehensive and differentiated care and treatment to adolescents and youth living with or exposed to HIV						

	AYH Service for special need groups (including highly vulnerable young people)	Establish guidelines and standardize health service delivery packages for vulnerable groups	Master TOT on SGBV					
		Ensure health service delivery to address adolescents and youth with special needs and vulnerable groups						
		Strengthen referral linkages with nearby health facilities;						
4. Quality Service delivery and service delivery platforms that optimize coverage	Mainstream continuous Quality improvement in AYH service outlets	Develop and/or revise national quality standards and monitoring systems (revising the minimum service packages).	Develop or revise national quality standards, indicators, and minimum service packages of AYH					
		[Revision of the existing quality guidelines, if required) (in conformity with global and national standards for quality health care for adolescents	Develop a standard AYH certification mechanism for health facilities					
		Promote the implementation of AYH quality standards	Health workers and partners training and sensitization on national standards					
			Establish a recognition scheme (annual workshop) for high-performing healthcare facilities.					
			Provide a means to encourage adolescent and youth engagement in providing feedback to facilities using new techniques such as IT and exit interviews.					
			Referral of AY to access AYH services					

5. Adolescent and youth competent workforce	Define core competencies in adolescent health and development in line with global standards for Adolescent Health and Development for Primary Care Providers	Revise/update in-service training materials on AYH for health workers	Conduct Consultative workshop to revise the in-service training material						
			Testing the revised training material						
			Duplicate 1000 copy printing and stationery						
		Support preparation of integrated or standalone pre-service curriculums or preparation of training materials	Advocacy workshops with higher institutions						
			Consultative workshops on the development of pre-service training materials.						
		Update CPD training materials including revision of e-learning modules	Consultative workshop to update CPD training m material on AYH						
			Testing the e-learning training module and rolling out the digital platform						
	Build adolescent and youth competent workforce	Build provider capacities in adolescent and youth-centered approaches and the principles of confidentiality, safety, and security, respect, and non-discrimination across all sectors.	LAFP, training for AYH service providers						
			cascade AYH training to 80% of health facilities (hospital, health center, and youth centers)						
		Build provider understanding of sexual violence issues and sensitivity to adolescent-specific gender and RH concerns	Provide training for all one-stop centers to have at least one health care provider on SGBV						
		Build the capacity of health care providers to manage and provide AYFHS	Provide training on AYFHS to health care workers and HEWs						
		Ensure that teachers and other education personnel receive periodic, relevant, and structured orientations.	Development of AYH orientation materials for teachers through three consultative workshops.						
		Organize catchment-based AYH mentorship	Conduct a consultative workshop to Include AYH mentorship into the RMNCAYH-N program.						

6. Health care Financing	Strengthen and scale up financing of the AYH program activities.	Ensure government for allocation of budget for AYH program and leverage and mobilize resource for AYH programming from partners and donors (both local and international), including privates.	·Conduct 5 Advocacy on AYH-specific budget allocation.		■			
			Regions committed xx amount of the budget for AYH implementation per annum	■	■	■	■	■
			Conduct 5 Advocacy on AYH-specific resource mobilization.					
			Conduct Resource mapping and partner alignment at all levels.		■		■	
			Develop one for AYH cost based on the map resources from the government and partners	■	■			
		Ensuring accountability of HCF management (auditing of revenue and expense, reimbursement, budget allocation and include adolescents in accountability) and utilization at all levels			■	■	■	■
			Mentoring /tracking for proper financial utilization.	■	■	■	■	■
			Develop coasted AYH strategy using one health tool for the next strategic document (2026-2030)					■
		Support capacity building on AYH program budgeting for the region, zone, and woreda decision-makers and managers and advocate for budget allocation on AYH program for decision-makers at all levels RHB, ZHD, and woreda	Conduct 5 Consultative workshops with regions.		■		■	
			build the capacity of Youth/Youth associations in budgeting and finance		■	■	■	
			Engage in Woreda based planning and ensure costing of AYH in the plan			■	■	■
			Participate in regional level AYH planning and budgeting.		■	■	■	■
	Financial risk protection for adolescent and youth health	Design and implement measures for adolescent financial risk protection (e.g., waivers, vouchers, and exemptions or reduced co-payments) and ensure that youth are covered by mandatory, prepaid, and pooled funding	Advocacy meeting on AYH service delivery structural and service availability		■	■	■	■
			Advocacy meeting on sensitization of laws, procedures, service platforms, and financial protection related to AYH					

	Promote the inclusion of adolescent health in the national health account and other existing accounting schemes of MOH.	Advocacy the inclusion of adolescent health in the national health account at the national level.	Conduct performance review meetings annually in the presence of all stakeholders	■	■	■	■	■
			Conduct advocacy workshop on safe school environment in line with substance access, substance abuse, RH issues, and mental health		■	■	■	
7. health management information system & evidence-based decision making	Ensure the inclusion of core AYH indicators into the HMIS reports, and disaggregation of data by age [10-14, 15-19, and 20-24] and sex.	Ensure and strengthen the inclusion of core AYH indicators and their disaggregation by age sex and marginalized segment of the population at the national level into the HMIS reports,	At least one times Advocacy workshop on the inclusion of core AYH indicators and their disaggregation by age, sex, and marginalized segment of the population at the national level into the HMIS reports			■		
		Ensure that district and national reports address adolescents and youth {10–14, 15-19, 20-24 years}, including cause-specific utilization of services and quality of care.	At least 10 Follow-up with PPMED integration of age disaggregated {10–14, 15-19, 20-24 years} data in the regular reporting.	■	■			
			At least 20 Monitoring of the implementation of the monthly reporting tally sheet against age disaggregated {10–14, 15-19, 20-24 years} data for AYH at least at the district level.	■	■	■		
		Ensure AYH indicators included in national surveys	Revise the standard AYH performance assessment tools and checklists.	■	■			
			Conduct at least two Advocacy workshops for the inclusion of core AYH indicators into the HMIS reports, EDHS, SARA, SPA+, BEmONC, and NHA at the national level.	■	■			
			Ensure the inclusion of core AYH indicators on CSA (EDHS), SARA, SPA+, BEmONC, and NHA at the national level		■			
		Implement participatory monitoring approaches to engage adolescents themselves in designing monitoring and evaluation systems, to capture the user perspective (i.e. service quality and policy implementation), and to ensure that mechanisms are in place to hear the voices of young adolescents (10–14 years).	Support Youth associations and build their capacity					
			Include youth association and organization biannually in planning, review meeting and experience sharing events at all levels by engaging adolescent and youth	■	■	■	■	■

		Capacity building for health extension workers, HITs, health care providers, and other relevant staff on data collection, data quality, analysis, and use.	Conduct at least 2 times workshops on revising the AYH standard performance assessment tools and checklists.		■		■	
			Conduct dissemination workshop on the revised performance assessment tools and checklists at all levels.		■		■	
	Strengthen Knowledge management, evidence, and learning	Establish an AYH database (resource center) and update it regularly. {this an information source for youth health promotion}	Conducting at least 5 training in collaboration with PPMED and HEP.		■		■	
			Database development and capacity building on data management		■	■	■	
		Establish AYH knowledge management Hub	Follow-up of the program	■	■	■	■	■
		Strengthen research and learning on the AYH program;	develop technical briefs to Incorporate the research findings and recommendations in the annual AYH planning	■	■	■	■	■
		Strengthen and scale-up up learning districts/ zone and health facilities.			■	■	■	■
		Organize regular experience-sharing events on innovative AYH programs.				■		■
		Establish and Strengthen the Centre of excellence of the AYH program in all regions.			■	■		
		Linkage of local Universities with RHBs and health facilities for evidence generation on AYH program in all regions.		■	■	■	■	■

		Ensure leadership commitment for the use of AYH program data in planning, implementation, M& E						
		Establish and revitalize the AYH research advisory council (RAC) at the federal and regional levels to develop a comprehensive research plan and support to implement.						
		Conduct assessment on CBA at industrial parks						
		Engagement of Adolescent and Youth on AYH program designing, planning, budgeting, implantation, and M&E at all level						
8. multisectoral approach and programming with other sectors for AYH	Multi-sectoral approach intervention to AYH service access	Design multi-sectoral approach for AYH including gender responsiveness and Social Inclusiveness for AYH service in all programming	Develop implementation guide for multi sectoral collaboration on AYH					
	Programming with the education sector	Establish programs to improve the nutritional status of adolescent girls	Increasing the coverage of WIFAS from 30% to 75%					
			Development of nutrition screening and counseling in 30% of school Material to teachers.					
			Increasing the coverage of deworming from 70% to 100% of schools					
			Teachers' orientation on nutrition screening and counseling					
			Screening and counseling of 70% of primary and secondary school.					
			Development of communication material on nutrition.					
			Providers Orientation for 100% of schools on deworming program.					

			Develop spot message on nutrition for Radio/TV					
			Disseminate spot message on nutrition by Radio/TV					
		Plan and implement comprehensive education-sector responses to substance use. (Such as panel discussion, dramas, workshops, rallies)						
		Implement programs to prevent youth violence, prioritizing promising approaches and strategies used						
		Implement programs to prevent teenage pregnancy,	Development of communication material on substance use/abuse.					
			Develop spot message on teenage pregnancy for Radio/TV					
		Implement national drug prevention programs in early and late adolescence	Disseminate spot message on teenage pregnancy by Radio/TV					
	Programming with Ministry of Women, Children, and Youth	Strengthen the capacity of AYH service providers at Youth Personality Development Centers	Orientation on youth violence for the school community					
			Conduct 5 advocacy workshops for high officials					
			Provide training for school science teachers on the prevention of teenage pregnancy					
		Provide technical support for the implementation of costed Road map to end child marriage and FGM	Conduct 5 advocacy workshops for high officials					
			Conduct 10 sensitization workshops on AYH service at all levels					
			Provide training for 50% of youth centers service providers on AYH					
		Provide technical support in the implementation of minimum AYH service package at the youth centers	Provide capacity building on CHCT, short-acting FP for youth centers					
			Coordinate capacity building for health care providers to ensure quality care services are provided to women and girls who are affected by child marriage and FGM/C					

		Strengthen the referral linkage between health facilities and Youth Personality Development Centers	Ensure that the services are effectively integrated and applied in the existing health service packages.		■	■		
	Programming AYH with Industrial Park Development Corporation	Strengthen the capacity of AYH service providers at industrial park clinics	Appropriate referrals and protection care are made to the child protection system.					
		Provide technical support in the implementation of minimum AYH service package at industrial parks	Integrate with catchment-based AYH mentorship ***(under strategic initiative 4 Adolescent and youth competent workforce)***	■	■	■		
			Consensus building workshop for revitalization and expansion of the service.		■			
		Strengthen the referral linkage between health facilities and industrial parks	Capacity building for AYH service providers at all industrial park clinics.		■	■	■	
			Training of 566 Health workers who are working in the youth centers and Industrial parks		■			
		Develop tailored service standard packages for the industrial park clinics	Conduct bi-annual supportive supervision (2 per year)	■	■	■	■	■
			Integrate with catchment-based AYH mentorship ***(under strategic initiative 4 Adolescent and youth competent workforce)***		■		■	
			Consensus building workshop for expansion of the service between the health facility and industrial parks.	■				
	Programming of AYH at TVETS and HEIs	Provide IEC/BCC technical support to higher educational institutions including TVETs	Orientation/sensitization to providers at Higher education including TVETs					
			Conduct 10 sensitization workshops on AYH service at all levels.		■	■	■	■
		Provide technical support in the implementation of minimum AYH service package at higher educational Institutions including TVETs	Provide training for 50% of service providers on AYH					
			Provide capacity building on CHCT, short-acting FP.	■	■	■	■	■
			Conduct bi-annual supportive supervision (2 per year).					
			Integrate with catchment-based AYH mentorship (***under strategic initiative 4 Adolescent and youth competent workforce***)	■				
		Develop tailored service standard packages for clinics of higher educational institutions including TVETS	5 Consensuses workshop among MOSHE, TVETs, higher educational institutions, and FMOH.	■	■	■	■	■

	Adolescent and youth health interventions in humanitarian and fragile settings	Build humanitarian workers' and careers' capacities in adolescent and youth-centered approaches and the principles of confidentiality, safety and security, respect, and non-discrimination.	Revising the existing referral linkage.		■			
			Capacity building for providers on AYH service and referral linkage.		■	■	■	
		Ensure that AYSRH service addressed in humanitarian and fragile settings through MISP	Establish, as appropriate, adolescent- and girl-friendly spaces		■			
			Revise and incorporate AYH issues at humanitarian setting into MISP document.	■	■			
		Strengthen the referral linkage between health facilities and clinics of humanitarian and fragile settings	Develop/revise monitoring tools addressing on AYH service	■	■			
	Coordination and collaboration on AYH intervention at all levels	Strengthen alignment and coordination of implementing partners working on AYH with the public health system program	Establish/strengthen AYH technical working groups at the national, regional, and zonal level					
			Support and/or lobby Adolescent and youth focal person assignment at regional, zonal, and district level	■	■			
			Strengthen the referral system for AYH services between health facilities and youth centers	■	■	■	■	■


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Annex IV:

AYH consultative meeting rating for each health problem per specific conditions

Table 9: AYH consultative meeting rating for each health problem per specific conditions

Health Problems	In school	Out school	Pastoralist	Agrarian	Humanitarian crisis	Industrial Parks	Other (Institutionalized orphan)	SUM in %
10-14 years								
Micronutrient deficiency	93	80	93	93	93			**90**
Communicable disease,	77	83	77	77	77			**78**
GBVs	80	80	67	73	80			**76**
teen pregnancy	60	73	80	80	80			**75**
HIV	80	80	67	67	73			**73**
menstrual hygiene management practice	73	73	73	73	73			**73**
Abortion	67	87	67	67	67			**71**
child Marriage	73	73	67	73	67			**71**
FGM/C	73	73	80	73	53			**70**
injury	73	73	53	60	73			**66**
Underweight	60	73	67	67	60			**65**
NTD	60	53	67	60	60			**60**
STI	60	60	60	60	60			**60**
Mental health problem	40	73	33	40	80			**53**
Substance use (chat)	40	53	40	47	33			**43**
NCDs	40	53	27	27	40			**37**
Bulling	80	0	0	0	0			**16**
Obesity	20	0	0	0	0			**4**
15-19 years								
teen pregnancy	93	80	73	80	80	80		**81**
unsafe abortion	93	80	67	73	67	100		**80**
HIV	73	87	73	72	73	100		**80**
GBVs	80	80	67	73	80	80		**77**
Communicable disease,	63	77	77	77	77	77		**75**
STI	73	80	67	66	60	97		**74**
Micronutrient deficiency	87	80	93	9	63	93		**71**
Menstrual hygiene management practice	73	67	67	73	73	53		**68**
injury	60	73	60	53	73	87		**68**
Mental health problem	67	73	40	47	80	87		**66**
Underweight	47	73	67	67	60	53		**61**
child Marriage	67	73	73	73	67	0		**59**
NTD	47	40	60	53	60	33		**49**
FGM/C	53	60	67	47	53	0		**47**

Substance use (chat)	53	60	47	53	33	27		**46**
NCDs	40	40	27	27	40	40		**36**
Bulling	80	0	0	0	0	0		**13**
Obesity	20	0	0	0	0	0		**3**
20-24 years								
HIV	87	87	80	80	80	100	100	**87.7**
unsafe abortion	100	80	67	80	80	100	93	**85.7**
unintended pregnancy	73	60	80	80	93	100	100	**83.7**
Micronutrient deficiency	73	60	87	80	93	93	93	**82.7**
STI	73	80	73	73	87	93	87	**80.9**
Mental health problem	73	73	53	67	93	87	80	**75.1**
GBVs	73	73	67	73	80	80	80	**75.1**
injury	57	47	60	67	73	87	73	**66.3**
Communicable disease,	50	53	53	67	80	77	77	**65.3**
Substance use (chat)	67	60	53	60	53	27	60	**54.3**
Menstrual hygiene management practice	27	33	53	53	60	53	73	**50.3**
Underweight	33	0	40	53	47	53	60	**40.9**
NCDs	47	40	27	47	40	40	40	**40.1**
NTD	0	27	33	40	60	33	47	**34.3**
teen pregnancy	0	0	0	0	0	0	80	**11.4**
Obesity	20	0	0	0	0	0	0	**2.9**
child Marriage	0	0	0	0	0	0	0	**0.0**
FGM/C	0	0	0	0	0	0	0	**0.0**
Bulling	0	0	0	0	0	0	0	**0.0**

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