

# NATIONAL ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH STRATEGY

2007 - 2015



FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA  
MINISTRY OF HEALTH



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ADOLESCENT AND YOUTH  
REPRODUCTIVE HEALTH STRATEGY**

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## Acknowledgements

The development of the National Adolescent and Youth Reproductive Health Strategy is the product of many consultative meetings organized and led by the Ministry of Health representing a wide cross-section of partners and stakeholders, including Ethiopian parliamentarians. The priority issues are grounded in national and regional demographic data, health systems information, and qualitative and quantitative research findings. The development of the National AYRH Strategy is based on program and research evidence from Ethiopia and international sources.

The Ministry of Health is grateful and acknowledges the support of all those who participated in these consultations. As youth reproductive health issues are cross-cutting, it is the Ministry's wish that close collaboration across line ministries, technical organizations, youth-serving organizations, UN Agencies, donors and other partners will continue to collaborate in support this strategy and its operationalization.

The Ministry of Health would like to acknowledge the extensive long-term technical and financial support of YouthNet/Family Health International, a global USAID-funded program devoted to improving reproductive health among youth. In addition, very high recognition and many thanks goes to UNFPA, UNICEF, the David and Lucile Packard Foundation, Population Council, Pathfinder International, European Commission and all institutions and individuals who collaborated and contributed to the development of the National Adolescent and Youth Reproductive Health Strategy. Special thanks go to the members of the Adolescent and Youth Reproductive Health Development Committee and the peer review group, established to assist in the development of the National AYRH Strategy.

Lastly, the Ministry of Health would like to recognize all the program managers and technical assistants in the Family Health Department, who have spent countless hours in developing and producing this innovative document.



Dr. Tesfanesh Belay CNM, MD, MPH  
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## Preface

The Government of Ethiopia is committed to improving the reproductive health status of young Ethiopians, 10-24 years old. This adolescent and youth reproductive health strategy reaffirms that commitment by setting forth its priorities and agenda for the next decade. This strategy advances the goal of Ethiopia to provide health services to all Ethiopians and to achieve the objectives of the National Reproductive Health Policy and the Health Sector Development Plan. The Government also seeks to enhance the effectiveness of the health system in meeting the PASDEP and the Millennium Development Goals.

The vision of the National AYRH Strategy is:

To enhance reproductive health and well-being among young people in Ethiopia ages 10-24 so that they may be productive and empowered to access and utilize fully quality reproductive health information and services, to make voluntary informed choices over their RH lives, and to participate fully in the development of the country.

The National Adolescent and Youth Reproductive Health Strategy builds on notable initiatives undertaken to serve the health needs of all young Ethiopians. Among these are:

- The Youth Policy, issued in 2004, calls for major interventions to enhance youth participation in the development of the country.
- The Policy on HIV/AIDS, launched in 1998, recognizes the increased vulnerability of young people.
- The Revised Family Laws, amended in 2000, protect young women's rights such as against forced marriages.
- The Revised Penal code penalizes sexual violence and many of the traditional harmful practices.

Youth friendly services and the successful RH strategies can only become realities if there is a commitment from all partners to develop an action plan that is implemented in an accelerated, flexible, and participatory manner. Strengthening youth RH is cross cutting and thus requires a multi-sectoral commitment across line ministries and major stakeholders. The Government's vision is to provide youth reproductive health services through the Health Extension Package at the community level and through other health interventions.

The AYRH development process is the result of many multi-sectoral consultative meetings, under the leadership of MOH, and line ministries, NGOs, UN Agencies, donors, technical organizations, and research institutions. The National AYRH Strategy outlines the major youth RH issues in Ethiopia and charts a way forward.

At this time, it is essential to emphasize that the National AYRH Strategy will require a thorough and detailed implementation plan with concrete activities. Such a plan needs to be developed at federal and regional levels to reflect regional priorities and context. The complementary role of NGOs, partners, and other stakeholders in support of this effort is needed not only at the time of the implementation plan design, but also in the actual execution of activities.

Finally, on behalf of the Federal Ministry of Health I would like to take this opportunity to express my gratitude to all partners for their continued support in this endeavor. I also appeal to all of our partners in health and development to contribute for the successful implementations of this strategy and use this National Adolescent and Youth Reproductive Health Strategy as a guiding tool in your future activities.

A handwritten signature in black ink, appearing to read 'Tedros Adh', with a stylized flourish at the end.

Tedros Adhanom Ghebreyesus (PhD)  
Minister of Health



## Acronyms List

ANC	Antenatal Care
AYRH	Adolescent and Youth Reproductive Health
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communication
CBO	Community-Based Organization
CBRHA	Community-Based Reproductive Health Agents
CHP	Community Health Program
CEDAW	Convention for Elimination of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSA	Central Statistics Authority
CSW	Commercial Sex Worker
DSW	German Foundation for World Population
EDHS	Ethiopia Demographic and Health Survey
EOS	Enhanced Outreach Services
EmOC	Emergency Obstetric Care
EPHA	Ethiopian Public Health Association
ESDP	Essential Services Delivery Program
ESOG	Ethiopian Society of Obstetricians and Gynecologists
FGAE	Family Guidance Association of Ethiopia
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FHD	Family Health Department
FHI	Family Health International
FLE	Family Life Education
FMOH	Federal Ministry of Health
FP	Family Planning
FWCW	Fourth World Conference on Women
HAPCO	HIV/AIDS Prevention and Control Office
HEP	Health Extension program
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Management Information Systems
HSDPIII	Health Sector Development Plan III
HTP	Harmful Traditional Practices
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
ISAPSO	Integrated Services for Aids Prevention Services Organization.
MCH	Maternal and Child Health

MDG	Millennium Development Goal
MOE	Ministry of Education
MOFED	Ministry of Finance and Economic Development
MOJ	Ministry of Justice
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
MORAD	Ministry of Rural and Agricultural Development
MOYS	Ministry of Youth and Sports
MOWAO	Ministry of Women's Affairs Office
NRH	National Reproductive Health
NCTPE	National Committee on Traditional Practice in Ethiopia
NGO	Nongovernmental Organization
OSSA	Organization for Social Services against AIDS
PAC	Post Abortion Care
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
SDPRP	Sustainable Development Poverty Reduction Program
SNNPR	Southern Nations, Nationalities, and Peoples Region
STIs	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WMS	Welfare Monitoring Survey
YRH	Youth Reproductive Health
YSDP	Youth Sector Development Plan

## Executive Summary

This document is the culmination of a vision, formulated over years of consultations with major stakeholders at the national and regional levels in the field of adolescent and youth reproductive health. Led by the Ministry of Health Family Health Department and undertaken in collaboration with key partners, the MOH commits itself to increase access to quality reproductive health services for young people in Ethiopia, ages 10-24 years, and to mobilize resources to implement the National Adolescent and Youth Reproductive Health Strategy.

Guided by the National Adolescent and Youth Reproductive Health Committee, the process of formulating the strategy has been very consultative. A multi-sectoral committee,<sup>1</sup> including members of the Adolescent Reproductive Health Working Group and other members drawn from relevant ministries, youth associations, non-governmental organizations (NGOs), UN Agencies and donor representatives met regularly to review the evidence, identify key priorities, and achieve consensus on the scope of the strategy and the way forward. A smaller peer review team, representing MOH major partners in AYRH, reviewed drafts in conjunction with the larger consultations.

Programmatically, this strategy reflects three overriding priorities. It supports the nation's commitment to achieving the Millennium Development Goals by 2015 and the National Plan for Accelerated and Sustained Development to End Poverty; it calls for a multi-sectoral approach to address the socio-cultural and economic factors that shape reproductive health; and it builds upon the Health Sector Development Plan III ultimate goal to increase health services at the primary level through the new and innovative Health Extension Program. In addition, it reflects the commitment of the National Youth Policy and the Plan of Action from the Ministry of Youth and Sports to create an empowered young generation. The National Adolescent and Youth Reproductive Health Strategy aligns its major goals with the National Reproductive Health Strategy, launched in March 2006.<sup>2</sup>

The strategy is fundamentally grounded in major principles that recognize the rights of all adolescents, including young adolescents to access tailored reproductive health programs; the diversity of young people and thus the need to develop tailored approaches to reach different segments of the youth, including the marginalized and vulnerable groups; and the need to empower youth led institutions to actively participate in the design and implementation of youth serving programs.

The vision of the strategy reflects the Government commitment to increasing access to reproductive health services and social services for young people in order to empower them to participate fully in the development of the country.

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1 Annex A

2 MOH, 2006c

***Vision of the National AYRH Strategy:***

*To enhance reproductive health and well-being among young people in Ethiopia ages 10-24 so that they may be productive and empowered to access and utilize fully reproductive health information and services, make voluntary informed choices over their RH lives, and participate fully in the development of the country.*

The National AYRH Strategy delineates four major goals to lead the efforts of the MOH in the next 10 years:

1. To meet the immediate and long-term RH needs of young people through increased access and quality of reproductive health services for adolescents and young people of Ethiopia.
2. To increase awareness and knowledge about reproductive health issues, which leads to healthy attitudes and practices in support of young peoples' reproductive health.
3. To strengthen multi-sectoral partnerships and create an enabling positive environment at all levels, with line ministries, research institutions, technical organizations, and partners, including communities and young people regarding the reproductive health needs of young adolescents and youth.
4. To design and implement innovative and evidenced based AYRH programs that are segmented and tailored to meet diverse needs of youth by marital status, age, school status, residence, and sex, including younger adolescents and marginalized and most vulnerable young people in the context of Ethiopian priorities and culture.

There is a need to increase access to quality reproductive health services. Currently youth have limited access to quality youth friendly services and are at increased risk of negative reproductive health outcomes. To increase access to such services, the MOH and its partners will develop the capacity of public health services by:

- Training health care providers at all levels, with a focus on Health Extension Workers at the community level
- Mobilizing resources to ensure continuous supplies of commodities for providers to provide the services needed
- Engaging its partners and communities to increase demand and knowledge of services.

Where needed, existing health facilities will be improved to provide youth friendly services.

Though the MOH is committed to provide youth friendly services, it also acknowledges that key partners, NGOs, private sector, and social marketing initiatives will play a partnership role in strengthening youth outreach programs. Tailored outreach programs with strong referrals

to public health facilities will play a major role in reaching adolescents who often are reluctant to access health facilities, such as young adolescents who migrated to urban areas, young adolescent girls in rural areas, or young married girls.

Within a life cycle approach, young people need to know about reproductive health so that they can make informed decisions about their reproductive health and sexuality. Young people and their communities —parents, peers, and community leaders — have limited awareness and knowledge regarding youth reproductive health rights and needs. Social mobilization at community levels is key to increasing knowledge of FP/RH, HIV prevention, and STI transmission. Mobilization also needs to address the negative community norms that increase the vulnerability of youth, especially adolescent girls. Community mobilization is essential to increasing awareness on the negative reproductive health outcomes associated with early marriage, harmful traditional practices, cross-generational gaps in marriage, gender inequities, and sexual violence. Working with men and boys on changing their attitudes is key in addressing negative gender norms that keep young women at increased vulnerability of early marriage, harmful traditional practices, and limited agency over their reproductive lives.

This strategy recognizes that a multi-sectoral approach is needed to address the underlying factors that place young people at increased risks of negative reproductive health outcomes. Keeping boys and girls in school, creating linkages with livelihood programs, addressing the social isolation of marginalized groups, and strengthening the legal framework to protect adolescent rights are all strategies outlined to improve the reproductive health status of youth. The MOH will collaborate with its partners and line ministries to increase linkages between such strategies and the mandate of the MOH.

Sharing of evidence, program successes, and research findings is key to enhancing the development of cost-effective youth programs, avoiding duplication, and addressing the RH needs of the diverse segments of young people. To date, there has been limited information sharing and transfer of research findings and best practices into youth interventions. Continued collaboration and coordination among all partners, including research institutions, will be strengthened.

In order to chart an effective and meaningful course of action, the Ministry of Health will coordinate implementation of the National Adolescent and Youth Reproductive Health Strategy and will assume responsibility for its execution, supervision, and monitoring in collaboration with key stakeholders and the broad membership of the National Reproductive Health Task Force. The next major steps are to develop operational plans at the federal and regional levels, develop guidelines, and begin implementation. This process will make possible meaningful cost estimates that will inform the allocation of resources as delineated in the HSDP III and will also help harmonize the discussion of resource mobilization among all partners.



## Introduction

Adolescents and young people ages 10 to 24 are the largest group ever to be entering adulthood in Ethiopian history. This cohort of 21 million makes up 30% of total population.<sup>3</sup> This strategy calls for immediate tailored and targeted interventions to meet the diverse needs and realities of young people. Ethiopia is at a crucial point, facing a large rapid population growth, 2.6% per annum, which puts tremendous pressure on the country's health service infrastructure. One of the most effective interventions to address the rapid population growth is to empower young people<sup>4</sup> to make informed choices on their reproductive health, including their desired fertility.

Young people are assets. Programs promoting gender equity, adolescent empowerment, and access to education and employment will have a major and long lasting impact on Ethiopian society as a whole. Investing in the health and well being of this large cohort is vital if Ethiopia is to meet the poverty reduction goals as stated in the Plan for Accelerated Sustainable Development for Eradicating Poverty (PASDEP) and the Millennium Development Goals (MDGs) by 2015. Social investments in education and health, with a renewed focus on vulnerable and marginalized groups, will build a strong economic base for the country.

Adolescence is a time of transition from childhood to adulthood where new behaviors are more easily learned than when in adulthood. Thus it is essential to design targeted interventions for three main reasons: to maximize investments Ethiopia has made on child survival interventions; to recognize and address the increased health risks faced by adolescents; and to promote and establish healthy behaviors that can be continued into adulthood.

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<sup>3</sup> MOH, 2002

<sup>4</sup> In this document, "young people" refer to those ages 10-24 as defined by the World Health Organization. The National Youth Policy defines "young people" as ages 15-29 years. Usually, especially in rural areas, young women, above age 24 are already mothers and often more than once (DHS 2005). Thus the National AYRH Strategy focuses on young people 10-24, while acknowledging that adults >24 years also need access to services.

*“What happens between the ages of 10 and 19, whether for good or ill, shapes how girls and boys live out their lives as women and men—not only in the reproductive arena, but in the social and economic realm as well.”<sup>5</sup>*

Addressing the reproductive health needs of young people is complex. Youth cannot be defined as a homogeneous group. They vary by age, sex, education, marital status, and residence. Adolescents’ health is directly affected by the socio-cultural and economic context in which they live. The National Adolescent and Youth Reproductive Health Strategy recognizes the diversity of the Ethiopian adolescents and calls for a wide range of strategies with a focus on integrated social investment (e.g., health, education, and life-skills) to address the heterogeneity of young people.

The Government of Ethiopia has adopted far-reaching policies and strategies to address some of the social, economic, educational, and health problems faced by youth. This National AYRH Strategy is grounded within the National Reproductive Health Strategy 2006-2015. The government is also committed to develop health services to reach all Ethiopians as stated as the major goal of the Health Sector Development Plan III.<sup>6</sup>

One of the strategies to reach this goal has been the institution of the Health Extension Program (HEP) to strengthen the delivery of preventive, promotive, and basic health care in the rural area (HSDP III, 2005) with the health extension workers as the main agents of change for health in the community. These health extension workers will be pivotal in reaching the adolescents and youth at the community level.

The National Adolescent and Youth Reproductive Health Strategy represents a further commitment and a major step forward by the Government to rally resources, to harmonize efforts and interventions, and to integrate programs across sectors: education, economic, health, and agriculture with its major partners to see that the adolescent population in Ethiopia is healthy and thriving.

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5 Mensch B et al. 1998

6 MOH, HSDP III, 2005 Ultimate Goal: “To improve the health status of the Ethiopian peoples through provision of adequate and optimum quality of primitive, preventive, basic curative and rehabilitative health services to all segments of the population.”

## Guiding Principles

### **Recognize the diversity of youth as a target population and therefore segment interventions by age, life stages, and vulnerability status:**

Programs need to recognize that the socio-economic and cultural environment shape adolescent reproductive health. The Ministry of Health and its partners recognize the need to design tailored intervention to youth according to their sex, age, school, marital, socio-economic, migrant and family status. The MOH and its partners also renew their commitment to design programs and policies that give special attention to vulnerable young adolescents ages 10-14 and those at risk of irreversible harm to their reproductive health and rights (e.g., coerced sex, early marriage, poverty-driven exchanges of sex for gifts or money, and violence). Special attention needs to be devoted to young married girls in rural areas and to most vulnerable and orphaned youth who are abused, orphaned, trafficked, physically or mentally impaired, or migrating to urban areas. This strategy commits itself to promote a way forward, recognizing the critical need to develop tailored approaches for young people 10-14 years, 15-19 years, and 20-24 years old.

### **Programs must be based on development-oriented and rights-affirming principles:**

The guiding principles of the National Adolescent and Youth Reproductive Health Strategy are embedded in the International Conference on Population and Development (1994), which highlighted the crucial needs to address adolescents' sexual and reproductive health issues; the Fourth World Conference on Women (1995); the Convention of the Rights of the Child (1989); the National Reproductive Health Strategy, and all relevant policies and strategies of the Ethiopian Government. The strategy is grounded in fundamental human rights and freedoms related to social, economic, cultural, and religious beliefs and practices.

### **Address the needs of youth through a holistic approach:**

The World Health Organization (WHO) and other international groups support a holistic approach to address youth reproductive health. This strategy recognizes that the Ministry of Health alone cannot increase the well being of the adolescent population in Ethiopia. Collaboration with all relevant sector ministries and all major partners from the public, private and non-profit sectors is crucial.

### **The recognition that gender differences are fundamental in framing AYRH:**

This strategy recognizes that gender considerations are fundamental to adolescents and youth because they are important determinants of access to social services and opportunities. This strategy acknowledges that the Ethiopian socio-cultural context of important gender inequities calls for different programs and interventions to reach both male and female adolescents, with a renewed allocation of resources to meet the needs of the adolescent girls, in rural areas, who are at increased risks of sexual violence including harmful traditional practices.



**Look for opportunities to integrate and link reproductive health services with other health and non-health interventions:**

Looking for opportunities to deliver reproductive health services through existing health services is necessary for increasing effective use of resources. Youth need access to an array of services: MCH, counseling, family planning, STI including HIV counseling and testing (VCT), and post abortion care. Hence, seeking out opportunities to link reproductive health services with the existing referral and delivery of health services is key.

**Promote youth involvement, youth leadership, and youth-adult partnerships:**

The strategy recognizes the critical role adolescents and young people can play in improving their own health and development. Adolescents/young people need to be listened to and included as partners in the development of policies and strategies to address their needs. Hence, youth participation will be promoted at all stages of program design, implementation, monitoring, and evaluation.

**Design and plan for scale-up and replication:**

In an environment where all resources need to be maximized, evidence-based and effective interventions are critical in order to reach the young people of Ethiopia. The National AYRH Strategy recognizes that youth interventions need to be designed within the context of sustainability and scaling up. Programs should not be started without a plan for cost-effectiveness and scale-up.

## Section I:

# Context of Youth Reproductive Health



This section outlines key contextual issues that affect youth RH in Ethiopia.

## Population Dynamics

Ethiopia has a very young population; 40% of its 77 million inhabitants are younger than 15 years. Ethiopia faces a very rapid population growth, with an estimated 2.6 million additional people a year.<sup>7</sup> This places serious challenges for poverty reduction and development.<sup>8</sup> Early age at marriage and extremely low use of contraceptives are key behavioral factors contributing to the high fertility in country.<sup>9</sup>

## Poverty

One of the most important factors influencing RH status of Ethiopians is poverty. Today it is estimated that 47 percent of the population lives below the poverty line.<sup>10</sup> Young people are among the groups most affected by poverty as they have very limited access to employment. According to a report by the Ministry of Labor and Social Affairs, 87% of all registered job seekers are between the ages of 15-29.<sup>11</sup> Young people in rural areas are increasingly migrating to urban centers. Migration increases the risks of exploitation and sexual violence such as domestic workers, street vendors, or boys. In addition, there are an estimated 100,000 street children nationwide, with an estimated 40,000 in Addis Ababa.<sup>12</sup>

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7 MOFED. 2005; PASDEP:4

8 MOE. 2006

9 Bongaarts J. 1998

10 MOH.2005a:3; World Bank. 2004

11 CSA. 2004a

12 Moreland S et al. 2001

## Education

Education is an important determinant of the quality of life and is strongly associated with healthy reproductive health outcomes such as seeking out ANC, contraceptive use, and knowledge of HIV/AIDS. Ethiopia has made enormous strides towards meeting the goal of universal education by increasing primary school enrolment three-fold over the past decade. The gross enrolment ratio in primary school reached 79% in 2004-2005.<sup>13</sup> Though studies show remarkable progress, girls still face major disparities regarding access to education. The gender parity index shows that boys in rural areas are twice as likely as girls to attend secondary school. It is estimated that half of girls ages 15-19 are literate compared to 75% of boys in the same age group.<sup>14</sup>

Girls in rural areas are often not enrolled at grade/age appropriate classes. They often are at risks of dropping out once primary school is completed. It is estimated that about three-fourths of the girls attend primary school but only about one quarter attend secondary school.<sup>15</sup> When looking at school drop out rates, more than one quarter of the females above age ten in rural areas are estimated to drop out of school, due to poverty, limited community commitment to girls' education, early marriage practices and the low status of women.<sup>16</sup>

## Status of Adolescent Girls and Young Women

The low status of women in Ethiopia underlies and directly affects the negative RH outcomes addressed in this strategy. Most Ethiopian young married women (15-24) have limited autonomy and control of their resources. Only half of married adolescents, 15-19 can decide how their own earnings will be used. Ten percent of these adolescents have no decision-making power at all on the use of their resources.<sup>17</sup> Harmful traditional practices, abduction, early marriage though declining still persist. The latest Ethiopian Demographic Health Survey (EDHS) 2005 data show that there is little change in women's status: 80% of women and about 50% of men believe that there are at least some situations in which a husband is justified in beating his wife.<sup>18</sup>

**Female Genital Mutilation/Cutting (FGM/FGC)** is widespread in Ethiopia, with more than half of girls ages 15-19 years having been circumcised.<sup>19</sup> Female genital cutting is strongly associated with negative reproductive health outcomes, such as infections, obstructed labor, perineal tears, fistula, and infertility. Though the support for this harmful practice is declining, about one quarter of girls ages 15-24 believe the practice should continue.<sup>20</sup>

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13 MOFED. 2005:77

14 CSA and ORC Macro, 2005

15 Welfare Monitoring Survey, 2004

16 Moreland S et al. 2001

17 CSA and ORC Macro, 2005

18 Ibid

19 Ibid

20 Ibid

**Abduction**, the unlawful kidnapping and forced seizure of a young girl for marriage, is a form of sexual violation. The practice is common in certain parts of Ethiopia, especially in the SNNPR (13%) and Oromia (11%) regions. Young women in rural areas are twice as likely as women in urban area to be abducted. Nationwide, 8% of married women (15-49) have reported being abducted.<sup>21</sup> In SNNPR, abduction has been singled out as the severest health threat to young girls.<sup>22</sup>

**Rape** is a common occurrence among young women in both rural and urban areas. A study of adolescents in six peri-urban areas in Ethiopia reports that 9% of sexually active adolescent girls and 6% of adolescent boys had been raped.<sup>23</sup> Another study on street violence among girls ages 10-24 in Addis Ababa found that 15% of the respondents had been raped, and during their first sexual activity, 43% had been coerced into sex.<sup>24</sup>

**Polygamy** has an impact on the reproductive health of young people. Young women with older co-wives often play a secondary role in the running of the household, have little autonomy and occupy a low status in the gender hierarchy<sup>25</sup> This affects their social life, economic capacity and fertility desire. More importantly, polygamy exposes women to increased risk of contracting sexually transmitted diseases. In many of the regions, including Oromia, SNNP, Somali, Benshangul, and Gambela polygamy is widely practiced 5% of women in their teens and 8 percent of women 20-24 are married to men who have more than one wife.<sup>26</sup>

**Legal and Policy Environment.** The Government of Ethiopia (GOE) has adopted a number of laws and major policies to advance women's status and social and reproductive rights. The GOE is a signatory on major international conventions that promote reproductive health in a broad context of social development. The implementation of these laws and policies, however, are constrained by the limited capacity of stakeholders for implementation.

The Government of Ethiopia has been highly committed to strengthening the legal policy framework to protect the rights of youth. The Ministry of Youth and Sports (MOYS), coordinates and ensures that youth priorities are addressed by all ministries. The MoYS launched the Youth Policy in 2004 to call for priority actions for youth development. Among other priority issues, the Policy emphasizes the need for overall youth participation and the creation of favorable conditions through capacity building efforts in order for the youth to have proper access to information, education, counseling, and other services in the areas of sexual and reproductive health and HIV/AIDS. Based on the Policy, the MoYS has also issued strategic and action plans for youth development.

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21 Ibid

22 WHO. Gender and the Social Context of Reproductive Health

23 OSSA and DSW. 1999

24 Molla M. 2000

25 WHO. Gender and the Social Context of Reproductive Health

26 Govindasamy P et al. 2002

The Policy on HIV/AIDS, adopted in 1998, acknowledges the low status of women and the increased vulnerability of street children, adolescents engaged in transactional sex, and AIDS orphans. One of its objectives is to strengthen youth empowerment to enable them to protect themselves against HIV infection.

The Government also reviewed major laws to protect women's rights and strengthen their role in the economic development of the country. The amended Family Law reiterates that the legal age of marriage is 18, and marriage can only take place with full consent of the marrying partners. The New Criminal Code has criminalized harmful traditional practices and has listed severe penalties for the perpetrators of such practices. The revised code also allows terminating pregnancy under special conditions including, when the pregnancy is as a result of rape, if the pregnancy endangers the life of the mother or the child, or if the pregnant woman is physically or mentally unfit to raise a child. In 2006, the Ministry of Health launched the National Reproductive Health Strategy before the Prime Minister and the Cabinet.

## Section II: Adolescent and Youth Reproductive Health in Ethiopia



Limited access to targeted RH care and services for young people contributes to, and exacerbates, many of the RH problems outlined below. Over a quarter of all pregnant youth and adolescents feel that their pregnancies are mistimed, reflecting this population's limited access to FP and RH services.<sup>27</sup> These unwanted pregnancies entail significant risks for maternal health, including high rates of delivery-related complications and high abortion rates.

### Early Sexual Debut

An estimated 94% of girls initiate sex within marriage in contrast to boys who often initiate sex outside marriage.<sup>28</sup> Early sexual debut and limited use of contraceptive methods have been associated with increased risks of unwanted pregnancy, STI/HIV infection, and maternal health mortality and morbidity. In Ethiopia, trends in sexual initiation have changed little over the last five years. Median age of sexual debut for girls is 16 and for boys is 20.<sup>29</sup> Urban adolescent girls initiate sex two years later than their rural counterparts. Women with at least primary education initiate sexual activity five years later than girls in the same age group with no education.

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27 MOH. 2006c

28 Population Council. 2000

29 CSA and ORC Macro. 2005

## Age at First Marriage

The median age of marriage for women age 25-49 in Ethiopia is 16.1 years, indicating that for most girls, marriage drives sexual debut. While there has been very little change in the age at first marriage over the last five years<sup>30</sup> age at first marriage does vary according to area of residence, education status, and region. Urban women marry more than two years later than rural women. There are also large regional differences: the median age at first marriage is the lowest in the Amhara region with 14.1 years and highest in Addis Ababa with 21.9 years. Men tend to enter marriage later in life, with almost eight years later than women.<sup>31</sup> These large age differences between men and women limit the young girls' autonomy and control of their reproductive life.

Early marriage for girls is the beginning of high frequency of unprotected sexual relations. Early marriage increases the risks of young married girls to HIV infection.<sup>32</sup> In addition, Child brides often experience psychosocial problems and constraints related to their loss of mobility, lack of a supportive environment, and an inability to pursue their education. As a result, almost half of these early marriages end in divorce or separation and the newly single young women often migrate to the urban centers in search of work.<sup>33</sup>

## Early Child Bearing

There are high normative expectations for married young couple to bear a child within the first year of marriage. As seen in Figure 1, motherhood starts early with about one quarter of all girls 18 years old and more than 40% of 19 years old having begun childbearing. The percentage of teenagers who have begun child bearing increases rapidly with age.<sup>34</sup>

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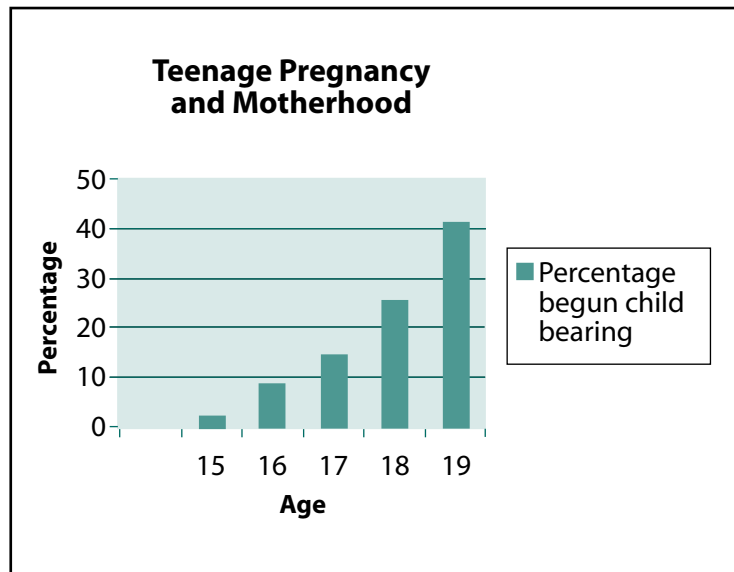
30 Ibid

31 Ibid

32 Clark. 2004

33 Bruce et al. 2006. NCTPE. 2003:145

34 CSA and ORC Macro. 2005

**Figure 1: Teenage Pregnancy and Motherhood<sup>35</sup>**

Source: EDHS 2005

A study reported that adolescents aged 15 or younger had higher odds of anemia and death, and of having a child die within its first week of life compared to young mothers, aged 20-24.<sup>36</sup> Young adolescent mothers are likely to suffer from severe complications during delivery that result in high morbidity and mortality of both the mother and child. Girls, age 15-19 years, are twice as likely to experience obstetric fistula compared to other women of reproductive age.<sup>37</sup>

## Unwanted Pregnancy

Limited knowledge of sexual physiology, early marriage, limited use of contraceptives, limited access to reproductive health information and education, and girls' limited agency over their sex lives all contribute to the high rate of unwanted pregnancy. In addition to the psychological trauma associated with unwanted pregnancy, adolescent pregnancy carries its own obstetric risks.

Unwanted pregnancy is one of the major RH challenges faced by adolescents in Ethiopia. As seen on Figure 2, 54% of pregnancies to girls under age 15 are unwanted (wanted later or not wanted) compared to 37% for those ages 20-24. This indicates the need to refocus programs and prioritize interventions tailored to adolescents under 15 years.<sup>38</sup>

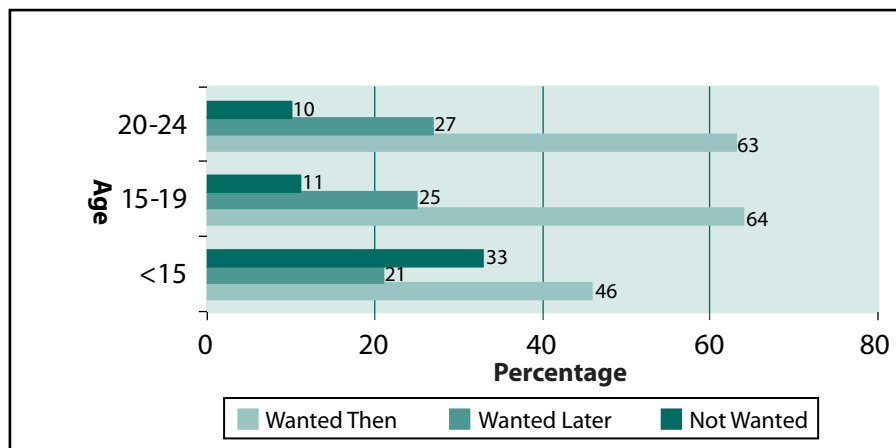
35 EDHS. 2005:56. Percentage of women ages 15-19, who have had a live birth or who are pregnant with their first child.

36 Conde-Agudelo et al. 2005

37 CSA and ORC Macro. 2005

38 CSA and ORC Macro. 2000, 2005; MOH. 2006



**Figure 2: Percentage of Planned Births**

Source: CSA Analysis 2002

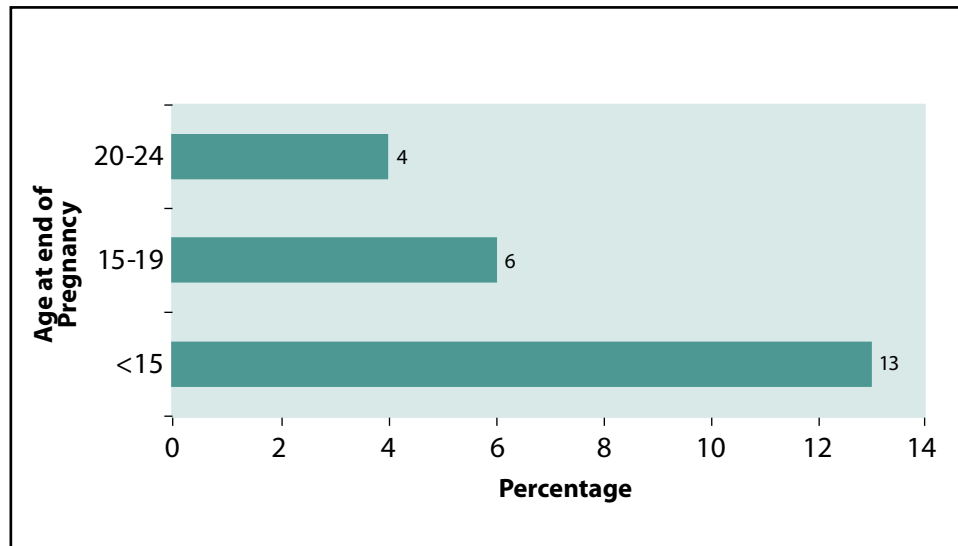
## Abortion

Abortion places many young women at risk as the termination of pregnancy is usually conducted under unsafe conditions. Most abortions are illegal. Though accurate data is difficult to collect, as seen on Figure 3, girls under age 15 are three times more likely to end their pregnancies in abortion compared to those ages 20-24. According to the Ministry of Health, abortion accounts for nearly 60% of gynecological and almost 30% of all obstetric and gynecological admissions.<sup>39</sup>

## Knowledge and Use of Family Planning Methods

Despite reported high knowledge of family planning in both the EDHS 2000 and 2005, married adolescents report very limited use of contraception methods. Fewer than 10% of currently married girls ages 15-19 report using any modern method; 15% of women ages 20-24 reported using any modern method. Half of young *unmarried* women 15-24 reported using some form of modern contraception. Contraceptive use differ significantly across regions, with about 3% of women in the Somali region reporting using modern contraception compared to about 60% in Addis Ababa. Urban women are five times more likely to use contraceptives than rural women. The most popular modern methods of contraception are implants and the contraceptive pills.

<sup>39</sup> MOH. 2006b

**Figure 3: Percentage of Pregnancies Terminated, by Age**

Source: CSA Analysis 2002

Fewer than 1% of currently married adolescents ages 15-19 and 1% of currently married women ages 20-24 reported using a condom as a family planning method. These findings are dramatic both in the context of preventing unwanted pregnancy and also in the context of preventing HIV infection given the scale of the epidemic in Ethiopia.<sup>40</sup>

Unmet need for family planning is the highest for young married adolescents, 15-19 years old, with 30% unmet needs for spacing and 8% for limiting. The unmet needs for 15-19 year-old women are twice as high as the unmet needs for women ages 45-49. Rural women (15-49) have twice as high unmet needs (39%) than women in urban areas (17%). Education is positively associated with contraceptive use. Married women aged 15-19 with secondary or higher education, are five times more likely to use any modern method of contraception than their peers.<sup>41</sup>

## HIV/AIDS and STIs

The HIV problem in Ethiopia has become a “feminine epidemic.” Girls ages 15-19 years are seven times more likely to be HIV positive than boys the same age. Women 20-24 years old are four times more likely to be infected than men the same age.<sup>42</sup> In addition to biological factors, young women are at increased risk of HIV transmission as they have earlier sexual debut than their male peers and marry husbands older than them. There are also large differentials

40 CSA and ORC Macro. 2005

41 Ibid

42 Ibid

between urban and rural women. Urban women are 12 times more likely to be infected than rural women. Unmarried, sexually active women have the highest risk of HIV infection, with a 9% prevalence rate. Programmatically, it is crucial to offer dual protection (condom and hormonal contraception) to unmarried, sexually active women to prevent HIV infection and unwanted pregnancies. Priority areas include urban and sexually active unmarried women and men.

Despite high awareness of HIV/AIDS, about one in four girls ages 15-19 does not believe there is a way to avoid HIV/AIDS. In general, knowledge of condoms and the role they can play in preventing the AIDS virus transmission is limited. Sixty percent of women and 30% of men are unaware that using a condom during sexual intercourse can reduce the risk of contacting HIV/AIDS.<sup>43</sup>

Knowledge of other STIs is much more limited than that of HIV. Only about half of the adolescents ages 15-19 had some knowledge of STIs and their symptoms. An STI is a useful marker for unprotected sex and also as a co-factor for HIV transmission. The 2005 EDHS reports quite low rates of STI prevalence among those ages 15-19 and 20-24.<sup>44</sup> Sexually active girls ages 15-19 are three times (1.4%) more likely to report an STI than sexually active boys in the same age group (0.5%). Thus young girls are at increased risks of contacting STI, as they probably engage in unprotected sex due to the limited control they may have over their sexual lives.

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43 EDHS. 2005

44 These are self reported rates from clients coming to the health facilities and underestimate the STI prevalence.



## Section III: Existing Services and Programs

### Services

Most of the youth RH programs that have been implemented in the last decade serve adolescents enrolled in school and those living in urban or peri-urban centers. Most young people live in rural areas, and only 15% are enrolled in secondary school.<sup>45</sup> Thus many adolescents living in rural areas are not currently being reached by the on-going YRH programs.<sup>46</sup> Even within urban areas, new research suggests that existing coverage is limited, with only 12% of young people sampled in Addis Ababa visiting youth centers and only 20% reached by peer educators.<sup>47</sup>

A national study conducted by MOH identified providers' attitudes and community norms as a major barrier to the provision of youth friendly services. The study reported on the limited provision of AYRH services in four major regions: Oromyia, SNNPR, Tigray and Amahara. The study also noted that respondents preferred seeking services from the private sector or from the community traditional healer than visiting the public sector.<sup>48</sup>

In addition, most programs for young people in Ethiopia, as well as in sub-Saharan Africa generally, tend to deliver generic, age- and gender-blind messages that fail to recognize the distinct needs of girls and boys at different ages, as well as the unique needs of married

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45 PASDEP:19. In rural areas, about 15% of both boys and girls are enrolled in secondary school. The gross enrolment ratio has increased from 7% in 2000 to 15% in 2005. In urban areas, about 65% of boys and girls are enrolled in secondary schools, nearly five times more than the youth in rural areas.

46 MOH. 2006a; Mekbid et al. 2005

47 Erulkar et al. 2006. The study reported that of all adolescents (10-19 yrs) surveyed, 11.9% attended youth centers and 19.6% were reached by peer educators. When disaggregating by gender, boys (20%) were three times more likely to attend youth centers than girls (7.2%), and boys (26%) were much more likely to be reached by peer education programs than girls (15%).

48 MOH. 2006a

adolescent girls.<sup>49</sup> Generally, youth programs tend to view youth as a homogenous group and programs. For example, behavior change communication/IEC materials and youth services have little regard to the different segments of youth.<sup>50</sup>

Very few youth programs deal with life skills, gender dynamics, livelihoods, and the social and economic factors that frame adolescents' decision-making processes.<sup>51</sup> The reports indicated that the more privileged in school youth and a very small proportion of girls 10-14 years (less than 0.5%) living apart from their parents were reached by such programs.<sup>52</sup>

## Family Life and Sexuality Education

Though students at the primary level are introduced to family life topics such as personal hygiene, harmful traditional practices, menstrual hygiene, and environmental hygiene, among others, there is very limited information on reproductive health topics such as physiology, reproduction cycle, and life skills. From grade 7 onwards, Family Life Education (FLE) is integrated in the natural and social sciences with RH issues mainly incorporated in biology. At this time, the Ministry of Education is integrating HIV prevention programs into all subjects but there was no reported link or integration with RH topics.<sup>53</sup>

Other initiatives are being developed by the Government and its partners to reach young people in- and out-of-school and those enrolled in anti-HIV clubs, RH clubs, and girls clubs. However there is limited harmonization and inclusion of best practices in many of these programs.<sup>54</sup> Although many stakeholders – notably, the Ministry of Education, National Office of Population, and NGOs – are promoting the implementation of FLE in-school and out-of-school, no responsible body oversees the proper implementation of the program. In view of the gravity of the current RH problems, and as MOE is the sole responsible body for the RH education and services in the schools, it is very important for it to review the effectiveness the program.

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49 Ibid

50 Giorgis et al. 2001; DSW 2003

51 Bruce et al. 2006

52 Erulkar et al. 2004

53 Conversations with the director of the Institute of Curriculum Development and Research, Addis Ababa

54 Conversations with Pathfinder International, FHI, and FGAE

## Section IV:

# Strategies for the Reproductive Health of Young People



## Vision

To enhance reproductive health and well-being among young people in Ethiopia ages 10-24 so that they may be productive and empowered to fully access and utilize quality reproductive health information and services, to make voluntary informed choices over their RH lives, and to participate fully in the development of the country.

## Goals:

1. To meet the immediate and long-term RH needs of young people through increased access and quality of reproductive health services for adolescents and young people of Ethiopia.
2. To increase awareness and knowledge about reproductive health issues, which lead to healthy attitudes and practices in support of young people's reproductive health.
3. To strengthen multi-sectoral partnerships and create an enabling positive environment at all levels, with line ministries, research institutions, professional organizations, and partners, including communities and young people regarding the reproductive health needs of young adolescents and youth.
4. To design and implement innovative and evidence-based AYRH programs that are segmented and tailored to meet diverse needs of youth by marital status, age, school status, residence, and sex, including younger adolescents and marginalized and most vulnerable young people in the context of Ethiopian priorities and culture.



**Goal 1: To meet the immediate and long-term RH needs of young people through increased access and quality of reproductive health services for adolescents and young people in Ethiopia.**

### Priority Issues:

- The health sector has limited capacity to provide youth friendly services. Inconvenient hours or location, unfriendly staff, and lack of privacy are among the main reasons many adolescents and young adults give for not using RH and HIV services. (MOH, 2005)
- Guidelines need to reflect the current realities of youth and the new legal framework on family laws.
- Teen pregnancy among rural youth is high, half of the pregnancies are unintended, and existing health services do not reach youth adequately.
- Contraceptive use among married adolescents is low, and the unmet needs for contraception are high.
- Rural adolescent girls are vulnerable to unintended pregnancies due to early marriage, abduction, rape, and intergenerational and transactional sex.
- Youth migrating to urban areas are at increased risks of trafficking, sexual violence, and transactional sex.

### Objective 1.1: To improve access to quality reproductive health and STI/HIV services.

#### Strategies:

##### **Build the capacity of health services at all levels to deliver youth friendly services**

*Health care providers* at all levels need pre-service and in-service training on AYRH to increase their understanding of the psychological, social, nutritional, and reproductive health needs of youth to ensure access to quality services. Providers should be non-judgmental, respect privacy, and know how to communicate with youth. Health extension workers also need training on providing AYRH services and should recognize that many adolescents in rural areas are already married. To ensure the quality of training, health training institutions will need to revise their curricula to include AYRH.

*Commodities are needed.* Continuous mobilization of resources for RH services (STI testing and treatment, family planning, and HIV prevention programs) at each level is needed to ensure providers have resources they need. Continuous supplies of HIV testing kits, pregnancy testing kits, and contraceptives (including emergency contraception) need to be available.

*Facilities.* Existing public health facilities and youth serving institutions can be rehabilitated, as a cost effective measure, to offer youth friendly services. These facilities can also offer linked and integrated services such as PMTCT, VCT, FP, nutrition, and immunization with strong referrals to higher level public health facilities. Research has shown that youth prefer many services under one roof.<sup>55</sup>

**Box 1: Example of Tailored Approaches**

***Young adolescent girls (10-14) in rural areas***

Health extension workers should collaborate with youth serving organizations at kebele level, including women’s associations and community-based reproductive health agents and other community leaders, to protect young adolescent girls from early marriage, FGC, and other harmful traditional practices.

***Highly vulnerable groups in urban areas***

In urban areas, marginalized groups of adolescents (e.g., street adolescents and HIV orphans) have very limited access to reproductive health services if they are sexually active. This group is at increased risks of unintended pregnancy and STI/HIV transmission. Health care providers need to be trained to provide non-judgmental services to these highly vulnerable groups.

**Develop and revise national guidelines and standards**

All national documents should be reviewed to ensure that youth RH needs are clearly and adequately addressed, including PMTCT, VCT, ANC, emergency obstetrics, and others. The AYRH guidelines must delineate clearly which RH services will be provided to different sub-groups of adolescents by age and must reflect the New Legal Code. The Family Health Department should establish a task force to harmonize all guidelines.

**Develop outreach programs**

As adolescents are reluctant to access public health facilities, programs need to reach out to young people. Following are several strategies for this program.

55 This strategy calls for modifying the existing health structures, rather than build new ones, to ensure that young people feel welcomed and that their privacy is respected.



## Box 2: Examples of Outreach Programs

Programs	Description
Strengthen linkages between the health system and venues where adolescents congregate	Health care providers can go to where adolescents are, such as schools, non-formal education settings, adolescent clubs such as RH clubs, anti HIV/AIDS clubs, sporting and recreational venues, youth centers, <sup>56</sup> bus stations, market booths, work places, and safe places. <sup>57</sup>
Create linkages between community volunteers and the HEWs	Community volunteers can seek out the adolescents and provide counseling, information, and education. Strengthen linkages between the HEWs and community members.
Review existing models of youth centers to ensure provision of tailored services	Offer tailored services at the youth clubs/centers disaggregated by age and sex. Renew efforts to reach young adolescents <15 years old.
Create mobile clinics or teams in areas where transient youth congregate. Transient is defined as either pastoralists or youth who migrated to urban areas but have no resident status.	Services need to be provided along the migration routes or at contacts where pastoralists rest. Mobile clinics could reach nomads along their migration routes. Mobile clinics, for example in a bus, could reach young people, who migrated to urban areas and who usually have limited access to health facilities. Youth who migrate to urban centers have no access to public health services as they do not have a resident card. Offer RH services through mobile clinics or “health kiosks” with a strong referrals to a nearby health center.
Integrate RH counseling with an Outreach Enhanced Strategy (EOS)	A pilot project in one region could test whether FP/STI counseling could be integrated during one EOS campaign with referrals for services to the nearby health post.
Expand peer promoters responsibilities	Peer promoters who provide information can also provide condoms and refer to youth friendly health facilities.
Institute hot lines	Hotlines are mostly appropriate in urban areas, where adolescents can gather information and counseling.
Increase the role of the private sector for expanding youth services	Pharmacies offer an opportunity for providing reproductive health information and services to youth, especially contraceptives and referrals to services for STIs. <sup>58</sup>
Increase the role of social marketing for expanding youth services	Urban adolescents have reported liking the access of contraceptives through social marketing as it protects their privacy.

56 Youth centers have been built in several regions in urban areas under the auspices of the MOYS and the financing of the World Bank. At this time questions are raised about their effectiveness in reaching their intended audience. Conducting research to identify the barriers that limit access to these youth centers is critical to develop more effective programs. (Conversation with UNICEF, July 2006)

57 Research has shown that highly vulnerable groups that have lost either the protective factor of family or school are at increased risks and vulnerability. (Hallman K et al. 2004) The concept of safe place is a place where adolescents can meet, discuss their aspirations and worries. A constellation of programs might be offered: life-skills, livelihoods, literacy, and reproductive health information. (Bruce J. 2005)

58 YouthLens No. 17. 2005

### **Review ANC, delivery procedures, and post-partum care in health facilities and strengthen training of HEWs to focus on the first time mothers**

As pregnant adolescent girls and young women are at increased risks of morbidity and mortality, it is essential that young pregnant girls attend health facilities during pregnancy. Review procedures to identify the barriers that limit **rural** young women's attendance to health facilities. Review ANC and post-partum services to ensure they offer nutrition and FP services.

### **Enlist participation of boys/men, gatekeepers such as mothers-in-law or other family members**

All programs need to include men and gatekeepers as women have very limited decision making power. Young adolescent boys can be sensitized early on about gender inequities, HTP, and sexual violence. Programs engaging young married men will increase the chances of young women's agency to decide on their reproductive lives.

### **Develop a cadre of health workers at the community level (health center) to provide emergency obstetric care services**

Engage professional organizations such as Ob/Gyn Association, the midwife association, and the Public Health Association to strengthen in-service and pre-service training programs in obstetric care for existing nurses and health extension workers. There are more than 17,000 nurses and more than 30,000 HEWs; this is an opportunity for the country to increase access to basic and emergency obstetric care services at the community level.<sup>59</sup>



**Goal 2: To increase awareness and knowledge about reproductive health issues, which lead to healthy attitudes and practices in support of young people's reproductive health.**

### **Priority issues:**

- Parents, care givers, and community members have limited knowledge to discuss RH with adolescents.
- Despite the reduction in HTP, some communities still need to address these issues.
- Community members are unaware of the negative reproductive health outcomes associated with HTP including early marriage.
- The low status of young girls and women is one of the main factors for perpetuating some of the harmful practices negatively associated with reproductive health outcomes.

<sup>59</sup> In alignment with one of the major goals of the National Reproductive Health Strategy. 2006

- Though there is a high awareness of HIV/AIDS, there is still limited knowledge among youth to protect themselves.
- Young people have limited knowledge of their human rights and legal structures.
- Young people have limited access to sexual and reproductive health information.

## **Objective 2.1: To influence community norms and attitudes to support adolescent reproductive health.**

### **Strategies:**

#### **Community sensitization and dialogue with community members to promote social change**

Identify respected influential community members and engage them in community dialogues on adolescent RH, harmful traditional practices, and gender inequities. Ensure that youth are active participants in these community dialogues as they are essential in identifying the RH issues they face and in promoting ways forward.

#### **Engage parents, family members to enhance family dialogue on reproductive health**

Parents and family members are the obvious mentors for young adolescents. Promote parents'/adolescents reflections on AYRH and the rights and responsibilities of adolescents. Develop programs to increase parents' knowledge on ARH (physiological and psychosocial) and communication skills. Young adolescence (age 10-14) is the time when boys and girls learn behaviors that will become more fixed in the later years; thus it is crucial to engage parents and family members in discussing ARH.

#### **Establish channels of communication between adolescents and adults**

Develop mentorship models for linking young adolescents with adults who provide guidance not only in reproductive health issues but also in life skills and livelihoods.

## **Objective 2.2: To increase knowledge and information about reproductive health to empower youth in making healthy choices.**

### **Strategies:**

#### **Promote targeted messages to reach different segments of the youth population**

Develop targeted RH behavior messages. Develop and promote messages informing adolescents about their bodies (physiology), healthy reproductive life choices, and their rights. Integrate life-skills to empower adolescents to make decisions on their reproductive life. Address gender concerns and inequities and the low status of girls. During adolescence boys begin to establish patterns of sexual behavior based on expected gender roles.

### Box 3: Segmented Approach to Behavior Change Communication

Young Adolescents	Sexually Active Youth
<ul style="list-style-type: none"> <li>• Emphasize delay of sexual debut (abstinence)</li> <li>• Emphasize practical skills: negotiating, problem solving, planning</li> <li>• Engage adolescents in reflecting on the role of girls/boys and gender inequities</li> <li>• Engage adolescents in assessing their own future risks and planning for making healthy reproductive health choices</li> <li>• Build social support (peers, family, and community)</li> </ul> <p><i>“Messages encouraging abstinence appear to work best when aimed at younger youth who are not yet sexually active, especially girls.” (Global Health Technical Brief)</i></p>	<ul style="list-style-type: none"> <li>• Emphasize messages to reduce HIV and pregnancy risks: be faithful and consistent condom use</li> <li>• Strengthen messages about the positive attributes of condoms</li> <li>• Concentrate on building confidence in youth on obtaining condoms and negotiating consistent condom use for both boys and girls</li> <li>• Integrate life skills to empower both boys and girls to make informed decisions on their reproductive lives</li> <li>• Build social networks (e.g., young married girls, domestic female workers, young street boys, and youth in school)</li> </ul>

#### Harmonize and strengthen peer promoters and educators programs

Review and harmonize the training guidelines for all peer promoters by setting up a task force that regroups all the NGOs engaged in peer promotion. Align the peer promoter training programs with best practices. In addition to the existing peer promoters programs that reach mostly adolescents in school in urban areas, promote the development of peer promoters programs to reach the most marginalized and vulnerable groups such as youth that migrated to urban areas, commercial sex workers, and HIV orphans.

#### Integrate SRH within the formal and non formal education sectors

Create a task force that regroups the Ministry of Education, Ministry of Youth and Sports, and other NGOs to develop reproductive health curriculum based on best practices to be taught at grade appropriate levels in the formal and nonformal education sector.

#### Strengthen the role of media and edu-tainment for youth

Promotion of healthy RH behavior needs to take place through multi-media channels such as community leaders, policy makers, mentors, peer educators, parents, teachers, HEWs, CBRHAs, and media including traditional folklores. Engage youth serving institutions and young people at all levels to develop appropriate IEC materials as young people know best how to communicate with each other.



**Goal 3: To strengthen multi-sectoral partnerships and create an enabling positive environment at all levels, with line ministries, research institutions, professional organizations, and partners, including communities and young people regarding the reproductive health needs of young adolescents and youth.**

### Priority Issues:

- There is limited implementation of the new legal framework that protects and enhances the role of youth and young women in society.
- Unemployment and poverty in the rural areas are driving youth urban migration. Youth migrating to urban areas are at increased risks of sexual violence and have no recourse to reenter the formal education system.
- Gender inequities across all sectors limit young girls and young women's empowerment.
- Despite the increased numbers of youth associations, the active participation of youth in designing policies, programs, and interventions in the field of RH is limited.
- There is limited harmonization among all FMOH partners in designing and implementing AYRH interventions.

### **Objective 3.1: Increase the knowledge and awareness and change the attitudes of policy makers on sexual reproductive health issues of adolescents:**

#### Strategies:

##### **Continue advocacy and social mobilization for improving community and political support towards AYRH issues**

Increase policy makers' knowledge regarding AYRH. Develop positive and supportive attitudes about AYRH as political commitment is essential to develop effective adolescent RH programs. At all levels, develop programs to inform policy makers, law enforcers, women's, and youth serving organizations regarding RH rights for youth and the role of policy makers' in engaging their constituencies to ensure that the laws are disseminated and respected.

## **Objective 3.2: Decrease risks and vulnerability of adolescents and empower them to make healthy transitions to adulthood**

Decreasing risks and vulnerability of adolescents require a multi-prong approach from all sectors. However, the MOH and its health partners can also play a major role in decreasing adolescent vulnerability.

### **Strategies:**

#### **Provide information and skills to strengthen what young women can do to protect themselves from HIV infection and unwanted pregnancy**

Give clear tailored messages:

- Delay sexual debut if not sexually active (abstinence)
- Use dual protection (consistent condom and hormonal contraception)
- Reduce numbers of partners (faithfulness)
- Counsel young women about their rights over their sexual lives
- Engage adolescents in evaluating their own risks perceptions and address the misconceptions
- Encourage social support for engaged couples to jointly seek premarital counseling and HIV testing. For example, provide counseling and VCT services to young married couples so that young married girls know their HIV status and their husband's status.

#### **Strengthen linkages to referral facilities that provide services for abused youth**

Health extension workers in the rural communities and health care providers in health facilities need to provide counseling and referrals to health facilities where women can receive medical and psychological services when abused – counseling, prophylactic treatment against HIV, emergency contraception, treatment of other ailments, and referral to legal system or groups that protect women's rights.

#### **Multi-sectoral strategies**

The following strategies are examples of cross-cutting areas that require a multi-sectoral approach and require the commitment of all actors: line ministries, religious groups, training institutions, and civil society.

**Box 4: Cross Cutting Strategies**

<b>Strategy</b>	<b>Lead Ministry</b>	<b>Remarks</b>
Promote girls' education	MOE, MOYS	Education level is strongly associated with positive RH outcomes such as delaying marriage, delaying pregnancy, and use of contraceptives.
Develop livelihoods programs for youth (urban youth included) with linkages to RH services.	MOYS, MOLSA	Livelihoods opportunities strengthen adolescents and young people's economic and social capacities and help them gain some autonomy and control over their lives, including their RH lives.
Develop social networks	MOYS, religious institutions, NGOs, MOWA, MOE	Social isolation and poverty have been associated with increased risks of sexual violence. <sup>60</sup> Design programs to reduce social isolation of marginalized and vulnerable groups so that youth can meet and discuss their issues, aspirations. Link such social networks to mentorship programs and referrals to health facilities.
Create safe places	MOYS, MOLSA, NGOs	Create places where youth can meet safely and places where tailored services for the different segments of the highly vulnerable groups are offered.
Promote youth participation	MOYS, NGOs	Promote youth participation in identifying priority issues and in designing and implementing YRH interventions. Strengthen youth leadership programs for young people to be actively engaged in YRH programs.

60 In a study of female adolescents 10-24 years old girls living on the streets of Addis, girls living alone were ten times more at risk to experience sexual violence. (Molla M. 2000)

### Objective 3.3: Increase coordination and collaboration among all partners

**Collaboration, partnership, coordination among line ministries, research and training institutions, technical organizations, implementing partners, professional organizations, CBOs, religious organizations, and donors**

Within the Ministry of health at the federal, regional, and woreda levels assign a AYRH focal person to lead and coordinate AYRH interventions. This focal person will liaise closely with the Ministry of Youth and Sports and the Ministry of Women's Affairs to ensure that youth RH rights are respected at all levels including the community.

Revitalize the Adolescent Reproductive Health Working Group at federal level to ensure harmonization and collaboration among all ministries and partners. Ensure that youth representatives are members of this working group.

Create task forces that include line ministries and partners to work on the priorities identified in the strategy: Redesign existing health care facilities; Strengthen tailored outreach programs; Develop National AYRH guidelines; Develop training and training plan for health care providers on AYRH; Develop AYRH curriculum for the formal and non formal education sectors.



**Goal 4: To design and implement innovative and evidence-based AYRH programs that are segmented and tailored to meet diverse needs of youth by marital status, age, school status, residence, and sex including younger adolescents and marginalized and most vulnerable young people in the context of Ethiopian priorities and culture.**

#### Priority issues:

- There is limited information on the reasons that continue to drive the cultural norms that are associated with negative reproductive health outcomes, such as early marriage, rape, coerced sex, and other forms of sexual violence.



- There is limited research on the most vulnerable and at risk groups of adolescents: young married girls, adolescents who migrated to urban centers, and young unemployed boys.
- Data collection from existing youth interventions is often not disaggregated by age (10-14, 15-19, 20-24), socio-economic status, living arrangement, migration, education, and marital status.
- There is very limited sharing and dissemination of research findings from international and national reproductive health partners.

## **Objective 4.1: Conduct program research and evaluation to design, implement, and monitor effective programs addressing the diversity of the young people in Ethiopia.**

### **Strategies**

#### **Dissemination and utilization of tools, materials, and best practices**

There is a wealth of existing tools, materials, and evidence regarding best practice in youth RH. Sessions to share evidence-based studies need to be held so that the research findings can be transferred into programs.

#### **Sharing of information among youth-serving organizations**

Sharing information and lessons learned among youth-serving organizations is needed to develop skills and organizational capacity to become actively and constructively engaged in designing youth programs.

#### **Conduct socio-anthropological research**

Strengthen the evidence base and data collection methods to increase understanding of the sociocultural factors related to barriers and opportunities for adolescents to access RH services. Identify factors that perpetuate HTP, early marriage, and low status of girls. Ensure that research findings are well disseminated and that an ARH library is set up at different levels within Ethiopia's research institutions.

#### **Collect disaggregated data for all youth programs**

Clearly identify the different segments of youth targeted by youth interventions and collect disaggregated data to monitor program effectiveness. Redesign registers in youth friendly public health services to identify clearly who is being met by such services. Review HEWs and CBRHA data collection tools to ensure that a youth component is part of community outreach programs in rural areas.

## Section V: Monitoring and Evaluation



The Government of Ethiopia considers monitoring and evaluation (M&E) crucial for planning, monitoring and measuring results. AYRH indicators and data disaggregated by age, sex, school, marital, residence, education, and living arrangement need to be instituted and integrated throughout the national data systems. (See Annex D for a list of illustrative indicators.)

The AYRH M&E Framework will be further developed in the operational plan and will use national and regional data sources for setting targets and planning. Formative assessment and program research will be used to guide and inform program interventions.

The targets and key indicators will need to be integrated with the HSDP III, PASDEP and other national goals stated in the development agenda. The data collection and recording at the health facilities need to be harmonized with the on-going HMIS and health related indicators. There is currently limited capacity of the existing national data management systems and careful work to ensure a feed back mechanism links back into the monitoring and evaluation of existing interventions.

One of the most important steps to be taken by the MOH will be periodic assessments of strategy implementation. This will further identify strengths, weaknesses, and if necessary, the need for adjustments. It will also chart process and successful results. Furthermore, steps will be taken to establish a system of AYRH indicators incorporated into the national HMIS and DHS to ensure effective monitoring of RH services.



## Section VI: The Way Forward

This National AYRH Strategy aims to formulate the vision, goals, objectives, and strategies, and it provides a basis for future work and efforts in Ethiopia. This strategy took into consideration an exhaustive consultation process representing an array of stakeholders, groups, and organizations. The document also synthesizes key findings outlining the context, challenges and opportunities that young people face regarding their reproductive health.

While this document will serve as a foundation, it represents only the first step in a larger process that will see the proposed strategies evolve into concrete programs, initiatives, and results.

To lead these efforts and actions, the Ministry of Health will coordinate the implementation of the National AYRH Strategy and assume responsibility for its execution, supervision and monitoring in collaboration with key stakeholders.

The next major step in the process will be to disseminate the strategy and formulate action plans with active input from the central and regional levels. This process will make possible the meaningful cost estimates that are in line with existing HSDPIII and the realization of the MDG's and PASDEP. It will also identify priority areas and gaps where donors, technical organizations, and implementing partners can contribute. Once action plans are completed, immediate efforts will be made to explore and identify opportunities to mobilize resources and buy-ins from donors and key national and international partners.

To coordinate and harmonize youth RH activities and to facilitate the sharing of information, the MOH will establish an adolescent RH interagency committee. This group will meet quarterly to share information, to update on progress, and provide feedback and recommendations to the MOH. It is proposed that the MOH appoint an AYRH national coordinator to facilitate the work of this group.

The MOH will create multi-sectoral technical working groups made up of experts, stakeholders, and implementing partners to advance key areas within youth RH. In some cases of linked and cross-cutting priorities, other line ministries may take the lead. Immediate key priorities include:

- The development of guidelines and national standards
- Exploring models of youth friendly services within the current context
- Training of health care providers and HEWs.

## **SECTION VII: ANNEXES**

- **Annex A: Summary of Key Strategies for Different Segments of Adolescents**
- **Annex B: List of Illustrative Indicators**
- **Annex C: Definition of Terms**
- **Annex D: National Adolescent and Youth Reproductive Health Strategy Development Committee**
- **Annex E: Bibliography**

## ANNEX A: Summary of Key Strategies for Different Segments of Adolescents Strategies and Key Actions for the Different Segments

No.	Segments	Main Issues /RH risks	Strategies	Key Actions
1	10 to 14 boys and girls/urban, living without parents/guardians, out of school	<ul style="list-style-type: none"> <li>• Sexual harassment /abuse, rape</li> <li>• Trafficking</li> <li>• Unwanted pregnancies, abortion (girls)</li> <li>• STI/HIV/AIDS, boys and girls (more likely girls)</li> <li>• Alcohol, chat, substance abuse (boys)</li> <li>• Gender inequality</li> </ul>	<ol style="list-style-type: none"> <li>1. Advocacy, awareness creation through community mobilization at all levels</li> <li>2. Create safe spaces in kebele, churches, mosque (other suitable places); assign mentors; and provide family life and sex education</li> <li>3. Organize this cohort in RH/HIV and appropriate clubs</li> <li>4. Select and train peer promoters from the group and</li> <li>5. Provide youth friendly services at community and facility levels</li> <li>6. Create referral linkage of RH/HIV/AIDS clubs to health facilities at all levels.</li> <li>7. Provide contraceptive services in health facilities and outreach and clubs to provide adolescents with dual protection against STIs /HIV/AIDS and pregnancy.</li> <li>8. Strengthen adult adolescent partnership</li> <li>9. Set up kebele AYRH committee with members from all stakeholders and the youth</li> <li>10. Provide youth friendly services at community and facility levels.</li> <li>11. Mobilize mass media to promote adolescent RH using multi media channels</li> </ol>	<ul style="list-style-type: none"> <li>• Train/sensitize community leaders, religious leaders, kebele officials, parliamentarians on SRH to advocate on access to information and services for 10 to 14</li> <li>• Select &amp; train mentors from the community</li> <li>• Train peer promoters from this segment (equal number of boys ad girls) on SRH to disseminate SRH and provide non-prescriptive contraceptives in clubs and different venues</li> <li>• Provide age appropriate family life education in clubs and other venues where this group gather,</li> <li>• Train health professionals to provide youth friendly services to this segment</li> <li>• Provide outreach services through the Health Extension Program</li> <li>• Awareness creation/sensitization at all levels on the New Family Code and Penal Code</li> <li>• Monitor and follow up implementation of SRH at the community level by establishing</li> <li>• Training on gender and its effects on RH</li> </ul>

No.	Segments	Key Issues/RH	Strategies	Key Actions
2	10 to 14 boys/girls / urban in school living with parents	Same as above but to limited extent	<ul style="list-style-type: none"> <li>Apply strategies 1, 3, 4, 5, 6, 8, 9, 11</li> <li>Create good communication between young adolescent and parents</li> <li>Provide age appropriate family life education in schools</li> </ul>	<ul style="list-style-type: none"> <li>The above key actions apply to this group</li> <li>Provide training to parents and guardians on RH, communication skills to enhance communication between parents and their children</li> <li>Conduct TOT of teachers on SRH</li> <li>Revise Family Life Education</li> </ul>
3	10 to 14 girls rural in school/ out of school	<ul style="list-style-type: none"> <li>Early marriage.</li> <li>Early child birth, leading to pregnancy complications including fistula</li> <li>Sexual violence including FGC, abduction, polygamy and rape for girls</li> <li>Limited ANC, post natal and postnatal care, unskilled delivery leading to high MMR</li> <li>Vulnerable to STI including HIV/AIDS (boys and girls), girls at increased risk of STI including HIV/AIDS, because of lack of economic resources and unequal power relations with spouse, unable to negotiate condom use with older spouses</li> <li>Boys are at risk of dropping out of school to work</li> <li>Migrate to urban areas to live on the street</li> </ul>	<ul style="list-style-type: none"> <li>Strategies 1 to 11 are applicable.</li> <li>Create Parent /teachers association in schools and kebele committee to advocate, follow up on enrollment, retention rate of female (male) students</li> <li>Advocacy against early marriage and other, gender violence and other HTPs.</li> <li>Create safe places (church, mosque, kebele) where the groups meet, support each other, exchange information and receive SRH information and services.</li> <li>Promote ANC, post natal and skilled delivery</li> <li>Encourage and provide incentives to bring married girls and boys (drop out of school) back to school</li> <li>Make schools gender sensitive (i.e. separate toilets for girls and boys, reduce harassment of girls on the road to schools)</li> <li>Organize RH/HIV/AIDS clubs in-school and out-of-school</li> </ul>	<ul style="list-style-type: none"> <li>Key actions for the first group apply to these groups as well</li> <li>Provide technical/material support to parent and teachers association</li> <li>Provide technical and material support to create safe space to child brides</li> <li>Provide SRH training and family life education, negotiation and assertiveness skills to girls age 10 to 14 about to be married and who have already married</li> <li>Train health extension workers / CBRH to seek out child brides and persuade them to come to health facilities for ANC, post natal and delivery</li> </ul>

No.	Segment	Key Issues/RH	Strategies	Key Actions
4	15 to 19 girls/boys in-school /out-school/ urban /rural	<ul style="list-style-type: none"> <li>• RH risks (girls) - sexual harassment, rape, abduction &amp; FGC and polygamy.</li> <li>• Risk of dropping out of school due to poor performance (boys, girls) due to work load (girls) lack of support</li> <li>• RH risks unwanted pregnancy, abortion, (girls) STI/HIV/AIDS.</li> <li>• Early marriage, early pregnancy and pregnancy communications and unsafe abortion</li> <li>• Migration to urban area only to engage in transactional sex to exchange sex for money or gifts (girls) and to live as street kids (mostly boys but also girls)</li> </ul>	<ul style="list-style-type: none"> <li>• Strategies 1 to 11 apply to these groups.</li> <li>• Youth friendly services at community and facility levels</li> <li>• Family life education in schools/out of school</li> <li>• Provide parents communication skills and sensitize them on SRH of adolescents.</li> <li>• Advocacy on sexual violence and HTP using community conversations and dialogues</li> <li>• Create referral linkages between schools and health facilities and outreach services</li> <li>• Organize youth/ in school/out of school RH/HIVAIDS clubs /gender clubs</li> <li>• Provide contraceptives in places where adolescent ages 15 to 19 congregate</li> </ul>	<ul style="list-style-type: none"> <li>• Key actions for age 10 to 14 also apply to these groups</li> <li>• Training /sensitization of parents /community members/faith based organizations on SRH on HTP, gender based violence and communication skills</li> <li>• Training of health care providers to provide youth friendly services at community and facility level</li> <li>• TOT of peer providers and teachers on SRH</li> <li>• Training of SRH in clubs and community meetings, informal gatherings, where young people gather</li> </ul>



No.	Segments	Key Issues/RH	Strategies	Key Actions
5	Young people 20 to 24 in school (vocational training, university), at work or out-of-school and not employed	<ol style="list-style-type: none"> <li>1. Unemployment,</li> <li>2. Gender based violence, (rape, abduction)</li> <li>3. Unwanted pregnancy abortion</li> <li>4. Exchange sex for money or gifts</li> <li>5. At risk of STI including HIV/AIDS</li> </ol>	<ul style="list-style-type: none"> <li>• Most strategies listed above apply to these groups</li> <li>• Skills and vocational training for gainful employment</li> <li>• Provide youth friendly services in vocational training schools and universities and colleges) and workplaces, and where these group congregate and provide adequate supply of contraceptive</li> <li>• Peer education on SRH</li> <li>• Strength referral network among health providers and health providers and young people.</li> <li>• Integrate RH/HIV AIDS and livelihood skill training</li> </ul>	<ul style="list-style-type: none"> <li>• Key actions identified above apply to these group as well</li> <li>• TOT for peer educators</li> <li>• Sensitization of community members on need of SRH to young people married or unmarried</li> </ul>
6	Orphans and vulnerable adolescents (10 – 19)	<ul style="list-style-type: none"> <li>• Lack of parental support.</li> <li>• At high risk of STIs, HIV/AIDS</li> <li>• Lack financial resources to sustain themselves</li> <li>• Vulnerable to risky behavior: engaging in sex for gift/money, and exposed to life on the street</li> </ul>	<ul style="list-style-type: none"> <li>• Create a safe place where they can meet support each other and obtain RH information and services</li> <li>• Select and train from the group to serve as peer providers</li> <li>• Create livelihood opportunities</li> <li>• Train health providers (HEW, CBRH) to seek out for them and provide them information and services</li> <li>• Create a network of referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Key actions listed above apply to these groups as well</li> <li>• Skill training for gainful employment</li> <li>• Provide credit for self employment</li> <li>• Train peer providers to disseminate SRH information and services</li> </ul>

## ANNEX B: List of Illustrative AYRH Indicators

### 1. To meet the immediate and long-term RH needs of young people through increased access and quality of reproductive health services for adolescents and young people of Ethiopia.

#### Objective 1.1: To improve access to quality reproductive health and STI/HIV services

Indicator Number	Illustrative Indicators	Indicator Definition/Notes	Data Source	Responsible Entity
1.1.1	Number of health facilities that offer youth friendly services.	In existing health facilities	Program	MOH
1.1.2	% of health care providers at all levels trained on AYRH	Attitudes, services, new guidelines	Program	MOH
1.1.3	% of adolescents who attend health facilities for RH/FP/HIV prevention services.	Disaggregate by age (10-14, 15-19, 20-24), gender, schooling, marital status	Survey; health facilities registries	MOH
1.1.4	Number of referrals made to youth for RH, HIV prevention, counseling and testing and other services.	Effectiveness of outreach programs		MOH
1.1.5	Referrals by health extension workers.	Assessing the linkages between HEW and other health facilities	Health facilities registries	MOH
1.1.6	Contraceptive prevalence rate (CPR)	Married and unmarried; area of residence, education, age	DHS, HMIS	MOH
1.1.7	Condom ever use	Married/unmarried, area of residence, age, education	DHS	CSA
1.1.8	Unmet need	For spacing, for limiting; age, marital, residence, education, region	DHS	CSA
1.1.9	% of adolescents who seek ANC	Focus on young married girls in rural areas	DHS; health facilities registries	CSA MOH
1.1.10	% of adolescents who seek delivery care at facilities	Focus on young married girls in rural areas	DHS; health facilities registries	CSA MOH
1.1.11	Number of programs providing emergency obstetric care at the community level	Accelerated training of nurses and health officer in midwifery skills	Program	MOH
1.1.12	% of pregnant women tested for HIV		HMIS	HAPCO
1.1.13	Prevalence of STI		Registry	HAPCO
1.1.14	HIV prevalence		DHS surveillance sentinel sites	CSA HAPCO

## 2. To increase awareness and knowledge about adolescent reproductive health issues, which lead to healthy attitudes and practices in support of young people's reproductive health.

### Objective 2.1: To influence community norms and attitudes to support adolescent reproductive health.

Indicator Number	Illustrative Indicators	Indicator Definition/Notes	Data Source	Responsible Entity
2.1.1	% of teachers, religious leaders, influential community members or mentors trained on AYRH, sexual violence and gender inequities		Program research	MOWA, MOYS, MOH, MOE CBOs, religious organizations, NGOs
2.1.2	Number of programs developed to encourage communities to discuss social norms associated with negative RH outcomes (HTP, sexual violence, gender inequities)		Program research	MOWA, MOYS, MOH, MOE CBOs, religious organizations, NGOs
2.1.3	% of parents sensitized on YRH		Program research	MOWA, MOYS, MOH, MOE, CBOs, religious organizations, NGOs
2.1.4	Number of programs strengthening adults' communication skills on AYRH with adolescents		Program research	MOWA, MOYS, MOH, MOE, CBOs, religious organizations, NGOs
2.1.5	Number of programs specifically involving men on AYRH, gender inequities and sexual violence		Program research	MOWA, MOYS, MOH, MOE CBOs, religious organizations, NGOs
2.1.6	Number of youth serving organizations		Program	MOYS, MOWA, MOE, NGOs
2.1.7	Number of youth organizations reporting involvement in program design and implementation		Program	MOYS, MOE

<b>Objective 2.2: To increase knowledge and information about reproductive health to empower adolescents in making healthy sexual choices.</b>					
<b>Indicator Number</b>	<b>Illustrative Indicators</b>	<b>Indicator Definition/Notes</b>	<b>Data Source</b>	<b>Responsible Entity</b>	
2.2.1	% of adolescents who know about sexual reproductive health (fertile period, STI/HIV prevention messages)		Operational	MOH, MOE	
2.2.2	% of adolescents who know how to protect themselves from unintended pregnancies.	Knowledge of AIDS, HIV prevention, fertile period	DHS	MOH, MOE,	
2.2.3	% of adolescents who know how to protect themselves from HIV and STI.		DHS Sentinel sites Survey	MOH / HAPCO	
2.2.4	Number of youth reached by peer education programs	Area of residence, marginalized and vulnerable groups	Program Survey	MOE, MOYS, MOH	
2.2.5	Number of teachers trained on Family Life Education (FLE) curricula.		Program	MOE	
2.2.6	Number of schools implementing FLE curriculum		Program	MOE	
2.2.7	Number of non-formal education initiative implementing FLE curricula		Program	MOE, MOYS	

**3. To strengthen multi-sectoral partnerships and create an enabling positive environment at all levels, with line ministries, research institutions, professional organizations, and partners, including communities and young people, regarding the reproductive health needs of young adolescents and youth.**

**Objective 3.1: Increase knowledge and awareness of policy makers towards ARH.**

<b>Indicator Number</b>	<b>Illustrative Indicators</b>	<b>Indicator Definition/Notes</b>	<b>Data Source</b>	<b>Responsible Entity</b>
3.1.1	Number of policy makers aware of AYRH		Program	
3.1.2	% increase of policies protecting youth RH and rights		Program	MOJ, MOWA
3.1.3	Number of community-based organizations advocating for YRH		Program	NGOs, religious orgs.

<b>Objective 3.2: Decrease risks and vulnerability of adolescents and empower them to make healthy transitions to adulthood.</b>					
<b>Indicator Number</b>	<b>Illustrative Indicators</b>	<b>Indicator Definition/Notes</b>	<b>Data Source</b>	<b>Responsible Entity</b>	
3.2.1	Number of policies protecting adolescents against sexual violence and trafficking			MOJ	
3.2.2	Gross enrolment ratio		MWS, DHS	MOE	
3.3.3	Parity Index	Measures gender inequities	MWS, DHS,	CSA	
3.3.4	Knowledge and support and prevalence for female genital cutting		DHS	CSA	
3.3.5	Multi-sexual partner		DHS Program	CSA, HAPCO, MOH	
3.3.6	Number of RH programs linked to livelihood		Program	MOLSA, MORAD, MOE, MOH	
3.3.7	Number of social networks		Program	MOYS, MOWA, NGOs	
3.3.8	Number of safe spaces	Safe spaces are desegregated by gender, age, living arrangement	Program		

<b>Objective 3.3: Increase coordination and collaboration among all partners</b>					
<b>Indicator Number</b>	<b>Illustrative Indicators</b>	<b>Indicator Definition/Notes</b>	<b>Data Source</b>	<b>Responsible Entity</b>	
3.3.1	Existence of a functional multi-sectoral adolescent reproductive health working group within the National RH Task Force	MOH position at the federal level	Program	MOH, MOYS, MOWA, MOLSA, MORAD, NGOS, FBOs	
3.3.2	Number of youth programs based on a multi-sectoral approach	Multi-sectoral	Survey	MOYS, NGOs, MOH, MOE, MOLSA	
3.3.3	Number of line ministries and partners actively involved in federal and regional working groups	MOH takes the lead in organizing working groups	Survey	MOH, MOYS, MOWA, MOE, MOJ, MOLSA, MORAD, NGO, FBO	
3.3.4	Number of organizations that deliver consistent gender messages to youth and influential adults		Survey; operational research	MOE, MOH, MOYS, MOWA, MOLSA, NGO, FBO	

**4. To design and implement innovative and evidence-based AYRH programs that are segmented and tailored to meet diverse needs of youth by marital status, age, school status, residence, and sex, including younger adolescents and marginalized and most vulnerable young people in the context of Ethiopian priorities and culture.**

**Objective 4.1: Conduct program research and evaluation to design, implement, and monitor effective programs addressing the diversity of the young people in Ethiopia.**

<b>Indicator Number</b>	<b>Illustrative Indicators</b>	<b>Indicator Definition/Notes</b>	<b>Data Source</b>	<b>Responsible Entity</b>
4.1.1	Number of studies conducted to understand youth behaviors, with a focus on youth at increased risks and marginalized groups		Program	Research institutions and professional organizations
4.1.2	Number of organizations that implement at least one best practice, by organization and by type	Need the skills to transfer the research findings into effective program designs	Program	MOH, MOYS, MOE, NGOs

## Annex C:

### Definition of Terms

1. **Access** is the extent to which a person can obtain appropriate services at a cost and effort that is both acceptable to them personally and within the means of a large majority in a given population.
2. **Adolescence** is a period of dynamic change representing the transition from childhood to adulthood and is marked by emotional, physical, and sexual maturation. Habits that are formed during adolescence had major effects in adulthood.
3. **Adolescents:** The World Health Organization defines adolescents as young people ages 10-19 years.
4. **Early adolescence** corresponds to ages 10 to 13 and is characterized by a spurt of growth and the beginnings of sexual maturation. Young people start to think abstractly. (WHO)
5. **In mid-adolescence** (ages 14-15), the main physical changes are completed, while the individual develops a stronger sense of identity and relates more strongly to his or her peer group. Families usually remain important.
6. **In late adolescence** (ages 16-19), the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions. (WHO)
7. **Young people or youth:** 15 to 24 years old.
8. **Contraception:** See next page.



### Contraception methods for young people:

**No medical reasons currently exist for denying any contraceptive method based on young age alone.**

Contraception options include:

- *Abstinence*. No sexual intercourse but other forms of sexual expression were possible.
- *Barrier methods*. Male and female condoms, spermicides, diaphragm, and cervical cap. Consistent and correct use is key to effectiveness. Success of this method depends on partner participation and on negotiating skills. Male condoms are the most effective method in terms of protecting against all types of STIs, including HIV.
- *Oral contraceptives* are safe for young women and very effective but do not protect against STIs
- *Injectables and implants* are safe for young women and a very effective means of contraception if used correctly. No STI protection.
- *Sterilization* is generally not appropriate for young adults because it is permanent.
- *IUD* offers long term protection, quick return to fertility, safe for young women at low risk of STIs. No protection against STIs including HIV.
- *Lactation Amenorrhea Method (LAM)* is an effective method for women who are amenorrheic and breast feeding up to six months post partum.
- *Emergency contraception* prevents pregnancy after unprotected intercourse but is not meant to be a regular method and provides no STI protection.

9. **Dual protection:** For many sexually active young people, this means using a condom to prevent against STIs and HIV infection and another form of contraception (hormonal) to protect against unintended pregnancy.
10. **Counseling:** To discuss reproductive health issues and choices, guiding the client to make informed decisions regarding his or her reproductive life while respecting confidentiality and privacy.
11. **Malnutrition:** Adolescent boys and girls have a need for extra nutrition as they grow rapidly and develop. An inadequate diet can delay or impair healthy development. Stunting can occur in childhood or during adolescence. In girls, poor nutrition can delay puberty and lead to the development of a small pelvis. Malnourished adolescent mothers are more likely to experience negative obstetric outcomes (obstructed labor and fistulae). Malnourished adolescent girls are at increased risk of being anemic and are more likely to give birth to low birth weight babies and are at increased risk of maternal mortality (WHO).
12. **Menarche:** A girl's first menstruation.

13. **Puberty:** A period of rapid change that occurs primarily in early adolescence, involving hormonal and body changes.
14. **Outreach services** refer to extending health services beyond facilities to youth centers, youth clubs, markets booths, bus stations booths, and pharmacies through community outreach workers – health extension workers, community-based RH agents, teachers, community members, peer educators, peer counselors, and others.
15. **Peer:** Children or adolescents who are of about the same age or maturity.
16. **Reproductive health** is a state of physical, mental and, social well being, not merely the absence of diseases or infirmity, in all matters related to the reproductive system and its functions and process. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases. (ICPD, Program of Action, para 7.2)
17. **Rights:** Something that an individual or a population deserves, which they can legally and justly claim.
18. **Rights on sexual and reproductive health.** These are rights specific to personal decision making and behavior on reproduction including access to RH information, privacy, guidance from trained personnel, obtaining RH services free from discrimination, and no coercion or violence in one's sexual life.
19. **Rape** is forcible sexual intercourse with a person who does not consent to it.
20. **Sexual coercion:** Forced sex. Studies have linked sexual coercion during childhood to increased consensual unsafe sexual activity during adolescence and also increased likelihood of multiple partners, and increased risks of unintended pregnancy, STIs, abortions, and mental health problems.
21. **A service provider** is a skilled health worker who can offer services according to the health needs of young people. Non health workers within settings and outlets that provide health services to youth need to be oriented on AYRH issues.
22. **Sexually Transmitted Diseases (STDs).** These are diseases that are transmitted primarily through sexual contact. The contact is not limited to vaginal intercourse but includes oral-genital contact as well.
23. **Youth friendly services:** Making services youth friendly is not primarily about setting up separate dedicated services, although the style of some facilities may change. The greatest benefit comes from improving generic health services in local communities and by improving the competencies of health care providers to deal effectively with adolescents. Key criteria for developing youth friendly services:

## **Characteristics of adolescent friendly health services**

### **Adolescent friendly procedures to facilitate**

- easy and confidential registration of patients, retrieval and storage of records, short waiting times, and (where necessary) swift referral
- consultation with or without an appointment

### **Adolescent friendly health care providers who**

- are technically competent in adolescent specific areas and offer health promotion, prevention, treatment, and care relevant to each client's maturation and social circumstances
- have interpersonal and communication skills, are motivated and supported, are non-judgmental and considerate, easy to relate to, and trustworthy
- devote adequate time to clients or patients, act in the best interests of their clients, treat all clients with equal care and respect
- provide information and support to enable each adolescent to make the right free choices for his or her unique needs

### **Adolescent friendly support staff who are**

- understanding and considerate, treating each adolescent client with equal care and respect
- competent, motivated, and well supported.

### **Adolescent friendly health facilities that**

- provide a safe environment at a convenient location with an appealing ambience
- have convenient working hours
- offer privacy and avoid stigma
- provide information and education material

### **Adolescent involvement, so that they are**

- well informed about services and their rights
- encouraged to respect the rights of others
- involved in service assessment and provision

### **Community involvement and dialogue to**

- promote the value of health services
- encourage parental and community support

### **Community based, outreach and peer-to-peer**

- services to increase coverage and accessibility
- appropriate and comprehensive services that address each adolescent's physical, social and psychological health and development needs

### **Characteristics (Continued)**

- provide a comprehensive package of health care and referral to other relevant services
- do not carry out unnecessary procedures

#### **Effective health services for adolescents**

- that are guided by evidence-based protocols and guidelines
- having equipment, supplies and basic services necessary to deliver the essential care package
- having a process of quality improvement to create and maintain a culture of staff support

#### **Efficient services which have**

- a management information system including information on the cost of resources
- a system to make use of this information

Source: WHO Global Consultation 2001 and 2002 WHO expert advisory group meeting

24. **Vulnerable groups:** These include young people who are hard to reach, for example:

- are denied the opportunity to complete their education
- have no stable home or support, living rough in towns and cities, exposed to risks of malnutrition, abuse, violence and disease
- are vulnerable to sexual abuse or violence, or are sexually exploited by people who are older and more powerful
- work long hours for little pay
- live in areas torn by conflicts
- are displaced into camps where traditional values and community structures are impossible to maintain
- live as young adolescent wives in families who have limited understanding of the increased risks of negative reproductive health outcomes associated with early marriage.

## Annex D: National Adolescent and Youth Reproductive Health Strategy Development Committee

Name of Organization	Name of Focal Person	Position
Federal Ministry of Health	Dr. Tesfanesh Belay	Lead Member
Federal Ministry of Health	Dr. Michael Tekie	Member
Federal Ministry of Health/WHO	Dr. Ayele Debebe	Member
Federal Ministry of Education	Takele Alemu	Member
Ministry of Rural Development	Abaynesh W/Giorgis	Member
Ministry of Youth and Sport	Seleshi Tadesse	Member
UNFPA	Nibretie Gobezie	Chairperson
UNFPA	Dr. Kidane G/Kidane	Member
UNFPA /CST	Anne Domatob	Member
UNFPA/Country Representative	Dr. Monique Rakotomalala	Member
Former National Committee on Traditional Practices (EGLDAM)	Abebe Kebede	Member
FGAE	Adinew Husien	Member
Ipas Ethiopia	Dr. Solomon Tesfaye	Member
Pathfinder International	Worknesh Kereta	Member
Pathfinder International	Gwyn Hainsworth	Advisor/Distant
CORHA	Ms. Jerusalem	Member
Ethiopian Youth Network	Atkilt Bekele	Member
Ethiopian Youth Network	Efrem Tesfai	Member
FHI	Konjit Kifetew	Member
DSW	Mekdes Alemu	Member
USAID	Dr. Kidest Lulu	Member
UNICEF	Dr. Alemach T/Haimanot	Member
WHO	Dr. Abonesh Hailemariam	Member
Packard Foundation	Yemisrach Belayneh	Member
Population Council	Tekle-Ab Mekbib	Member
Population Council	Judith Bruce	Advisor/Distant
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Photo credits: FHI, Packard Foundation, UNFPA and photographer Tiina Tuppurainen		

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Youth Conversation on HIV prevention and care over coffee ceremony

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