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MINISTRY OF HEALTH - ETHIOPA

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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

Reproductive Health Strategic Plan

2021 - 2025

Federal Democratic Republic of Ethiopia

Ministry of Health

2021

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ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immune deficiency syndrome
ANC 4+	Antenatal Care 4 times and more
ANC	Antenatal Care
ARV	Anti-retrovirus
AYRH	Adolescent and Youth Reproductive Health
AYSRH	Adolescent youth sexual reproductive health
BEmONC	Basic Emergency Obstetrics and Newborn Care
BMI	Body Mass Index
CBHI	Community Based Health Insurance
CEmONC	Comprehensive Emergency Obstetrics and Newborn Care
CMTP	Child marriage and Teenage Pregnancy
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence rate
CRC	Compassionate Respectful and Caring
CRVS	Civil Registration and Vital Statics
CSA	Central Statistics Agency
CSO	Civil Society Organization
CTG	Cardiotocography
DBS	Dry Blood sample
EDHS	Ethiopian Demographic and Health Survey
EID	Early Infant Diagnosis
EMwA	Ethiopian Midwifery Association
EPI	Expanded Program of Immunization
EPSA	Ethiopian Pharmaceutical Supply Agency
ESOG	Ethiopian Society of Obstetrics and Gynecology
FGC	Female Genital Cutting
FP	Family planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
HDA	Health Development Army
HC	Health Center
HCI	Human Capital Index
HDI	Human Development Index
HEI	HIV Exposed Infant
HEP	Health Extension Program
HEW	Health Extension Worker
HIV	Human Immune-deficiency Virus
HMIS	Health Management Information System
HP	Health Post
HPV	Human Papiloma Virus
HSTP	Health Sector Transformational Plan
IARC	International Agency for Research on Cancer
ICT	Information Communication Technology
IDP	Internal Displacement
IESO	Integrated Emergency Surgical Officer
IPLS	Integrated Pharmaceutical Logistics System

IUD	Intrauterine Device
KMC	Kangaroo Mother Care
LARC	Long Acting Reversible Contraceptive
LBW	Low Birth Weight
LMIS	Logistics Management Information System
MDG	Millennium Development Goal
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Rate
MNCH	Maternal Newborn and Child Health
MNHQoC	Maternal Newborn and child Health Quality of Care initiative
MoFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
MPDSR	Maternal and Perinatal Death Surveillance and Response
MTCT	Mother to Child Transmission of HIV
MTR	Mid-Term Reviews
NGO	Non-Government Organization
NMR	Neonatal Mortality Rate
OF	Obstetric Fistula
PCC	Pre-conception Care
PH	Primary Hospital
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
POP	Pelvic Organ Prolapse
PPE	Personal Protective Equipment
RAC	Research Advisory Committee
RH	Reproductive Health
RHB	Regional Health Bureau
RMNCAYHN	Reproductive Maternal Newborn Child Adolescent Youth health and Nutrition
ROC	Reproductive Organ Cancer
SARA	Service Availability and Readiness Assessment
SBR	Skilled Birth Attendance
SDG	Sustainable Development Goal
SMH TWG	Safe Motherhood Technical Working Group
SNNPR	South Nations, Nationalities and People's Region
SRH	Sexual and Reproductive Health
SRA	Sub Regional Average
STI	Sexual Transmitted Infection
TFR	Total Fertility Rate
THE	Total Health Expenditure
UHC	Universal Health Coverage
UNAIDS	United Nations Program on HIV/AIDS
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection using Acetic acid
WHO	World Health Organization
WorHO	Woreda Health office
ZHD	Zonal Health Department

FORWARD

The Government of Ethiopia is committed to advance and maintain the Reproductive Health (RH) status of women, men and young people to achieve the demands of the community. Hence efforts are required to achieve the three zero's "zero unmet need for family planning services and information", "zero preventable maternal deaths and morbidities." and zero sexual and gender based violence (SGBV). Indeed, the zero SGBV includes zero child, early and forced marriage as well as zero female genital mutilation". The strategy will help further to achieve the globally agreed Sustainable Development Goals (SDGs). To realize this RH strategy and other health issues, the second Health Sector Transformation Plan (HSTP) with the principles of equity and universal access to primary healthcare is developed.

The 2016-2020 RH strategic plan improved health development inputs, and outcome indicators through time, with a remarkable reduction in maternal, newborn and adolescent and youth morbidity and mortality. This was happened due to the significant reduction of preventable obstetric complications such as eclampsia/preeclampsia, sepsis, obstructed labor, abortion related morbidity and mortality, and HIV/AIDS. However, the RH service to the community is now challenged by emerging COVID-19 pandemic. The new 2021-2025 RH strategic plan is five-year plan which strengthen the second Health Sector Strategic Plan (HSTP II). Reaching the unreached part of the community, mainly for emergency RH services by deploying midlevel health care providers and deploying then to the hard to reach areas of the community is the focus area for this strategic plan. The plan also focuses on strengthening RH investment areas such as health workforce, health infrastructure, digital health system, innovations in health, strengthening multi-sectoral collaborative approach through which we can tackle the social determinants of health in the country.

Cognizant of this, the Ministry of Health reiterates its commitment towards achieving the targets by 2025. This strategy puts forth the key priorities, which should guide the government, private sectors, and non-governmental organizations in terms of resource mobilization, community engagement, monitoring and evaluation.

Therefore, I call upon government sectors, all stakeholders, including Development Partners, Civic Society Organizations, Private sectors, and the community to utilize this strategy in guiding the planning implementation, monitoring and evaluation of programs geared to satisfy reproductive needs of the society.

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ACKNOWLEDGMENT

The National Reproductive Health Strategy (2021-2025) was designed in collaboration with a wide group of people from various national and subnational organizations and institutions. The strategy was based on information gathered from a situational and SLOT analysis, as well as feedback from program managers and implementers at several directorates, agencies, and development organizations. Regional Health Bureaus (RHBs), Non-Governmental organizations (NGOs), Professional Associations and other members of the reproductive health expertise. With the close follow up of Maternal and Child Health Directorate's management and the national consultant, the Technical Working Group (TWG) closely engaged and tracked the strategy's development progress. The Ministry of Health is grateful to all individuals and organizations, Universities, non-governmental organizations, Directorates(PPMED) under MoH and all case team's in MCH directorate, Agencies (EPHI, EPSA), RH TCT members who contributed enormously to the development of the RH 2021-2025 strategic plan.

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Dr. Meseret Zelalem (MD, Pediatrician)
Maternal, Newborn, Child and Nutrition Directorate Director
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EXECUTIVE SUMMARY

Reproductive health is a development issue, hence efforts are required to achieve the three zero's "zero unmet need for family planning services and information", "zero preventable maternal deaths and morbidities." and "zero sexual and gender based violence including zero child, early and forced child marriage as well as zero female genital mutilation". Investing in adolescent and youth education, economic opportunities, and health including family planning and sexual and reproductive health, is critical, among other things, to harvest the demographic dividend. Building peaceful, just, and inclusive societies in which no one is left behind is critical. All people, regardless of race, color, religion, sex (male or female), age, disability, or language, should feel respected and have the opportunity to shape their own future and contribute to the prosperity of their societies.

To achieve all these, Ethiopia developed the third Reproductive Health (RH) Strategic Plan, which covered the years 2013–2017 in Ethiopian fiscal years (2021–2025 GC). This strategy is in line with the HSTP II and Ethiopian health policy. It is based on a desk review of an in-depth situational analysis of the country's reproductive health performance. Despite continuing challenges including internal conflicts leading to population displacement and the COVID-19 pandemic, a significant improvement was made during the second Reproductive Health Strategic Plan (2016–2020) period.

The Reproductive Health Strategic Plan 2016-2020 witnessed remarkable progress, including maternal mortality falling from 676 deaths per 100,000 live births (LB) in 2011 to 401 in 2017. There was a significant decline in total abortion-related morbidity and mortality. Additionally, skilled birth attendance increased from 10% (EDHS 2016) to 50% (Mini EDHS 2019). However, over the years, there has not been any significant reduction in neonatal mortality (33 deaths per 1000 LB in 2019 as compared to 29 deaths /1000 LB in 2016 (EDHS, 2016)).

Despite the significant improvement in maternal and neonatal health, the 2016-2020 Reproductive Health Strategic Plan has not achieved the envisioned targets. There were targets to reduce maternal mortality from 353 to 199/100000 LB, Neonatal mortality from 28 to 10/1000 LB, still birth rate from 18 to 10/1000 LB, HIV infection rate of exposed newborns from 12 to 0 % and total fertility rate from 4.1 to 3.

As shown by the increased use of some health services, the efficiency of major health systems has improved. For example, 41% of married Ethiopian women used contraception in 2019, compared to 27 % in 2011 and 35% in 2016. The unmet need remains considerably high at 22 percent. While only 43% of pregnant women had ANC4+ contacts, ANC1 coverage has improved from 62% in 2016 to 74% in 2019. The skilled birth attendance rate has risen from 28% in 2016 to 50% in 2019. The availability of tracer products for BEmONC is over 85% in hospitals, 74% in health centers (HCs), and 55% in higher clinics. Safe abortion and post-abortion treatment are also available.

Several interventions have been put in place to improve financial risk protection when it comes to accessing critical health services. This includes providing high-impact measures for all maternal health programs without any cost through a reimbursement protocol.

To resolve the social and environmental determinants of health, efforts have been made to enhance collaboration with professional associations, local and international partners, and stakeholders. Strong leadership and governance systems supported the implementation of the Reproductive Health Strategic Plan 2016-2020. Furthermore, stakeholder involvement and collaboration with the health sector was promoted through various forums such as the Safe Motherhood Technical Working Group and Research Advisory Committee, as well as with RHBs through frequent meetings of the Joint Core Coordinating Committee.

The Reproductive Health Strategic Plan 2021-2025 aims to draw on the strengths and lessons learned from the 2016-2020 strategic plan. The Reproductive Health Strategic Plan 2021-2025 is aligned with the country's overall macro-economic development framework, emerging public health problems, and national and international goals and agenda's. It was developed in consultation with the National Safe Motherhood Technical groups, the Core Technical Team (CTT), University senior experts, and professional associations involved in reproductive health interventions. The development process was so iterative in that different versions of the plan were shared with a wide-range of stakeholders including government sectors and RHBs, academia, professional associations, private sector, civil services organizations and development partners for inputs.

The overall objective of the RH strategic plan 2021-2025 (RH 2021-2025) is to improve the reproductive health status of women and their families, new-borns, adolescents and youths. This is to be achieved through realization of enhanced progress towards Universal Health Coverage, protection of people from health emergencies, and improvement of health system responsiveness.

Targets for monitoring and evaluating the execution of the RH strategic plan 2021-2025 have been set. The majority of the priorities are based on HSTP II, as well as national and international requirements and anticipated resources. The strategic plan has set ambitious targets, such as lowering the MMR to 277 per 100,000 live births, lowering neonatal mortality to 21 per 1000 live births, and lowering the overall fertility rate to 3.2%.

To achieve the set impact and outcome targets, 12 strategic directions with corresponding strategies and strategic initiatives are designed:-

1. Enhance provision of equitable and quality reproductive maternal, new born, adolescent and youth health services.
2. Enhance good governance, leadership and partnership for RH.
3. Improve supply chain management and medical equipment fulfillment for consistent availability of RH commodities and services.
4. Improve community participation and engagement.

5. Improve research and evidence for decision-making.
6. Enhance use of technology and innovation.
7. Development and management of human resource for RH.
8. Improve health infrastructure for RH services.
9. Enhance policy and procedures.
10. Address the social determinants of RH.
11. Enhance quality planning, quality improvement and quality assurance are integrated in RH programs.
12. Strengthening resource mobilization for RH services.

In line with HSTP-II, the strategic plan has given emphasis on the five priority "transformation agenda". Key strategic initiatives will be implemented to address these priority issues to transform the health system and to achieve 'health for all'. The transformation agenda are:

1. **Quality and equity:** Refers to ensuring equity in the delivery of quality health services through the creation of high-performing primary health care units; active engagement of the community in service delivery; and continuous improvements in clinical care outcomes.
2. **Information revolution:** Refers to the phenomenal advancement on the methods and practice of collecting, analyzing, presenting, using and disseminating information that can influence decisions.
3. **Motivated, Competent and Compassionate (MCC) health workforce:** Aims to ensure equitable distribution and availability of adequate number and skill mix of health workers that are motivated, competent and compassionate (MCC) to provide quality health services.
4. **Health financing:** Aims to reform public financial management and health financing to improve efficiency and accountability, while pursuing the agenda of sustainable domestic resource mobilization for health.
5. **Leadership:** Aims to enhance leadership and governance mechanisms at all levels of the health system, to drive attainment of the national strategic objectives through improved alignment and harmonization efforts, thereby creating an enabling environment for the translation of plans into results.

The strategic plan's total costing is calculated using the One Health Tool (OHT), a tool based on the WHO's six health system building blocks framework. The total cost of the RH strategy is calculated based on various assumptions, and the One Health tool pre-defined as well as customized intervention list. As a result, the cumulative cost over the five years for 2021-2025 is USD 2,379,306,124.

The Reproductive Health Strategic Plan 2021-2025 will be implemented at all levels of the health system, and annual operating plans will be established. The agreed-upon M&E framework will be used to track and assess its execution.

CHAPTER 1: INTRODUCTION

Individuals, couples and families all benefit from reproductive health (RH). RH is also beneficial for social and economic growth of communities and the country as a whole. The previous reproductive health strategy which was developed for the period 2016-2020 has come to an end. It is now time for the subsequent 2021-2025 reproductive health strategic plan to comply with the HSTP II and incorporate other public health concerns.

Despite promising progress and successes, more work remains to be done to enhance the RH of women, girls, teenagers, youth and people living in remote areas. There were tensions that resulted in significant internal displacement of people for a brief period of time, putting an additional strain on the health system to meet the people's health care needs. In addition, the COVID-19 pandemic struck in the fifth year of the previous strategic plan period, posing significant challenges to the health system and affecting the country's strategic direction and economic development. Despite all the challenges, the nation has made significant progress in improving the reproductive health and socioeconomic status of its people.

The implementation of the Reproductive Health Strategic Plan 2016-2020 has been objectively assessed using annual performance evaluations such as: the Health Management Information System (HMIS), HSTP I Mid-Term Reviews (MTR), Joint Review Mission reports, and various population and facility-based surveys. The results of the analysis revealed that the country has achieved the set goal addressing all the challenges it faced during the strategic period. The country has made incredible progress by introducing high-impact programs, mostly through the Health Extension Program. The health sector has been successful in stirring momentum in the health sector through the implementation of different transformation programs such as: Woreda Transformation, Information Revolution, Transformation in Quality & Equity of health services, and Compassionate, Respectful and Caring health workers stimulated momentum with the health sector to transform critical barriers of the health system. The health sector has also strived for multi-sectoral cooperation to resolve social determinants of health and contribute its share in realizing the country's strategic direction and achieve socio-economic growth.

A strategic plan does not move an organization into the future if it is not updated or revised when needed. The revised reproductive health plan is based on the practical implementation of the new HSTP II and includes mechanisms to support its implementation. The new RH strategic plan addresses the gaps identified in the implementation of the previous strategic plan. It builds on the existing RH Strategic Plan and associated framework of priorities, targets, and benchmarks to provide

consistency, with necessary revisions to increase transparency and emphasis. For the period of the new Strategic Plan (2021-2025), the current thematic programs are still applicable.

In this strategic plan period (2021-2025), the sector envisions to build on the successes and consolidate the gains achieved during the completed strategic plan period. An in-depth situational analysis of the results of the previous strategic plan aided the creation of the current updated strategy. Despite its achievements, Ethiopia faces challenges such as low maternal health service utilization, low awareness of healthy behaviors, cultural barriers, inequities in health service utilization, and low quality care. The ministry of health analyzed the challenges and imagined a system that is equitable, sustainable, adaptable, effective, as well as that meets the population's health needs. The RH strategy also advocated for the development of a more detailed guide to help in the achievement of the ambitious 2025 target.

Since 2000, the global maternal mortality ratio has decreased by 37%. Despite this, 95 000 women died in 2017 during and after pregnancy and childbirth. Aside from maternal mortality, more than 30 million women do not give birth in a health facility each year in developing countries; more than 45 million receive insufficient or no antenatal care; and more than 200 million women choose to prevent pregnancy but do not use modern contraceptives.[1] The Sustainable Development Goals (SDGs) and the Global Strategy for the Health of Women, Children and Adolescents (2016–2030) set optimistic but important goals. The adoption of the SDGs by the United Nations (UN) in September 2015 reaffirmed maternal and newborn mortality reduction as a global priority in the coming decades.[2] Africa Agenda 2063 aspires Africa to be a prosperous continent with the resources and means to drive its own growth, where Africans enjoy a high standard of living and quality of life, as well as social health and well-being.[3]

In Ethiopia, under the current SDG period, the welfare of mothers, newborns and children remains a top priority for the health sector. Owing to decades of relentless efforts to strengthen the health system and expand access to critical health services, Ethiopia has attained remarkable gains in health related MDGs, guided by the country's policies and strategies, resulting in significant improvements in the health status of the nation. As a result, Ethiopia had done remarkably well in meeting most of the Millennium Development Goals (MDG) targets. These include the remarkable achievements in MDG-4 and 5 with a 72% and 60% reduction in under-five mortality and maternal mortality respectively from the 1990 estimates. Through the journey, there were major challenges in the health sector, including lack of human resource for health (HRH) and low utilization of health services. These were addressed through the innovative Health Extension Programme (HEP), accelerated midwifery training, Integrated Emergency Surgery and Obstetrics (IESO) task shifting, and scaling up of family planning (FP) services. The HEP trains health extension workers (HEWs) to deliver a

[1]Lancet 2018; 391: 2642–92 Published Online May 9, 2018. http://dx.doi.org/10.1016/S0140-6736 (18) 30293-9.
[2] United Nations, 2015.
[3] African Union Commission, 2015.

basic package of preventive and curative health services, including maternal and child health services, in rural, pastoral and urban areas.

The Ethiopian government's top priorities are reflected in the National RH Strategy (2021-2025), which is outlined in the following sections. The first is the country's commitment to achieving the Sustainable Development Goals. These include lowering the global maternal mortality ratio to less than 70 per 100,000 live births and ensuring equal access to sexual and reproductive health-care services including family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030.

CHAPTER 2: BACKGROUND

2.1. Geography

Ethiopia is located in the north eastern part of Africa which is also known as the Horn of Africa. It is bordered on the west by Sudan and South Sudan, on the northeast by Eritrea and Djibouti, on the east and southeast by Somalia, and on the south by Kenya. Ethiopia lies north of the equator between 30°N and 150°N latitude and 330° E and 480° E longitude. The country has an area of 1.1 million square kilometers, with water bodies covering 7,444 square kilometers. Ethiopia is a country with a wide range of geographical features. Rugged mountains, flat-topped plateaus, deep gorges, and river valleys make up the landscape.

2.2. Demographic profile

Ethiopia, with a population of around 101 million people in 2020, is Africa's second most populous country next to Nigeria and ranks 12th in the world. The country is characterized by a rapid population growth (2.6%), young age structure and a high dependency ratio with a high rural-urban differential. The population increased from 18 million in 1950 to 40 million in 1984, and from 54 million in 1994 to 74 million in 2007. Ethiopia has one of the highest total fertility rates of 4.1 births per woman (2.3 in urban areas and 5.2 in rural areas) and a corresponding crude birth rate of 32 per 1000 in 2016. According to the 2007 population and housing census, the population of the country is projected at 109.5 million by 2024 (CSA projection). If it follows its current rate of growth, the population will reach 122.3 million by 2030. Ethiopia is home to various ethnicities, with more than 80 different languages spoken.

Figure 1 below shows the predicted population pyramid of Ethiopia for 2020 and 2029. Children under age 15 and age group of 15 to 65 years account for 47 % and 49 % of the population respectively. Individuals aged 65 and older account for only 4% of the total population. While the sex ratio between males and females is almost equal, women of reproductive age constitute about 23% of the population. The population is predominantly rural with nearly 80% living in rural areas, mainly based on subsistence agriculture. *Source: EDHS 2016 and CSA*

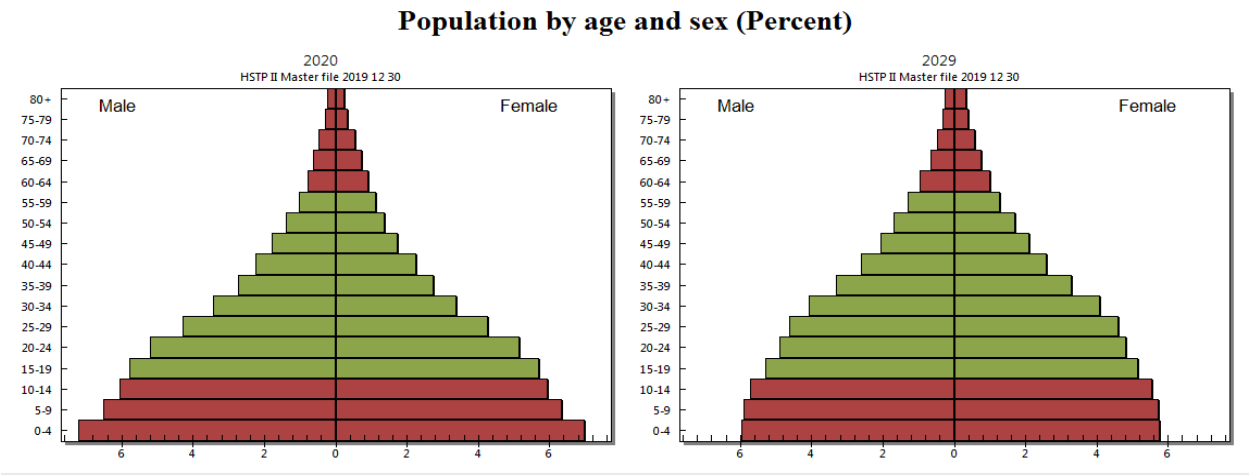

Figure 1. Ethiopian population distribution by age and sex for years 2020 and 2029.

2.3. Demographic shift / dividend

Ethiopia is committed to reducing infant and child mortality, improving reproductive health and family planning, and the subsequent fertility decline. It is, as a result, on track to a population age structure that may enable a demographic dividend. However, harnessing this dividend depends on the country's ability to scale up investments in human capital by addressing disparities among different equity dimensions. Different reports show that some regional states are not making sufficient progress in the key factors of the demographic dividend requiring intensified effort. With enhanced effort to reduce health and education disparities between urban and rural as well as among regional states, the country can gain a sizable demographic dividend that can fuel the reforms towards improving the quality of life of the people. Effective implementation of supporting policies, strategies and reform agendas are crucial to tap from the opportunity of demographic dividend; otherwise the flipside of this may be a concern leading to social instability.

2.4. Socio-economic situation

Ethiopia is pursuing massive and systematic development activities in order to rapidly move out of poverty and progress in the long-term to dependable growth and prosperity. The country has also made significant progress towards achieving the Millennium Development Goals (MDGs), which include universal primary education, gender equity, prevention of malnutrition, HIV/AIDS and malaria, and lowering infant and neonatal mortality.

Since 1991, Ethiopia has implemented a number of macroeconomic policies, including a market-based and agriculture led industrialization. The government has made every effort to ensure economic transition from an agricultural to an industrial economy. Ethiopia is a low-income country, according to the World Bank, with a GDP per capita of US $ 930 in 2020, up from about US $ 340 in 2010. Between 2004 and 2014, the country had one of the fastest growing economies in Africa, with an

average annual growth rate of around 10%. Agriculture, industry and the service sector are the key contributors to the GDP growth. According to Ethiopia's poverty assessment report, the poverty rate has dropped dramatically from 39 % below USD $1.25 purchasing power per day in 2004/05 to 29 percent in 2010. Between 2011 and 2016, the poverty rate dropped by about 20% (World Bank, 2019). Despite the rapid economic growth, the country is still one of the poorest in the world. Poverty and income inequality are still major issues in Ethiopia.

The important feature of the economic reform in Ethiopia is empowering women through the creation of an enabling environment for equal opportunity for women to participate in the economic development of the country which is treasured in the constitution. The concept of equitable access to economic opportunities, employment and property ownership for women is recognized in the Ethiopian constitution. The Ministry of Women's Affairs was created as a result of this recognition. The national income inequality coefficient rose from 0.298 in 2010/11 to 0.328 in 2015/16, according to the CSA report.[4]

Ethiopia's Human Development Index (HDI) rose by 63.5 percent from 0.283 to 0.463 between 2000 and 2017, but it remains below the global average of 0.504. Ethiopia's HCI (Human Capital Index) is 0.38, ranking 135th out of 157 countries in the 2019 World Bank report.[5].

The length of roads in the country has increased six-fold to 105,000 km compared to the length in 1990. About 10,765 rural kebeles are connected with the Universal Rural Road Access Program creating a better healthcare access to millions of mothers and children. Connectivity of citizens through modern communication means are showing prominent strides evidenced by 32 million mobile phones creating better electronic community health information system by supporting health extension workers to share basic healthcare services being implemented at community level.

2.5. Humanitarian impact and needs

Ethiopians' national context cannot be analyzed without recognizing Ethiopia's risk profile to natural and man-made shocks and stresses. Ethiopia experiences cyclical hazards that affect households, infrastructure and systems' resilience. Like many countries in the world, the global COVID-19 pandemic has also tested Ethiopia's health system resilience. In addition, the occurrence of epidemics such as measles, yellow fever and cholera has posed a challenge to the health system.

In 2020, an estimated 8.4 million were in need of humanitarian assistance[6]. There is a disparate effect of protracted food insecurity on women and girls, who are most negatively affected by macro- and micronutrient deficiencies, especially during their reproductive years. For the health sector specifically, 5.9 million people were estimated to have health related humanitarian needs; of which

[4]CSA report: the national income inequality coefficient assessment in 2015/16.
[5] World Development Report, 2019. World Bank Group.
[6] Humanitarian Needs Overview 2020.

1.2 million people were women and girls in need of family planning and maternal health services. Internally Displaced People (IDP) are more vulnerable and require additional health services for pre-existing and new disease conditions, physical and mental trauma, and sexual and gender-based violence. IDPs put additional pressure on local health systems, straining healthcare workers, stocks of medicines and other essential supplies. People affected by drought and food insecurity are at higher risk of malnutrition.

2.6. Health system organization

Ethiopia's health care system is divided into three tiers: primary, secondary and tertiary levels of care. (See figure 2 below)

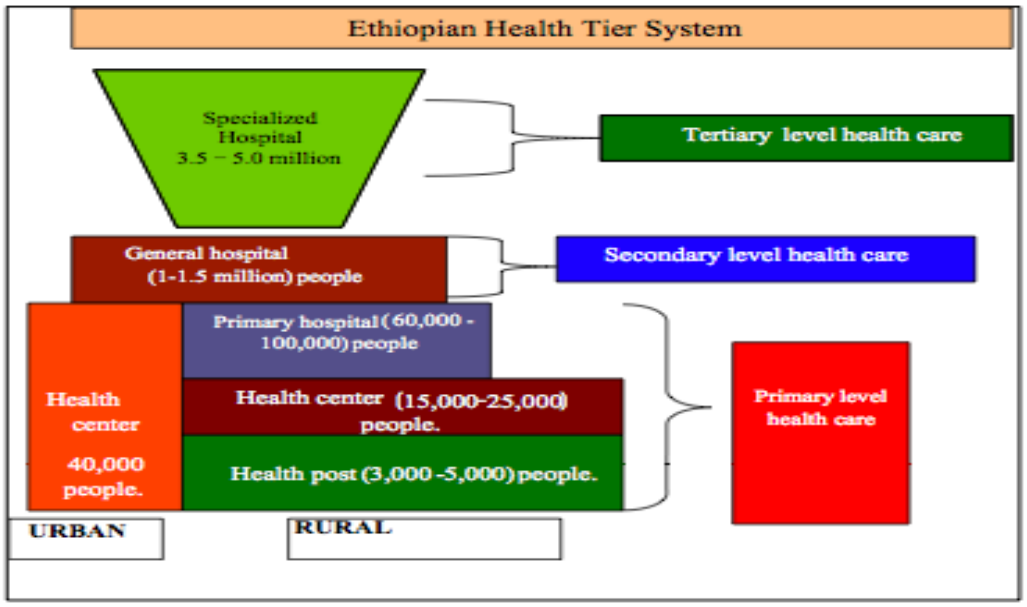

Figure 2. Health care system tiers of Ethiopia.

Primary level health care is composed of a health center (HC), five satellite health posts (HP) and a primary hospital (PH). The catchment population to be served by a health center ranges from 15,000-25,000 people for the rural health center to 40,000 people for an urban health center. Health centers provide both preventive and curative services and serve as referral centers and practical training sites for HEWs. A health center is expected to offer the 7 BEmONC signal functions and most of the reproductive health services based on the Essential Health Services Package of Ethiopia. Primary hospitals provide both inpatient and outpatient services to an average population of 60,000 - 100,000. It has an inpatient capacity of 25-50 beds. In addition to services provided by a health center, primary hospitals provide additional services such as clinical management for cases of victims of sexual assault, and emergency surgical services including cesarean section and blood transfusion (all the 9 CEmONC signal functions). It also serves as a referral center for health centers under its catchment areas and a practical training center for undergraduate students.

Secondary level health care comprises a general hospital which provides inpatient and outpatient services to an average of 1 – 1.5 million people.

Tertiary level health care is composed of a specialized hospital that serves an average of 3.5 - 5 million people, has a standard staffing of 440 health workers and serves as a referral center to general hospitals.

CHAPTER 3: SITUATIONAL ANALYSIS

3.1. Impact analysis (mortality, morbidity)

The aim of this section of the analysis is to assess and characterize progress towards achieving the RH strategy's goals (2016-2020). As a result, the analysis is based on proposed metrics for assessing the RH strategy's effects (2016-2020): MMR, NMR, SBR, percentage of HIV infection among children born to HIV-positive mothers, and TFR (See table 1 below).

Table 1. *Targets for impact indicators, RH strategy (2016-2020)*

SN	Indictor	Baseline in 2015	Target for 2019/2020	Periodicity	Source of information	Remarks
1	Maternal Mortality Ratio (MMR)	353	199	5 years	UN estimate	Not achieved
2	Neonatal Mortality Rate (NMR)	28	10	5 years	EDHS / Vital registration	Not achieved
3	Stillbirth rate per 1000 pregnancies lasting 7 months or above	18	10	Routine / 5 years	HMIS/EDHS	Not achieved
4	HIV infection among children born to HIV+ve mothers (%)	12	0	5 years	Special facility survey	Not achieved
5	Total fertility Rate (TFR)	4.1	3	5 years	EDHS	Not achieved

Despite, the remarkable achievements in all reproductive health services the RH targets set for the year 2020 were not achieved. Some of the reasons for the failure to achieve the RH targets include: COVID-19 pandemic, low emergency health service coverage in remote areas of the country, transportation for referral of emergency cases, supplies and equipment at the health facility level, low provider population density, providers' motivation and commitment to serve the community and attract to the service, and poor community health seeking behavior.

3.1.1. MATERNAL MORTALITY

Maternal mortality is described by the World Health Organization (WHO) as the death of women during pregnancy, childbirth and puerperium as a result of direct or indirect obstetric causes. It is one of the indicators used to assess the state of maternal health.

Maternal mortality ratio (MMR) quantifies the risk of mortality associated with a single pregnancy or a single birth. By contrast, the **maternal mortality rate (MMRate)** captures both the risk of

maternal death per pregnancy or per birth (whether live birth or stillbirth), and the level of fertility in the population (i.e. both factors mentioned above).

During the MDG era, the maternal survival had improved significantly in Ethiopia which was evidenced by a decline of maternal mortality by 61% between 2000 and 2017 with an annual reduction rate of 5.5%.[1] In 2016, the government of Ethiopia reaffirmed its commitment to keep this remarkable achievement and improve further through its five-year RH strategy (2016-2020) which set an ambitious target of reducing MMR to 199 by the end of 2020.[2] (Figure 3)

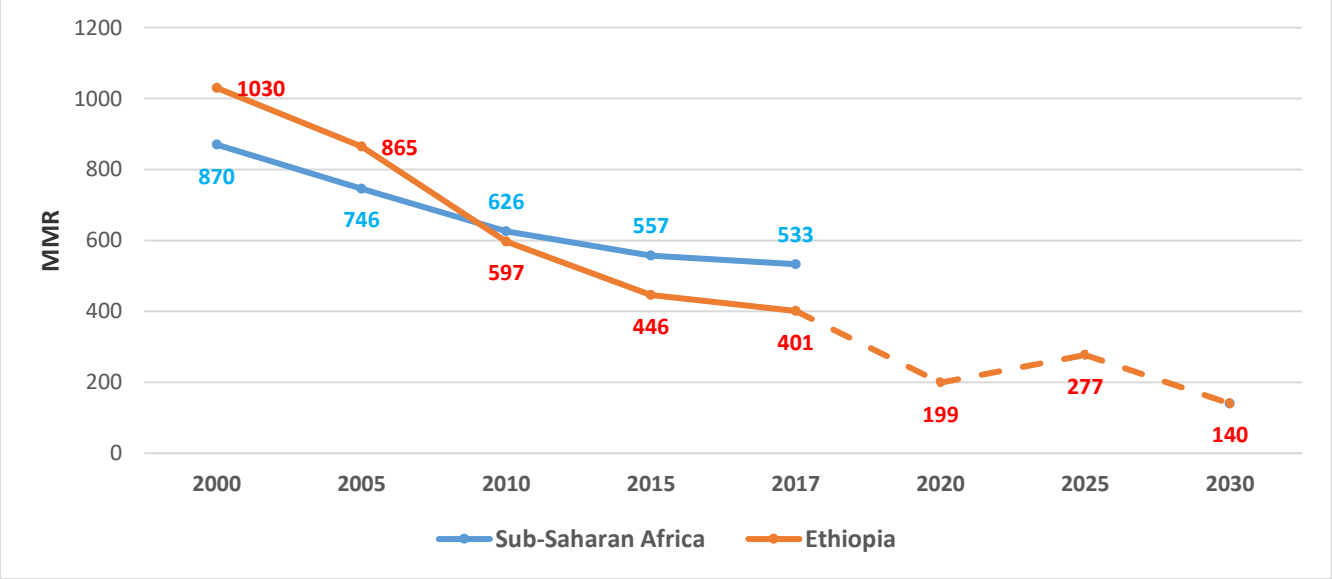

Figure 3. Trend of estimated MMR between 2000 and 2017.

Measurement of maternal mortality is difficult in Ethiopia due to lack of complete and strong vital civil registration and vital statics (CRVS) system. Hence, information on maternal mortality depends on the DHS and UN reports. Within the SDG reporting period, the latest available source of data on maternal mortality is the 2019 UN/WHO report that presents country-level estimates and trends for maternal mortality for the period between 2000 and 2017.[7]

According to the UN estimates, Ethiopia`s MMR was estimated at 401 deaths per 100000 live births (UI: 298 -573 in 2017). In terms of absolute numbers, it was reported that about 14,000 maternal deaths a year occurred in Ethiopia. This categorized Ethiopia among the three countries (including Democratic Republic of Congo and United Republic of Tanzania) having more than 10, 000 maternal deaths in 2017.[2] The life time risk of maternal death for a fifteen years old girl is estimated at 1 in 55 which is higher than the global average (1 in 190) but lower than the Sub-Saharan Africa regional average (1 in 37).

Abortion had been contributing to over 20 to 50 % of maternal deaths before 2003, but over time it has become a much less common cause of maternal death[7]. Recently, the contribution of abortion to maternal death was as low as 4%.[8] According to the 2017 countdown report, majority of maternal deaths occurred mainly due to hemorrhage (25%), pre-eclampsia/eclampsia (16%), infection (10%), and unsafe abortion 10% that are avoidable by avoiding all the three delays.[9] Obstetric hemorrhage remained the leading cause of maternal death accounting 41% in 2018, followed by hypertension during pregnancy and sepsis, accounting for 19% and 9% respectively.[10]

3.1.2. NEONATAL MORTALITY

The effort of Ethiopia in preventing childhood deaths and achieving the MDG targets was successful. However, the prevention of neonatal mortality has not been significant. The proportion of neonatal deaths from the total under-five deaths increased from 43% in 2013 to 55% in 2019[11]. With current rates, 95,000 newborns die every year. In addition, equivalent numbers of stillbirths occur, representing a "silent epidemic". Close to half of the stillbirths occur during the process of labor and delivery.

According to the Ethiopia Mini-Demographic Health Survey (EDHS) 2019, under 5 mortality decreased from 123 in 2005 to 55 in 2009 per 1000 live births. Similarly, infant mortality rate declined from 77 in 2005 to 43 in 2019 per 1000 live births. However, neonatal mortality rate was consistently high without any sign of decline stagnating at around 30 deaths per 1000 live births.

The stagnantly high rate of neonatal mortality (30 neonatal deaths per 1,000 live births in 2019) indicates gaps in access and quality of healthcare during the perinatal period. Most new born deaths occur during the first week of life. As many as half of all new born deaths occurred during the first 24 hours of life and three-quarters during the first week.[12]

According to the WHO and Maternal Child Epidemiology Estimation Group report in 2018, more than 80% of all new-born deaths are caused by preventable and treatable conditions like prematurity (26%), intrapartum asphyxia (30%) and sepsis/tetanus (18%).[13] Currently congenital anomalies are also becoming notable contributors to neonatal mortality, morbidity and disability.

[7] Abdella A. Maternal Mortality Trend in Ethiopia. Ethiop. J. Health Dev. 2010;24 Special Issue 1

[8] Health sector Transformation Plan II. Federal Democratic Republic of Ethiopia Ministry of Health.July 21, 2020

[9] (Every Woman Every Child, 2017)

[10] (Ethiopian Public Health Institute, 2018)

[11] Ethiopia Mini-Demographic Health Survey (EDHS) 2019

[12] WHO/UNICEF, Every Newborn Action Plan to End Preventable Deaths (road map), 2014

[13] WHO and Maternal and Child Epidemiology Estimation Group (MCEE), 2018

What are risk factors for new-born illness and death?

New-born deaths are inseparably linked to the health and nutritional status of the mother and the care provided during the antenatal, labor and delivery, and immediate post-partum periods. However, the care currently provided to women is suboptimal. According to the mini EDHS 2019, women aged 15-49 with live birth had 74% and 43 % at least one ANC, and ANC 4+ services respectively. Similarly, 49% of births were protected against neonatal tetanus, 50% delivered by a skilled provider, and 34% of women had a postnatal check within the first 2 days after birth.[14]

3.1.3. PERINATAL MORTALITY

Perinatal mortality rate is an indicator of the quality of pregnancy and intra-partum care. Perinatal mortality also slowly declined: 52, 37, 46 and 33 per 1000 total births lasting seven months or more after pregnancy in the EDHS 2000, 2005, 2011 and 2016 respectively. In addition, a 2016 EmONC assessment reported the institutional perinatal mortality of 39 per 1000 births.

3.1.4. CONTRIBUTING FACTORS FOR MATERNAL AND NEW-BORN MORTALITY

Despite increasing accessibility of services, there are several challenges in terms of service availability, accessibility and awareness. Uneven distribution of health resource, sub-optimal quality of care, low new-born health care seeking behavior of communities, low coverage of Kangaroo Mother Care (KMC) services, and shortage of essential health commodities and equipment at service delivery points remain to be key challenges contributing to high rates of neonatal mortality.

Most maternal deaths result from problems that are often not predictable but are almost always treatable. Weak health system such as critical lack of midwives, equipment and supplies, essential medicine, poor referral linkages, low health awareness of mothers and cultural barriers, and lack of emergency obstetric and neonatal care are the major challenges leading to poor quality of care along the continuum of care.

Although post-partum hemorrhage can kill a woman in less than two hours, a woman has between 6 and 12 hours or more to get life-saving emergency care. Similarly, most perinatal deaths occur around delivery or in the first 24-48 hours afterward. The 'three delays' model helps to identify the points at which delays can occur in the management of obstetric complications. According to MDSR 2010 EFY annual report delay one was cited as a contributing factor in 66.8% reports, delay two in 37.7% and delay three in 48.6% in 2010 EFY. Generally, delay one factors persisted as the top contributing factors to maternal death in the five years (2006 - 2010 E.C.).

[14] Mini EDHS 2019

Recommendations:

- Review the national hemorrhage response plan (2017-2019) and strengthen implementation of effective evidence based interventions that address the top three causes of maternal death.
- Strengthen the measurement system: finalize the evaluation of MPDSR system and use evidences to strengthen MPDSR system and linkage with the national CRVS system.
- Improve the quality of care:-
    - Strengthen the health system including the competencies of healthcare providers.
    - Establish an alternative mechanism that addresses financial barriers to access health care by reviewing the existing in kind re-imbursement protocol

3.1.5. ABORTION

Studies have also shown that there is a reduction in overall morbidity related to abortion. However, despite improvement in service availability and utilization over time, the case fatality rate for abortion increased from 1.1% in 2003 to 3.6% in 2007.[15] A report from Guttmacher institute also showed an increment in the number of women receiving care for complications secondary to abortion from 52600 to 103600 despite a reduction in abortion related mortality.While maintaining the strength, still more work is needed to be done to improve the quality of comprehensive abortion care and to ensure equitable access of the service across all communities.

3.1.5.1. Morbidity difference between regions

Among women with severe disease and hospitalization, severity of abortion complication is more common in less urban regions compared to Addis Ababa and Diredawa. Overall, 43% of women who required care for abortion presented with severe complications compared to 21% of those who sought care from Addis Ababa (see table 2 below).[16]

[15] Gebrehiwot Y., Liabsuetrakul T. Trends of abortion complications in a transition of abortion law revisions in Ethiopia Article in Journal of Public Health · September 2008

[16]Gebreselassie H.,Fetters T.,Singh S.,Abdella A. Caring for Women with Abortion Complications In Ethiopia: National Estimates and Future Implications. International perspectives on sexual and reproductive health 36(1):6-15 March 2010

Table 2. *Number and percentage distribution of women by severity of morbidity; and percentage of the women who were hospitalized—all according to region.*

Region	All	Severe		Moderate		Low		% hospitalized
	No.	No.	%	No.	%	No.	%	
Addis Ababa	7,233	868	12***	651	9	5,714	79	13 (9–18)**
Other	50,731	14,816	29	7,052	14	28,863	57	24 (20–27)
Dire Dawa/Harari	3,671	918	25	220	6	2,533	69	31 (15–48)
SNNP	10,896	2,724	25	1,416	13	6,756	62	20 (13–27)
Oromiya	20,310	6,093	30	2,843	14	11,374	56	26 (19–33)
Amhara	9,242	2,865	31	1,386	15	4,991	54	14 (8–19)
ASBG	3,274	1,048	32	786	24	1,440	44	24 (16–33)
Tigray	3,338	1,168	35	401	12	1,769	53	46 (34–58)

**Percentage for Addis Ababa is significantly different from percentage for other regions at p<.01. ***Percentage distribution by severity of morbidity in Addis Abada is significantly different from that in other regions at p<.001. *Notes:* All data are weighted. Hospitalization refers to a stay of at least 24 hours. SNNP= Southern Nations, Nationalities and People's Region. ASBG=Affar, Somali, Benishangul-Gumuz and Gambela.

3.1.6. FERTILITY

Fertility is one of the three principal components of population dynamics that determine the size and structure of the population of a country. The total fertility rate (TFR) in Ethiopia decreased from 5.5 children in 2000 to 4.1 children in 2019. The TFR among women in rural areas declined from 6.0 children in 2000 to 4.5 children in 2019. However, urban TFR rose from 3 children in 2000 to 3.2 in 2019 (figure 3).

Moreover, there were substantial differences in the TFR among regions, ranging from 1.8 children per woman in Addis Ababa to 7.2 children per woman in Somali. Fertility levels were higher than the national average in Somali, Afar, Oromia, Tigray, SNNP and Benishangul-Gumuz.

Low education status and the lowest wealth quintile contributed for the higher fertility rate in Ethiopia.[17] Despite the recent fertility changes in Ethiopia, the population is still growing fast with annual rate of 2.6%. If uncontrolled, the growth of the Ethiopian population will be faster, and the doubling time will further decrease to less than 25 years. This needs conscious planning to control high fertility in the country.

3.1.7. INFERTILITY

Family planning allows individuals and couples to anticipate and attain their desired number of children and the healthy timing and spacing of their pregnancy. It is achieved through the use of

[17] CSA and ORC Macro, 2000, 2005, 2011, CSA, 2016.

contraceptive methods and the treatment of infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health, the outcome of each pregnancy and educational as well as other Socio-economic attainments.

Infertility affects up to 15% of reproductive-aged couple's worldwide. The psychological burden of couples without a child can be significant. Even when a country faces population pressure, infertile couples have the rights to get support for having a child.

There are various causes of infertility, e.g. tubal occlusion from reproductive tract infections, which are often sexually transmitted, postpartum complications, unsafe abortion practices and ectopic pregnancy.

Polycystic ovarian syndrome (PCOS) can also lead to infertility. It is perceived to be a common problem in Ethiopia that deserves further review on the magnitude of the problem and its predisposing factors. Despite their importance, infertility prevention and care often remain neglected public health issues.

3.1.8. OBSTETRIC FISTULA

Because of lack of regular national surveillance and lack of confidence to disclose by many rural women (who are probably stigmatized and discriminated), estimating the incidence and prevalence of obstetric fistula (OF) is not an easy task in Ethiopia. The available community based primary prevalence studies are the EDHS 2005 and 2016, which has shown a 1% (out of the total deliveries) and 0.4% (out of the total women aged 15-49 years) prevalence, respectively. In the 2016 data, the estimated prevalence of obstetric fistula among the total deliveries was 0.6%, highest in Tigray (1.1%) and Amhara (0.7%) and lowest in Harari (0%). Although there are multiple factors, obstetric fistula is commonly associated with obstructed labor which often occurres in home deliveries. The consequence of obstetric fistula is overwhelming; it results in life-long disabilities and poor quality of life including depression and infertility. Beyond the medical conditions, the social consequences are severe. They usually are socially isolated and blamed for their condition, viewing it as punishment for sin or curse.

In one year period, in 2018, about 818 obstetric fistula patients were treated and fistula free Woreda implementation guideline was developed.[18] Preventing and managing obstetric fistula contribute to the Sustainable Development Goal 3 of improving maternal health. Obstetric fistula is preventable. It can largely be avoided by delaying the age of first pregnancy, cessation of harmful traditional practices and timely access to obstetric care. In Ethiopia, more than 2 in 3 women (70%) report having at least one of the specified problems in accessing health care.

[18] ARM Report, 2018

3.1.9. TEENAGE PREGNANCY AND CHILD MARRIAGE

Many teenage pregnancies in Ethiopia occur within marriage. Although the legal age of marriage in Ethiopia is 18 years 14.1% of girls aged 20-24 are married by age 15, and 40.3% by age 18.[19] There is large variation between regions, the highest being in Amhara region. Child marriage and teenage pregnancy has strong effects on the possibilities of girls to escape poverty. 13% of women age 15-19 have already given birth. Teenage childbearing is more common in rural than in urban areas (15 vs 5%), and among women in Afar (23%) and Somali regions (19%) compared to Addis Ababa (3%). In Ethiopia, the abortion rate is 28 per 1000 women out of which 52.2% is accounted by adolescent and youth[20].

Teenagers in rural areas are three times more likely to have begun childbearing than their urban peers: 15% of rural teenagers have had a live birth or are pregnant, as compared with 5% of urban teenagers. Afar has the highest (23.4%) followed by Somali (18.7%) and Oromia (17%) regions. There was a steady decline to 8.3% in Amhara while Addis Ababa had the lowest proportion (EDHS, 2016). Median age at first sex for women is at 16.4 years (PMA 2015).

3.1.10. SEXUALLY TRANSMITTED INFECTIONS (STIs) INCLUDING HIV

An estimated 340 million new cases of sexually transmitted bacterial infections, most of which are treatable, occur annually. Many are untreated because they are difficult to diagnose, related to poor competency of providers, and affordable services are lacking. In addition, millions of cases of mostly-incurable viral infections occur annually, including five million new HIV infections, 600000 of which are in infants owing to mother-to-child transmission.[21]

Overall, 4% of women and men age 15-49 reported having an STI and/or symptoms of an STI in one year period (2016). Fewer than one in three of women and men (32% for each) who had an STI or STI symptoms sought advice or treatment from a health professional. One percent of women and 3% of men sought advice or treatment from a shop or pharmacy. However, 67% of women and 66% men did not seek any advice or treatment.[22] The 2016 Ethiopian Demographic and Health Survey (EDHS) has shown that the national HIV prevalence among women and men aged 15-49 years was 0.9 %, with the highest prevalence being in the age range of 25-39 years. Although there is a progressive decline in its prevalence in the last decade, HIV is still one of the top public health issues because of the chronic nature of the disease, and little change in practicing risky sexual behaviors.

Effective treatment of STIs should be a major intervention to prevent both the HIV infection and the immediate and long term complications of STIs. Thus; STIs screening, treatment and follow up need

[19] Ethiopian Demographic Health Survey 2016 data downloaded from https://www.statcompiler.com/en/
[20] Ethiopian Demographic Health Survey 2016 data downloaded from https://www.statcompiler.com/en/
[21] EDHS, 2016
[22] EDHS, 2016

to be a main component of all reproductive and sexual health services. The integration of prevention and treatment of STIs including HIV within a package of reproductive health services needs to be strengthened. It is well noted that because of the close links between the different aspects, the interventions in one area of reproductive health is highly likely to have a positive impact on the others.

3.1.11. PELVIC ORGAN PROLAPSES

Little is known about the extent to which women in low and middle-income countries suffer from urological and urogynecological complications of childbirth. Pelvic organ prolapse can expressively compromise a woman's quality of life by compromising her physical, social, psychological and sexual functions. Pelvic organ disorders and its consequences have high economic burden to the patient as well to the country.

A systematic review and meta-analysis study revealed that the overall national prevalence of pelvic organ prolapse in Ethiopia was 23.52%. Being a rural resident, women having < 18.5 BMI and age > 40 were the associated risk factors for pelvic organ prolapse.[23] Another study also indicated high parity, older age, obesity, pregnancy and vaginal delivery, menopause, constipation, persistent coughing, early age at first delivery, forceps delivery, prolonged second stage labor, and prolonged heavy lifting to be contributing factors for pelvic organ prolapse.[24] Thirty-seven percent of women selling firewood in back loading for less than 2 years, and 30.3% of women selling firewood in back loading for 5-10 years are exposed for POP.[25]

In Ethiopia, factors contributing to the high proportion of POP include: low institutional delivery rate (48%), high fertility rates (4.1), and higher rates of gynecologic diseases.[26] There is so far no strategy to prevent and manage pelvic floor disorders both in private and governmental health institutions in the country.

3.1.12. MENOPAUSE

The World Health Organization (WHO) projects that women in sub-Saharan Africa can expect an increased life expectancy of 76 years on average. The prevalence of women experiencing menopause, commonly between the ages of 45 and 55, will also markedly increase. This population poses unique considerations given that sub-Saharan African women will spend a larger proportion of their lives in

23 Getnet et al, Burden of pelvic organ prolapse in Ethiopia: a systematic review and meta-analysis, 2020

24 Olsen AL, Smith VJ, Bergstrom JO, Colling JC, Clark AL. Epidemiology of surgically managed pelvic organ prolapse and urinary incontinence. Obstet Gynecol. 1997; 89:501–6.

25 Andualem Henok. Prevalence and Factors Associated with Pelvic Organ Prolapse among Pedestrian Back Loading Women in Bench Maji Zone. Ethiop J Health Sci 2017;27(3):263. doi:

26 Mini EDHS, 2019

post menopause. In Ethiopia alone, the 2007 National Census revealed 9.7 million women to be aged 30 and older with 2.1 million being in the menopausal age range of 45 to 55 years.[27]

The most commonly reported individual menopausal symptoms are hot flushes (65.9%), difficulty falling asleep (49.6%), depressive mood (46.0%), irritability (45.1%) and anxiety (39.8%). Women self-reported differing severity levels of symptoms with high severity reported in 8.4% of total Menopause Rating Scale (MRS), 1.3% of somatic, 10.6% of psychological, and 8.4% of urogenital scales.[28.]

3.1.13. PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV, SYPHILIS AND HEPB

The estimated MTCT rate of HIV for 2018 is 13.4%. Ethiopia is not on track to achieve virtual elimination of MTCT.[29] (Figure 4)

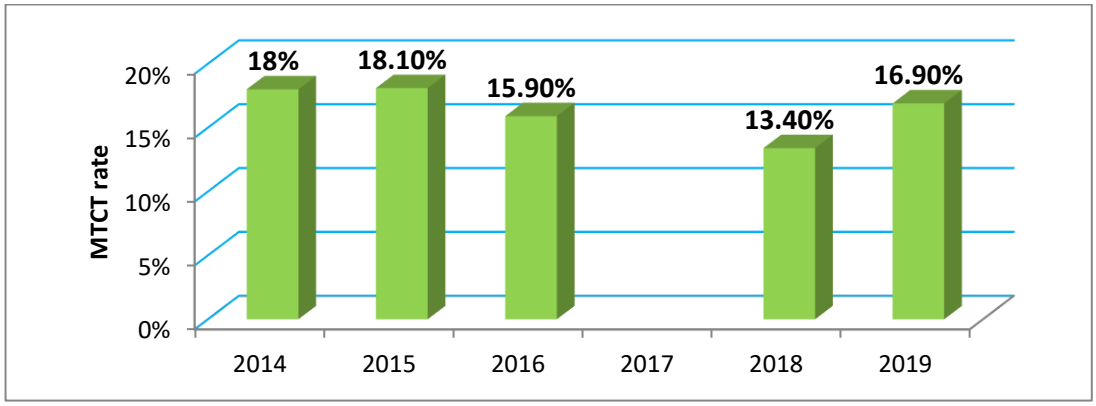

Figure 4. UNAIDS, MTCT rate with time from 2014 -2019.

3.1. 14. MATERNAL, NEWBORN AND ADOLESCENT NUTRITION

Maternal malnutrition is a worldwide public health problem affecting a high proportion of pregnant women. Poor nutritional status harms women's own health and is a risk factor for intrauterine growth status and other poor obstetrical outcomes. Severe anemia during pregnancy is associated with increased maternal mortality.

[27] Engida Y. et al,:Prevalence and severity of menopause symptoms among perimenopausal and postmenopausal women aged 30-49 years in Gulele sub-city of Addis Ababa, Ethiopia, 2017, BMC

[28] Engida Y. et al,:Prevalence and severity of menopause symptoms among perimenopausal and postmenopausal women aged 30-49 years in Gulele sub-city of Addis Ababa, Ethiopia, 2017, BMC.

[29] UNAIDS report.

Poor nutritional status during pregnancy and pre pregnancy is linked to poor birth outcomes and subsequent linear growth.[30] Maternal height is strongly associated with reduced risk of stunting and the intergenerational nature of maternal and infant nutrition is well documented.[31]

Furthermore, maternal mortality in Ethiopia is high (412 / 100,000 LB (EDHS 2016)), as is under nutrition in reproductive age women with 22% underweight (BMI < 18.5) and 24% anemia prevalence during pregnancy.

Several studies reported that malnutrition increases the risk of poor pregnancy outcomes including obstructed labor, premature or low-birth-weight (LBW) babies and postpartum hemorrhage. An adequate well-balanced diet is the foundation for child survival, health and development. Well-nourished children are more likely to be healthy, productive and ready to learn. Under-nutrition, by the same logic, is devastating. It blunts the intellect, saps productivity and perpetuates poverty.

Maternal malnutrition is caused by a complex interaction of a multitude of factors. Severe illness, breastfeeding and having several children below 2 years of age are negatively associated with maternal nutritional status. In contrast; higher maternal age and socio-economic status, and household food security have positive effect. In addition, social factors such as marital status, education and income also have influence on maternal nutritional status.

Besides, poor nutrition during pregnancy, especially deficiencies of certain vitamins and minerals, have been associated with negative pregnancy outcomes for both the mother and the infant. Severe iron-deficiency anemia has been linked to preterm labor, poor anthropometric measures and birth asphyxia. Studies on the impact of maternal malnutrition during lactation are rare. Several reports suggested a possible association of malnutrition among lactating mothers with production of smaller quantities of breast milk, and low levels of B vitamins, vitamin A and essential fatty acids in breast milk.

According to EDHS 2016, maternal under nutrition has declined from 30% in 2000 to 22% in 2016. However, Ethiopia is still among countries with a high burden of maternal malnutrition. It is reported that 17% of pregnant women aged 18-49 are malnourished and have low awareness of prenatal nutrition, which may relate to increasingly high rates of maternal and infant mortality. Therefore, strengthening integrated nutritional intervention with maternal health is very important.

3.1. 15. REPRODUCTIVE ORGAN CANCERS (ROCs)

The completed RH strategy highlighted that, lack of data source was the critical challenge for the estimation of the burden of ROCs in Ethiopia. According to the International Agency for Research

[30] CSA E, International I. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: 2012.

[31] Ramakrishnan U, Martorell R, Schroeder DG, Flores R. Role of Intergenerational Effects on Linear Growth. The Journal of Nutrition. 1999; 129(2):544.

on Cancer (IARC) estimation the numbers of cervical, breast, female genital organ cancers and male genital organ cancers in Ethiopia in 2012 were approximately 7,095, 12,956, 10,181 and 1,427 respectively. Factors that attributed to the morbidity and mortality of women from these common cancers include delay in reporting, lack of mass screening, and lack of radiotherapy and chemotherapy. (RH strategy 2016-2020)

Cervical cancer incidence and mortality has been drastically reduced in high resource countries during the last decades. This can largely be attributed to the implementation of screening programs for the detection of precancerous lesions and HPV, and improved therapy.[32] However, in low and middle income countries including Ethiopia cervical cancer remains to be a significant health problem where access to screening programs for the detection of precancerous lesions and HPV is limited.

HIV-positive women have an almost 1.5 times increased risk of diagnosis at a more advanced stage. In Ethiopia cervical cancer patients are diagnosed late leading to advanced stages at diagnosis. Measures to raise awareness about cervical cancer, to increase screening and shorten the time interval from recognition of symptoms to diagnosis are urgently needed.[33] Accordingly, it was planned to scale up cervical lesion screening using VIA, strengthen HPV vaccination, establish oncology centers and strengthened National Cancer Surveillance and Registry system.

3.2. Outcome and output analysis

3.2.1. FAMILY PLANNING

Modern contraceptive use among married women increased over the last 15 years, from 8% in 2000 to 41% in 2019. According to Mini EDHS 2019, the most popular contraceptive methods used are injectable (27%) followed by implants (9%), and IUD and the pill (2% each). The contraceptive prevalence rate (CPR) among married women increases with age, peaking at age 20-24 (52%) before declining steadily to 18% among women age 45-49. Urban women are much more likely than their rural counterparts to use any method of contraception (50% versus 38%). Besides, CPR ranges from 3% in Somali to 50% in both the Amhara Region and Addis Ababa city administration.

Contraceptive use increases with women's education and household wealth. Fifty-eight percent of women with more than secondary education are using any contraceptive method compared to 32% of women with no education. Likewise, 28% of women in the lowest wealth quintal are using any contraceptive method compared to 53% of women in the highest quintal. Women with no living children (28%) and those with five or more children (32%) are the less likely to use any method of contraception compared with those who have 1-2 children (54%) or 3-4 children (44%).

[32] Aranda S Et. al. Ending cervical cancer: a call to action. Int J Gynecol Obstet. 2017; 138:4–6

[33] Matthias B. Et al. Cervical cancer in Ethiopia – predictors of advanced stage and prolonged time to diagnosis, BMC.

EDHS 2016 data showed that 22 % of currently married women have an unmet need for family planning services. At present, 59 % of the potential demand for family planning being met is almost entirely by modern methods. Thus, if all married women who said they want to space or limit their children were to use family planning methods, the CPR would increase from the current level of 41% (2019 Min EDHS) to 63%.

Among family planning methods, short acting injectable (35.1%) contributes the highest share of method use whereas the Long Acting Reversible Contraceptives (LARCs) increased gradually from 0.6% in 2000 to 10% in 2019. On the other hand, the met need of contraceptive use among women aged 15- 49 years has increased from 45 % in 2000 to 58% in 2016.

Regarding discontinuation of contraception among women who started an episode of contraceptive use within the two years preceding the survey, the percent of episodes discontinued within 12 months was 37.2 %.

As per the national PMA survey from 2014-18, the overall quality of family planning counseling was low with only 30% of women reporting to have received sufficient information during counseling. The likelihood of good quality counseling was the least among those who had no formal schooling compared to those who had higher educational attainment. Women from the wealthiest quintile were nearly 2 times more likely to receive good quality counseling compared to women in the lower wealth quintile. Women from rural areas were 1.51 times more likely to have received good counseling compared to those in urban areas.

Amhara residents were less likely to receive good counseling compared to those in SNNPR. Women who acquired their method from the private sector had worse counseling compared to those from the public sector. Those using short-acting methods were more at risk of receiving lesser quality counseling compared to users of long-acting methods. Improving the quality of contraception counseling for women across all demographics, including wealth quintiles and education, is a crucial strategy to support positive reproductive health outcomes with a rights-based focus.

3.2.2. ABORTION CARE

The number of abortions increases overtime, it was 326200 (22 abortions per 1000 women of 15-49) in 2008, which raised to 620,300 by 2014. Over time, the proportion of women receiving legal abortion at health institutions also increased from 27% (88074) in 2008 to 53% (32859), an increase in service utilization of safe abortion.

In Ethiopia, the legal framework has expanded to include wider range of indications for accessing safe abortion care. The previous abortion law which allowed abortion to be performed only under circumstances to save the life of the women has now made abortion legal in case of rape, incest, fetal

impairment, minors, physical and mental disability.[34] Following the adoption of the new law, the country has prepared a national implementation and technical guideline on abortion which is in line with World Health recommendation on clinical management of safe abortion.

Since the revision of the country's abortion law, there is a marked increase in the proportion of abortions that are performed legally. The number of abortions that are performed outside health facilities have also diminished remarkably.[35]

Task shifting allowed significant proportion of abortion cases to be treated by midlevel health providers. In the year between 2008 and 2014, the number of abortion cases managed by physicians has decreased from 52% to 18% while the number of abortions managed by midlevel providers increased from 48% to 83%.[36]

Collaboration with the private sector, non-governmental organizations and funders has contributed enormously to this achievement of increased access and task shifting throughout the country. The partnership helped in increasing the capacity and resources needed by mid level health care workers in providing comprehensive abortion care.[37]

There is also regional disparity in terms of post abortion cases with severe complications. This indirectly shows that areas where there is increased access to safe abortion services have low proportion of post abortion cases with severe complication.[38]

3.2.3. PRE-PREGNANCY/PRECONCEPTION CARE

Global situation of preconception care

Globally, 4 out of 10 pregnancies are unplanned and this indicates that 40% of pregnancies do not have essential health services or provided too late. Providing counseling on adequate nutrition and providing proper medication including folic acid and iron before and during pregnancy prevents maternal deaths. Globally 20% of maternal deaths occur because of malnutrition and iron supply.[39] Similarly, neonatal deaths could have been prevented with proper preconception care. Maternal tetanus vaccination, avoiding habits of smoking, providing HIV testing and PMTCT intervention saves neonatal deaths. Preconception care using maternal tetanus vaccine prevents 58000 neonatal

[34]Ethiopia Ministry of Health, *Health Sector Development Program IV in Line with GTP, 2010/11–2014/15,* Addis Ababa, Ethiopia: Federal Democratic Republic of Ethiopia, 2010.
[35] Guttmacher institute Induced Abortion and Postabortion Care in Ethiopia, 2017.
[36] Gebrehiwot et al. Changes in Morbidity and Abortion Care in Ethiopia After Legal Reform: National Results from 2008 and 2014.
[37] Health Worker role in providing safe abortion care and post-abortion contraception, WHO 2015
[38] Ethiopian Emergency Obstetric and Newborn Care (EmONC) Assessment 2016.
[39] Meeting to develop a global consensus on preconception care to reduce maternal and childhood mortality and morbidity. Geneva, World Health Organization, 2013.

deaths. Eliminating smoking can prevent up to 24% of sudden infant death syndrome. Some of the causes of maternal and newborn deaths have a global evidence of reducing the burden of diseases as there is growing experience in implementing preconception care initiatives both in high-income countries, such as Italy, the Netherlands and the United States, and in low- and middle-income countries, such as Bangladesh, the Philippines and Sri Lanka.

National situation of preconception care

The awareness and utilization of preconception care in Ethiopia is very low. Limited studies on preconception care showed that women's knowledge on preconception care is as low as 27.5%.[40] Another study showed that utilization of preconception care is much lower, 18.2%. Other recent studies showed that the knowledge and practice of professionals in Ethiopia towards preconception care varies among different health care settings and professions. A study done in Tikur Anbassa Hospital in 2018 showed that the obstetrician and gynecologist had better knowledge compared to internists.[41] According to two studies done in northern and Southern Ethiopia good knowledge on PCC was seen only in 52% and 31% of providers respectively requiring an approach of providing capacity building to health care providers on importance of PCC and the PCC packages.[42,43]

3.2.4. ANTENATAL CAR, DELIVERY AND POST NATAL CARE

Antenatal care

Skilled care during pregnancy and delivery are essential interventions that ensure good maternal and neonatal outcome. Universal access and quality ANC and delivery care will help to end preventable maternal and neonatal mortality. According to EDHS the first ANC (ANC1) coverage significantly improved from 62% in 2016 to 74 %, over 5 years.[44] Furthermore, the number of pregnant women who had four or more visits has increased from 32% to 43%. However, a significant proportion of women (43%) discontinued ANC before getting ANC4 services and only 20% of women had started early ANC in the first trimester.[45]

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[40]Ayalew Y, Mulat A, Dile M, Simegn A. Women's knowledge and associated factors in preconception care in adet, west Gojjam, northwest Ethiopia: a community based cross sectional study. Repro d Health 2017 May 12;14(1):15.

[41] Wolela Alemu Seman, Sisay Teklu Waji. *Ethiop Med J, 2019, Vol. 57, No. 2*

[42] Bekele M., Gebeyehu N. etal. Knowledge of Preconception Care and associated Factors among Healthcare Providers Working in Public Health Institutions in Awi Zone, North West Ethiopia, 2019: Institutional-Based Cross-Sectional Study.Journal of Pregnancy Volume 2020, Article ID 6978171, 7 pages https://doi.org/10.1155/2020/6978171

[43] Kassa A, Human SP, Gemeda H (2018) Knowledge of preconception care among healthcare providers working in public health institutions in Hawassa, Ethiopia. PLoS ONE 13 (10): e0204415. https://doi.org/10.1371/journal.pone.0204415

[44] Ethiopian Mini Demographic and Health Survey: 2019

[45] Ethiopian Demographic and Health Survey: 2016

Even though, there is an improvement in ANC coverage, the quality of care women receive is still poor. In 2016, only less than half (45%) of them were informed of pregnancy complications or danger signs of pregnancy. Between the year 2000 and 2016, there is an improvement in service trend for key investigation modalities required during pregnancy (Table 3). The number of women protected from tetanus during their last birth has increased only from 48% to 49% in the years between 2011-2016.[3,46] The number of women that received iron during pregnancy also increased from 17 to 42% in the same year.

Table 3. *Service trend between 2000 and 2012.*

S/N	Service provided	EDHS 2000	EDHS 2016
1	Urine sample taken	41%	66%
2	Blood sample taken	54%	73%
3	Blood pressure measured	72%	75%

According to the annual report by MOH in 2019, there is a significant disparity in ANC between the regions with the highest in Addis Ababa (81.8%) and the lowest in Somali (11.1%).[47]

More over according to MEDHS there is also inequality in ANC 4+ service utilization among urban (58.7%) and rural (37.4%), uneducated (32.4%) and with more than secondary level education (78.9%), lowest (20.6%) and highest (69.7%) wealth quintiles.[48]

As recommended by World Health Organization, one way of reducing maternal mortality is by improving the availability, accessibility, quality and use of services for the treatment of complications that arise during pregnancy and childbirth by Emergency Obstetric Care. The met need for EmONC services is still very low (18%). According to the WHO, a minimum of 5 EmONC facilities is needed for every 500,000 population.[49] Based on this, in 2016, the country was expected to have a minimum of 921 facilities to meet this standard. But only 370 (40%) of the recommended facilities were able to provide EmONC services.

Delivery care

The government of Ethiopia has invested more to expand accessibility of health facilities and free maternal health services. Skilled delivery increased from 6% in 2005 to 50% in 2019, indicating more than half of deliveries continue to take place at home. In addition there is inequality of service

[46] Ethiopian Demographic and Health Survey: 2011
[47] Ministry of Health Annual Performance Report 2019
[48] Ethiopian Mini Demograhic and Health Survey 2019
[49] WHO, monitoring emergency Obstetric care handbook, 2009

utilization between urban (72%) and rural (43%).[50] The caesarean delivery rate was 2.7 percent, though there were large regional disparities; cesarean delivery rates ranged from 25 percent in Addis Ababa to less than 1 percent in Afar and Somali regions.

Postnatal care

A significant number of maternal deaths occur in the first 48 hours postpartum. This makes the first two days post-delivery an important period to identify and manage any life-threatening condition for both the mother and the newborn. This is also a high time to advise women on important health components including counseling on family planning and newborn care. Based on EDHS data, there is an increase in the number of women who received a check-up within two days after delivery. The 2018 national guideline on post natal care has given emphasis on the importance of staying for 24 hours following delivery.[51] However, there is lack of implementation data to show the level of implementation of this guide at the country level.

3.2.5. PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV, SYPHILIS AND HEPB

The Ethiopian Federal Ministry of Health (FMOH) endorsed Option B+ in August 2012 as an approach to avert new pediatric HIV infections and improve the survival of mothers and their babies. The National Operational Plan (December 2012) was developed to guide the implementation roll out of Option B+ strategy throughout the country. By December 2013, most sites across the country have introduced Option B+.

Access and utilization of PMTCT services also expanded to 2865 health facilities in the country (84% of public facilities offer PMTCT services, but only 5% of privates). Rural facilities have highest percentage, 59% of facilities offer PMTCT services (SARA, 2018 report). Implementation of Continuous Quality improvement (CQI), dashboard mother baby cohort analysis and EID point of care testing are some of the initiatives that have been implemented to improve quality and access of PMTCT services.

Key achievements

To prevent the transmission of HIV from mother to child, all mothers are expected to have HIV testing during ANC, labor and delivery, or post-natal care visit. Comparison of ever tested for HIV between EDHS 2011 and EDHS 2016 among females and males showed a promising trend although more

[50] Ethiopian Mini Demographic and Health Survey 2019

[51] Implementation guide for 24 hours' postnatal care and stay, EMOH 2018

males were tested than females in the age group 25-49. This shows much effort is needed to Prevent Mother to Child Transmission (PMTCT) of HIV. (Figure 3)

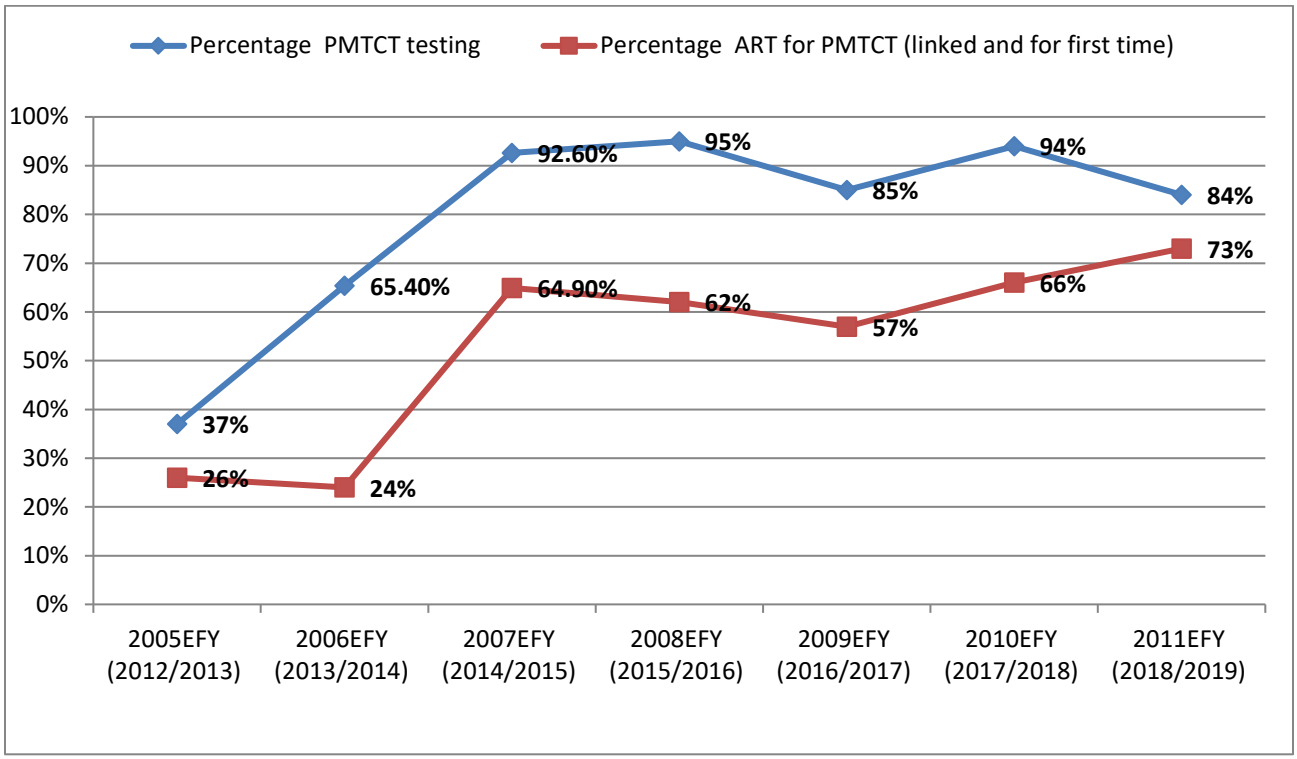

Figure 5. Testing for HIV among pregnant and lactating women – DHIS2

Nationally, there were 24,641 estimated HIV positive mothers in 2018/2019 of which 73% mothers received ARV. From the total mothers, 38% of them were newly diagnosed in the fiscal year and the remaining, 62% were known HIV positive and linked to PMTCT. About 65.6% of HIV exposed infants received HIV test within 12 months and 46.1% of HEI received ARV prophylaxis (MOH, 2019). The proportion of HIV positive pregnant and lactating women who received Antiretroviral Treatment (ART) to prevent MTCT of HIV, and the proportion of infants born to HIV-positive women receiving virologic testing for HIV also showed good progress. Overall, improving the proportion of infants born to HIV positive mothers who received ARV prophylaxis needs much effort. The regional disaggregation also shows Somali region to be the least performing. Syphilis screening for pregnant women showed progress for the last five years from 36.5% in 2015 to 65.9% in 2019.

Key challenges

The country has witnessed that several demand and supply side challenges continued to hamper implementation of National Strategic Plan for the Elimination of Mother to Child Transmission of HIV and Syphilis (2017-2020). Population based knowledge on pregnancy-related HIV transmission remained low for years. Results from the 2016 Ethiopia Demographic Health Survey (EDHS) indicated that 43% of women and 45% of men do not know that HIV can be transmitted by all the

three modes of transmission, i.e. during pregnancy, labor and delivery and breastfeeding. Only 51% of women and 61% of men were found to know that the risk of MTCT can be reduced by mothers taking special drugs. Challenges on the supply side include failure to implement quality improvement interventions, gaps in linking HEI immediately after birth (most are linked when they return for vaccination), gaps in maternal and HEI cohort monitoring analysis, shortage of DBS kits and interruption of EID testing, stock out of co-trimoxazole syrup for HEIs, poor performance in implementing enhanced postnatal prophylaxis (only about half of the visited facilities started implementation) and lack of trained staff.

3.2.6. ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH (AYRH)

The past AYH strategies have contributed to increasing awareness levels, raising contraceptive prevalence rate, reducing the rate of early marriage and improving women's and young people empowerment in Ethiopia. However, there is still a great disparity of contraceptive utilization when taking residence into account. Early sexual engagement in the form of marriage or otherwise limits girls' opportunities and compromises their health. In Ethiopia, early marriage is a serious concern where 19% of Ethiopian girls are married before their 15th birthday. However, this has either stabilized or declined in recent years. Although contraceptive use by unmarried girls is generally well below 50%, the younger girls (15-19 years) are relatively better than those 20-24 years of age.

Unmet need for family planning among young girls has declined over the years 2000-2016 although the problem is still an issue. Unmet need did not decline satisfactorily with age 15-19 having more unfulfilled than those 20-24 years of age.

Evidences on maternal health service utilization among married young girls reveal that ANC, skilled birth attendance and postpartum care has slowly improved over the years. Nonetheless, the level of such maternal health service use is unacceptably low.

The preceding evidences altogether show SRH indicators are worrying particularly in terms of the slow changes over the last 20 years. Good examples with slow change but strong impact on the future of adolescents and youth are: median age at first sex, marriage, contraceptive use among adolescents and youth, engagement with multiple sexual partner and condom use, comprehensive knowledge on HIV and AIDS and ever tested for HIV. The implication is critical in light of Ethiopia's commitment to the global agreements such as SDGs and health sector transformation plan.

3.2.6.1. HIV/AIDS and STIs among adolescents and youth

According to the EDHS 2016 report, the comprehensive knowledge of HIV among adolescents and youth, especially among rural females is very low. Only 16 % of rural females had comprehensive HIV knowledge, compared to 38 % of rural males, 39 % of urban females and 48 % of urban males. By contrast, large proportions of adolescents and youth knew where to get voluntary counseling and testing (VCT) for HIV. Over 90 percent of urban youth knew where to get VCT, while 82 % of rural

males and 69 % of rural females knew where to get the test. Urban females were the most likely to have undergone VCT (65 %), followed by urban males (59 %).

A meta-analysis from Sub-Sahara Africa including Ethiopia, documented that of 19,148 males aged 15–24 years who had sexual intercourse 12 months preceding the survey, 75% of those 15-19 years of age were engaged in unprotected sex.[52]

3.2.7. RH SERVICES IN EMERGENCY SITUATION

Humanitarian crises around the world are growing in magnitude, frequency and duration, as is the need for assistance including in meeting the RH needs of adolescent boys and girls. Of the nearly 100 million people in need of humanitarian assistance globally, approximately 26 million are women or adolescent girls of reproductive age. Natural disasters, human-made emergencies, and protracted conflicts disrupt the support systems that many adolescents, such as family, social, and economic structures. In these settings, education, social support, and health systems are suspended or unavailable leaving young people without access to SRH information and services when they need them most.

During emergencies, providing the full range of reproductive health services remains a significant challenge due to the lack of infrastructure, incomplete supply of health commodities and limited capacity of the health personnel during emergency situation. It is at least as outlined in the minimum initial service package (MISP) for sexual and reproductive health to be provided during the emergency situation, when it happens.

3.2.8. GENDER-BASED VIOLENCE

Gender-based violence (GBV), with intimate partner violence as its most common form, is highly prevalent in many societies, where it erodes social cohesion and development. Emergency situations, such as the ongoing COVID-19 pandemic, aggravate the threat of GBV to individuals, families and societies.

According to WHO estimates, globally approximately one woman in every 3 (35%) has experienced physical and/or sexual violence by an intimate partner or sexual violence by someone else at some point in their lives, most of these by intimate partners[53].

The age difference between a woman and her intimate partner has a positive effect on emotional and sexual violence while the opposite is true for physical violence. Moreover, physical violence was significantly associated with place of residence, and husband education. Both emotional and sexual

[52] Erulkar A. Early Marriage, Marital Relations and Intimate Partner Violence in Ethiopia. International Perspectives on Sexual and Reproductive Health. March 2013; Vol. 39(No. 1, pp. 6-13).
[53] WHO, LSHTM, SAMRC, 2013.

violence were predicted by wealth of the household and husband's employment status.[54] In response to these international conventions and legal framework, the health sector is putting efforts to translate these commitments to action and adopted various measures to prevent and respond to GBV/SV.

Based on its international obligations, Ethiopia has adopted various policies and laws against various forms of GBV/SV.[55] The Federal Democratic Republic of Ethiopia (FDRE) Constitution protects women from any form of discrimination and violence. The revision in the legal and policy framework, such as Revised Criminal Law and Federal Family Law, Proclamation No. 1064/2017 which prohibits sexual harassment at workplace, etc. have created an enabling environment for the prevention of GBV/SV, the protection of survivors and accountability of perpetrators. Despite these remarkable progresses being registered, there remain some gaps in the legal enforcement like the lack of adequate protection for domestic violence survivors are among few of others.

The health sector is better placed to respond to GBV given its position as the first entry point to the different range of services that should be available to survivors of GBV. Women face challenges to access health service because of "lack of information about sexual and reproductive health, poor perceptions about sexual and reproductive health, feeling of shame, and fear of being seen by others, restrictive cultural norms, lack of privacy and confidentiality, and unavailability of services".[56]

The health sector has taken various measures in support of the policy measures by putting in place structural pillars to address structural gender inequality issues in the health sector and to prevent and protect survivors of GBV. It has established a Women, Children and Youth Affairs Directorate within the Federal Ministry of Health and assigned gender focal points at regional, zonal, and Woreda offices.[57]

FMoH in collaboration with its stakeholders took measures that put in place frameworks and structures to prevent and respond to GBV. Among them, the major actions are development of GBV guidelines and protocols, Establishment of one-stop Centers, the ministry of health engagement in the coordination efforts, incorporation GBV in the teaching curriculum of medical schools, the banning of medicalization of Female Genital Mutilation/Cutting (FGM/C) and Trainings and awareness creation efforts.

[54] Kidus Y. et al. Time for action: Intimate partner violence troubles one third of Ethiopian women

[55] Ethiopia ratified CEDAW, ICCPR, CRC and ACHPR that protect women from any forms of violence. Under article 9 (4) of the FDRE Constitution, these international human rights instruments are integral part of the law of the land.

[56] USAID, 2019, Gender-Based Violence Landscape Analysis- USAID/Ethiopia Transform: Primary Health Care Project, p. III.

[57] USAID, 2019, Gender-Based Violence Landscape Analysis- USAID/Ethiopia Transform: Primary Health Care Project, p. III.

3.2.8.1. Female Genital Cutting

Female genital cutting (FGC) is traditionally practiced satisfying the demand of the local culture and men as well for no health benefit. It is globally recognized as a violation of fundamental human rights of girls and women that causes severe physical and psychological trauma. According to WHO 2020 estimate, approximately 3 million girls are still at risk of FGM every year at the global level.

Data from the latest Ethiopia Demographic and Health Survey (EDHS 2016) show that 65 per cent of women and girls aged 15–49 years, 47 per cent of girls aged 15–19 years, and 16 per cent of girls under 15 years are circumcised. Ethiopia is home to 24 million women and girls who have experienced FGC. FGC is not, however, a homogenous phenomenon; there are disparities across regions and settings. For example, nationwide, FGC is more prevalent in rural areas (68 %) than urban areas (54 %). Amongst women and girls aged 15–49 years, Tigray and Gambella have the lowest prevalence (24 % and 33 % respectively), and Somali and Afar regions have close to universal prevalence (99 % and 91.2 % respectively).

In Ethiopia, the EDHS showed a decrease in the national prevalence of FGC over the past 15 years i.e. from 80 per cent in 2000 to 65 per cent in 2016. The overall level of FGC among girls aged 15 to 19 years has decreased from 87 per cent in 1970 to 47 per cent in 2016. Ethiopia has pledged to eliminate FGC and early marriage by 2025 during the Global Girls' Summit in London held in 2014, including increasing the budget for the effort to end the practice altogether or decrease it by 10%.

3.2.9. REPRODUCTIVE HEALTH FOR HOMELESS AND STREET DWELLERS

The number of street dwellers in Ethiopia is rapidly increasing, particularly in major cities.[58] What is certainly known is that their number is increasing for various reasons, including the global population growth, poverty, rapid urbanization, and the AIDS pandemic.[59] Street dwellers are considered one of the vulnerable groups whose survival and developmental progress is jeopardized and who are in need of alternative health care services.[60] For younger people, their vulnerability is aggravated because of a lack of understanding of the changes associated with adolescence.

Street dwellers are exposed to harmful practices such as substance abuse, gambling and engaging in risk sexual activities including commercial sex work.[61] Living on the street without any family support and protection makes street people more vulnerable to a range of sexual and reproductive

[58]Kassa M, Buruh G, Berhe S, Aregay A, Berhe H. Prevalence and determinants of substance abuse among street children in Mekelle city, Tigray, Ethiopia. J Bio Innov. 2014; 3(6):269–82.

[59]Kebede SK. The situation of street children in urban centers of Ethiopia and the role of NGO in addressing their socio-economic problems: the case of Hawassa City. Int J Acad Res Educ Rev. 2015;3(3):45–57.

[60]WHO. Understanding sexual and reproductive health including HIV/AIDS and STDs among street children. Geneva: WHO; 2000.

[61] Consortium for Street Children: State of the World's Street Children: Research, Street Children serious. https://www.streetchildren.org/reStrategic Direction urces/(2011). Accessed 15 May 2019.

health problems such as sexual violence, unwanted pregnancy and sexually transmitted infections.[62] Moreover, homelessness facilitates HIV transmission and its progression due to lack of nutrition and co-infections with other problems.[63] Substance use, exchanging sex for money and risky sexual behavior among street dwellers may increase the likelihood of STIs.[64] HIV is terribly problematic for factory workers. In Ethiopia, a cohort study found that 8.5 % of factory employees were HIV-positive, with an incidence of 0.4 per 100 person-years.

3.2.10. REPRODUCTIVE HEALTH SERVICES FOR FACTORY WORKERS

Youth working in factories and industrial parks are highly vulnerable in the context of the covid-19-related economic downturn and are also at heightened risk of contracting the virus due to the crowded nature of their workplaces and on-site accommodation. According to a recent study in Ethiopia, youth workers were more likely victims to verbal violence by supervisors and management in the factories. Many youth workers are migrants living apart from their families and have limited social support networks to provide support and guidance, especially in the stress-inducing context of the covid-19 pandemic.[65] Only 63 (16.8%) factory workers were receiving health and safety training. The magnitude of occupational injury was high (32.6%). Sex, Educational status, utilization of PPE and safety training in both quantitative and qualitative studies were factors for injury in building construction workers.[66]

HIV transmission is a risk for factory employees in low- and middle-income countries (LMICs). In order to prevent HIV in this population, interventions are required. According to a study report 25% of male factory workers were involved in family planning practices. Educational status is a significant predictor of involvement on family planning services. Besides, those who stayed in marriage for 4 to 13 years were about 18 times more likely to be involved on family planning compared to respondents stayed more than 22 years.[67] However, industrial jobs gave unemployed people a steady income that came at substantial risk to their health.[68]

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[62]KA, Handema R, Schmitz RM, Phiri F, Comm H, Kuyper KS, et al. Multi-level risk and protective factors for substance use among Zambian street youth. Subst Use Misuse. 2016;51(7):922–31.

[63] Bhunu CP. Assessing the impact of homelessness on HIV/AIDS transmission dynamics. Cogent Mathematics. 2015;2(1):1–13.

[64]Tyler KA, Whitbeck LB, Hoyt DR, Yoder KA. Predictors of self-reported sexually transmitted diseases among homeless and runaway adolescents. J Sex Res. 2000;37(4):369–77.

[65] Tsinu A. Et al. Experiences of vulnerable urban youth under covid-19: the case of youth working in factories and industrial parks, Ministry of women, children and youth, UNFPA, 2020

[66]Teferi G. Et al: prevalence of occupational injury and associated factors among building construction workers in Dessie town, northeast Ethiopia; 2018

[67]Walle, Yeshareg, and Zelalem Alamrew. "The current states of male involvement on family planning and factors correlated with among male factory workers in Bahir Dar City." *Am J Public Health Res* 2.5 (2014): 188-197.

[68]New Haven, September 26, 2016

A systematic review indicated that educational intervention increased condom use and reduced the use of recreational drugs and alcohol before sex. Community interventions that proactively provide HIV counseling and testing (HCT) services increase the detection rate of HIV and other sexually transmitted diseases (STDs).[69]

3.2.11. MALE INVOLVEMENT IN REPRODUCTIVE HEALTH SERVICES

Men's participation in family planning (FP) and reproductive health (RH) can benefit their partners and children, as well as the men themselves. Slow but steady progress has been made in broadening the vision of strategically involving males in FP and RH (Dunn & Gage, 2010). Men should be encouraged to be supportive partners of women's RH while also addressing their own RH needs, and involved as change agents in their families and communities, according to gender experts (Greene, et al., 2006). Spending money on well-designed health initiatives that encourage men and boys to engage in more gender-equitable behaviors can be seen as an investment in a bigger process of gender transformation.

Global evidence demonstrates the positive effect of men's involvement on family planning use, antenatal care (ANC), safe birth practices, and postnatal care (PNC). Male involvement leads to improved family planning, ANC visits, birth and complications preparedness, use of skilled birth attendants, birthing in health facilities, postpartum care, and reduced post-partum depression.[70]

3.2.12. PROVIDER SUPPORTED SELF CARE

Health systems around the world are being challenged by increasing demand for care of people with COVID-19, compounded by fear, stigma, misinformation and limitations on movement that disrupt the delivery of health care for all conditions. When health systems are overwhelmed and people fail to access needed care, both direct mortality from an outbreak and indirect mortality from preventable and treatable conditions increase significantly.[71]

Worldwide, an estimated shortage of 18 million health workers is anticipated by 2030, a record 130 million people are currently in need of humanitarian assistance, and disease outbreaks are a constant global threat. At least 400 million people worldwide lack access to the most essential health services.

[69]Dahui Chen1 et. al. †Efficacy of HIV interventions among factory workers in low- and middle-income countries: a systematic review

[70]Yargawa, Judith and Jo Leonardi-Bee. 2015. Male involvement and maternal health outcomes: systematic review and meta-analysis. Journal ofEpidemiology and Community Health: 69:604 – 612.

[71]Parpia AS, Ndeffo-Mbah ML, Wenzel NS, Galvani AP. Effects of response to 2014–2015 Ebola outbreak on deaths from malaria, HIV/AIDS, and tuberculosis, West Africa. Volume 22, Number 3—March 2016 - Emerg Infect Dis, 2016;22(3):433-441. doi:10.3201/eid2203.150977

There is an urgent need to find innovative strategies that go beyond the conventional health sector response.

In Ethiopia, there is limitation on staffing health facilities with sufficient number of trained and motivated health workers, supported by a well maintained infrastructure and a reliable supply of commodities, equipment and technologies, backed by adequate funding. Furthermore, there is also a challenge in access to the most essential health services. Currently, in the context of COVID-19, our dependencies on a stretched health workforce are brought to the forefront, demanding a significant support and community engagement. Possible shift of the health workforce and the health system towards COVID-19 response coupled with fear of communities to seek care contributed towards low utilization of most essential RMNCAYH-N health services could negatively impact the gains of the health system realized over decades.

Self-care interventions are among the most promising and exciting new approaches to improve health and well-being, both from a health systems perspective and for people who use these interventions. Self-care interventions have the potential to increase choice, when they are accessible and affordable, and they can also provide more opportunities for individuals to make informed decisions regarding their health and health care. In humanitarian settings, for example, due to lack of or limited health infrastructure and medical services in the crisis-affected areas, self-care could play an important role to improve health-related outcomes.[72] Learning from the current implementation of essential health services and considering the global recommendation on health technologies, a guideline was developed by Ministry of Health (MoH), Maternal and child Health (MCH) directorate to support the introduction, implementation and guidance of self-care interventions in Ethiopia for improved RMNCAYH-N health services.

Self-care interventions can empower women and girls need for RH services. It can be done at home so that privacy and confidentiality is guaranteed. It can increase update and utilization of MCH services despite the pandemic. It can also create a strong bondage between the primary health care, community and health system, minimize harms related to unsafe abortion and its complication, maintaining privacy and confidentiality issues, and increase youth friendly service uptake.

3.3. Input and process analysis (health system)

3.3.1. LEADERSHIP, GOVERNANCE, AND MANAGEMENT OF REPRODUCTIVE HEALTH

The ministry of health of Ethiopia has devoted its efforts to improve maternal, newborn, child, adolescent and youth health in the country. Substantial changes have been done to achieve improved

[72]WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.)

efficiency, collaboration, and coordination in different RH programs. There has been noticeable change in improving access to RMNCAYHN services. These include governance reforms to manage retention and utilization of revenue for improving logistics, drugs and supplies, establishment of a functioning facility governance body, out sourcing of non-clinical services, establishing of private wings in health facilities and the exemption of fee for certain services.

The effect of the reforms in ensuring access and utilization of quality RH services would largely improve the health of women, newborns, children, adolescents and the youth. Recently, the MOH made a reform on its structure to improve the efficiency in providing country-wide leadership of the health system. The reform was reflected on the reorganization of departments in the ministry by program and operational areas with human resources under each area. Subsequently, eight main programs were organized under the Maternal, Child Health and Nutrition Directorate (Family planning, Maternal and Newborn Health, Child Health, adolescent and youth health, expanded program of Immunization (EPI), Nutrition, Sekota Declaration and PMTCT) and similar structures are also established at regional level. Responsible senior MOH experts are also assigned to lead and coordinate the MNCH activities.

Ethiopia has won international recognition for successfully designing and implementing primary healthcare reform that introduced the innovative health extension program (HEP). Investment in demand creation through health extension program and women development army has been significant in addressing equitable access to RMNCAYH services by linking with PHCU. The HEP is a cost-effective primary healthcare approach that facilitates access to basic preventive and curative health services in rural, urban and pastoralist areas through the expansion of physical health infrastructure and increasing the number of HEWs.

3.3.2 HUMAN RESOURCE FOR RH

Human resource is one of the key components of health system and having adequate numbers and mix of motivated, competent and motivated human resources are essential at all levels of the health system.

According to the 2020 Ethiopian National Health Workforce update, Ethiopia currently has 273,601 health work force employed in public facilities; of which 181,872 (66.5%) are health professionals and the remaining 33.5% administrative staffs. Ethiopia had a health worker density of 1.74 per 1000 population, in the year 2018.[73] In EFY 2011, physician to population ratio was 1: 10,734. Ethiopia started to implement continuing professional development program which will be implemented in selected disciplines (Medical laboratory, Medicine, Midwifery, Anesthesia, Pharmacy, Health Officer, and Nursing). This will improve the quality of health care to the community provided by providers.

[73] HSTP II

The 2021-2025 human resource for health (HRH) strategic plan emphasized on the development of quality human resource with equitable distribution of HRH critical for RH services. According to the health workforce administrative data from public health institutions, there were a total of was 41826 (15%) HEWs, 59063 (22%) nurses, 18336 (7%) midwives, 26,152 (10%) other health professionals, 12504 (5%) pharmacy professionals, 11,007 (4%) medical doctors and specialists, 10843 (4%) medical laboratory professionals, 1484 (0.54%) anesthesia professionals and 660 (0.24%) mental health professionals.

The target for health workforce is not yet met; the current density of midwives, IESOs, general practitioners, obstetrician & gynecologists do not enable adequate staffing of all healthcare facilities for the RH services. Moreover, available workforce is not distributed equitably with severe shortages in hard-to-reach and remote areas, particularly in the developing regional states. The overall health worker density was 0.47 in Somali and 0.49 in Afar against 2.23 in Addis Ababa and 2.28 in Harari.

The MOH together with regional health bureaus, professional societies, partners and other relevant stakeholders, is working diligently to provide need-based, standardized, and institutionalized in-service training to ensure sustainability and ownership in capacity-building of the health workforce. As a result, the pre-service education has been strengthened with different types of need and skill-based in-service trainings like FP, BEmONC / CEmONC and SRH.

3.3.3. REPRODUCTIVE HEALTH COMMODITY SECURITY (RHCS)

Commodity security exists when a person is able to choose, obtain and use good quality reproductive health supplies, including contraceptives, whenever s/he needs them. RH commodities include not only a wide choice of contraceptive commodities for family planning, but also all essential drugs, equipment, reagents and consumables required for the efficient delivery of all reproductive health services.

In every country, there is a **context** that affects the prospects for RHCS – on the one hand, national policies and regulations that bear on family planning/reproductive health particularly on the availability of RH supplies, and on the other hand, broader factors like social and economic conditions, political and religious concerns, and competing priorities. Within this context, **commitment**, evidenced by in part by supportive policies, government leadership, and focused advocacy, is a fundamental underpinning for SRH. It is the basis from which stakeholders will invest the necessary **capital** (financing), **coordinate,** for RHCS, and develop the necessary capacities.

CONTEXT

The success of an RHCS strategy depends on a range of contextual factors affecting individuals' ability to choose, obtain and use RH supplies. To define the broader health, political and economic environment as it affects RHCS, this section considers: policies and regulations that bear on the ability

of public and private sector programs to secure and deliver reproductive health supplies; and basic demographic, health, and other development indicators.

Even though the strategies do not explicitly cover the supplies chain components, but by setting up targets to be met, the strategies indirectly address RH commodity issues. For example, CPR is set to be achieved 60 percent by 2015, and this addresses the commodity issue. National level strategy for RHCS/CS is being developed by MOH is believed to provide a clear guidance to the below points.

COORDINATION

This section addresses the need for coordination among a wide range of stakeholders and at multiple levels to achieve reproductive health commodity security. There are a number of stakeholders that need their RHCS activities be coordinated. Among these stake holders are: RHB, EPSA, Ministry of Finance and Economic Development (MoFED), Adolescent Youth and Women's Affairs Bureau from the government side; a number of NGOs working on RH such as Engender Health, Pathfinder, USAID | DELIVER and IPAS; and Social marketing agents like DKT, Marie Stopes, PSI.

COMMITMENT

It is worth mentioning that there is strong political commitment in developing and implementing supportive policies to RHCS, like the health care financing strategy and having budget line item for the procurement of contraceptives and/or RH supplies.

CAPITAL

The current health care financing strategy in Ethiopia focuses on financing of primary health care services in a sustainable manner. The share of donor funding for SRH gradually declined from 52% in 2011 to 42% in 2016 and 2017. Similarly, critical RH care services (ANC, PNC, delivery, prevention and treatment of infertility, prevention and management of complications of abortion and safe motherhood activities) accounted 16 percent, a decrease from 19% (2015). Similarly, donor support for family planning declined from 10% in 2015 to 8% and 9% in 2016 and 2017 respectively.[74] To achieve universal health coverage investing in health particularly Rh financing which can be achieved by mobilizing resources for domestic financing is crucial. However, LMIC countries are challenged due to limited resource, poor political commitment/leadership to mobilize resources and prioritize allocating domestic budget for RH.

The government of Ethiopia has given emphasis to promote health equity. The government implemented several strategies, including: provision of high impact interventions free of charge through an exemptions program; subsidization of more than 80% of the cost of care in government health facilities; implementation of CBHI schemes; and full subsidization of the very poor through

[74] Funding for SRHR in low and middle income countries, threats, outlook and opportunities

fee waivers both for health services and for CBHI premiums. Despite these efforts, direct household payment to facilities during service use still remains unacceptably high. According to NHA-7, out-of-pocket (OOP) spending on health amounted to 31% of total health expenditure (THE) in 2016/17, considerably higher than the global recommended target of 20%. A significant proportion of households (4.2%) face the effect of catastrophic health expenditure[75]. In general Budget allocation for Rh/FP commodities and the existence of community participation indicates that there is a commitment from the government side to generate funding mechanism and ensure product availability to clients who want them. However, RHCS still needs to gain a core attention in terms of adequate financing.

COMMODITIES

The public health sector's supply chain initiative, the Integrated Pharmaceuticals Logistics System (IPLS), has been designed and implemented since 2009 as a main intervention to improve the supply chain system in the country. One of the achievements is the integrated management of program products, including contraceptives and lifesaving maternal health medicines, supplies and equipment.

During the years 2016-2020, there has been significant expansion in the provision of modern contraceptives at health facilities and involvement of Level 3 Health Extension Workers in the provision of long acting reversible contraceptive such as IUD. This has increased the demand for contraceptive which goes in line with the increased contraceptive prevalence rate to 41% (EMDHS 2019).

According to the last EmONC assessment in 2016, most facilities had all the essential life saving medications like anticonvulsants, uterotonic, antibiotics, antihypertensive drugs and parenteral steroids like dexamethasone. Almost all (99 percent) health facilities had one or more antibiotic related to the signal functions and emergencies. Among all health facilities, about 87 % had one or more anticonvulsant, which varied from almost 100 % in hospitals to 25 % in MCH specialty clinics. In the same report, the general availability of supplies in the maternity areas such as fetoscope and thermometer was good. The least available equipment was an external or internal CTG (cardio-tocography) machine (3 %) and ultrasound (8 %) and pulse oximeter (12 %). Similarly, 97 % of health facilities reported that a government supplier was their primary source for gloves, syringes and other medical supplies; and 2 % of health facilities reported that a private pharmacy was their primary source of gloves, syringes and medical supplies.

The availability of basic equipment and supplies in health care facilities that are needed for newborn care are very crucial in reducing neonatal morbidity and mortality. Nationally the availability of equipment for resuscitation within the delivery unit was 90 %. The national availability of decontamination supplies for bag and mask was also 88 %. Though more than 70% of facilities had basic equipment needed for neonatal resuscitation, instruments that are needed for sophisticated

[75] Special Bulletin, 20th Annual Review Meeting, 2018, MOH.

neonatal resuscitation such as infant laryngoscope and small size endo-tracheal tubes were least available (5-7%).[76]

LOGISTICS MANAGEMENT INFORMATION SYSTEM (LMIS)

The implementation of IPLS across the country is a good opportunity. However, the availability of formats, quality of recordkeeping and storage conditions in health facilities needs to improve, particularly in health centers and health posts. Poor capacity of health workers in logistics management information system (LMIS) has created a persistent gap in instituting a complete demand-driven supply system.[77] High proportion (59%) of health centers were stocked out of one or more of the lifesaving maternal/RH medicines. In addition, a delay in the re-supply of the maternal/RH medicines due to inefficient distribution systems was hampering facilities not to offer maternal/RH medicines when required.

FORECASTING

Forecasting for RH/FP commodities is conducted annually by a team of experts from EPSA, MOH and development partners supporting RMNCH. It is reasonable to conclude that a good forecasting cannot be done in the absence of a well-functioning LMIS. Forecasting is done using consumption data from EPSA, and service and demographic data from MOH. It was reported that this forecast suffers from lack of quality logistics and service data. The RH strategy should give due emphasis on strengthening the timely collection and reporting of logistics and service data that are essential for commodity forecasting.

PROCUREMENT

EPSA is responsible for the procurement of RH/FP commodities and currently the framework agreement that has been develop to decrease the procurement lead time is playing key role. But, still it needs regular update on the list of procurement list as well as on the framework agreement list. Besides the maternal health commodities as stated in capital needs further advocacy for the sustainable funding, it should include in the framework agreement list.

INVENTORY CONTROL AND DISTRIUTION

There is a combination of push and pull inventory control system in place for RH commodities. There are established guidelines for maximum and minimum stock levels at all levels for RH and family planning. For other reproductive health commodities even though there is no guideline, there is a redistribution of products for overstocks informally. In EPSA and all health facilities, physical inventory is conducted at least once a year and there is a guideline on destruction of expired and damaged products. Most of the time, expired and damaged products are separated from the usable

[76] EmONC Report, 2016
[77] Pharmaceutical Fund and Supply Agency (PFSA) survey

ones and FEFO is widely practiced in most facilities and stock movement cards are available in most facilities. However, there is no regular habit of timely destruction of expired and damaged products attributed to limited staff, low motivation and capacity of staff with inventory control and lack of guideline for products redistribution. Medical equipment and medicine storage warehouse with a total area of 10,000m2 has been constructed and the structural construction of 2B + G+7 administration building has been completed for EPSA in Addis Ababa.

3.3.4. RH FINANCING

The provision of RH services requires a functioning health system and effective delivery of an integrated package of services. To ensure universal health coverage of RH, policy makers need to know about health financing policy options available in their respective countries.[78] The current health care financing strategy in Ethiopia focuses on financing of primary health care services in a sustainable manner. The share of donor funding for RH gradually declined from 52% in 2011 to 42% in 2016 and 2017. Similarly, critical RH care service (ANC, PNC, delivery, prevention and treatment of infertility, prevention and management of complications of abortion and safe motherhood activities) accounted 16 %, a decrease from 19% (2015).Donor support for family planning also declined from 10% in 2015 to 8% and 9% in 2016 and 2017.[79] To achieve universal health coverage investing in health particularly RH financing which can be achieved by mobilizing resources for domestic financing is crucial. However, LMIC countries are challenged due to limited resource, poor political commitment/leadership to mobilize resources and prioritize allocating domestic budget for RH.

The government of Ethiopia has given emphasis to promote health equity and equality. The government implemented several strategies, including: provision of high impact interventions free of charge through an exemptions program; subsidization of more than 80% of the cost of care in government health facilities; implementation of CBHI schemes; and full subsidization of the very poor through fee waivers both for health services and for CBHI premiums. Despite these efforts, direct household payment to facilities during service use still remains unacceptably high. According to NHA-7, out-of-pocket (OOP) spending on health amounted to 31% of total health expenditure (THE) in 2016/17, considerably higher than the global recommended target of 20%. A significant proportion of households (4.2%) face the effect of catastrophic health expenditure.[80]

In the 7th round NHA (2016/17), Ethiopia's total health expenditure was estimated at 72 billion ETB (US $ 3.1 billion) accounting for 4.2% of the country's GDP. The total health expenditure has grown steadily since 1995/96. It grew by 45% from 49.6 billion birr in 2013/14 to 72.1 billion birr in 2016/17. However, this growth was 15% in real terms after adjusting for inflation.[81] Furthermore, the share of

[78] WHO 2006

[79] Funding for SRHR in low and middle income countries, threats, outlook and opportunities

[80] Special Bulletin, 20th Annual Review Meeting, 2018, MOH.

[81] NHA 2016/17

GDP is lower than the expected average of 5% for low-income countries, and well below the global average of 9.2%.[82] The share of government contribution was 32% in 2016/17 - only slightly higher than the 30% contribution in 2013/14. The share of government health expenditure was 1.4% of GDP in 2016/17, lower than the low-income country average of 1.9% for the same year. Average health expenditure per capita is US $ 33 as compared to a regional average of US$ 38.[83] Although the government allocates 60-70% of total budget to pro-poor sectors to date, allocations to health fall well short of the Abuja Declaration target or WHO's recommended US$ 86 per capita spend to deliver UHC.[84]

3.3.5. EVIDENCE-BASED MONITORING, ACCOUNTABILITY AND PARTNERSHIP

The reproductive health strategy of 2016-2020 identified evidence-based decision making as one of its strategic objectives to transform the existing monitoring and evaluation system.[85] Various activities were performed in the past five years to enhance evidence based decision making practice including annual planning, routine data collection and data aggregation, monitoring and evaluation of reproductive health programs and integrated supportive supervision. The new DHIS2 includes main RH indicators for monitoring performance and tracking program progress. Facility assessments such as EmONC survey-2018 and ESPA+-2014 and MNCH scorecards are used to inform MNCH policy and increase accountability.

Maternal and perinatal death surveillance and response (MPDSR) has also been introduced as a monitoring system in 2013. In 2016, almost two-third of facilities (64 %) implemented maternal death surveillance and response initiatives. However, only 30 % of facilities had a routine system for MPDSR. In addition, there is a regional disparity, the lowest being in Somali (10 %) and Gambella (11%).[86] Only 22 % of facilities registered maternal deaths. Similarly, obstetric fistula surveillance and response is on the process to be integrated into MPDSRP system in response to obstetric fistula elimination in the coming five years.

The government has also started to institutionalize the civil registration system. About 25 % of facilities had a system for registering the birth of their baby on-site (Civil Registration System) which is highest in Harari (93 %) and Diredawa (90 %) while lowest in Afar (6 percent) and Gambella (7 %).

The national health account survey provides detailed sub-account analyses for tracking resources dedicated to RH and child health services among others. Ethiopia has increased the proportion of the

[82] WHO, Global Health Expenditure Database 2016.

[83] WB Ethiopian PER Review Report, 2016.

[84] MOF Data

[85] RH strategy 2016-2020

[86] EmONC 2016 final report

national budget allocated to health to 8.5% in 2013 fulfilling the pledge for the Abuja Declaration by more than 50%.

Just as a specific example, during the revision process of HMIS in 2017 the key indicators of AYSRH such as contraceptive use, safe abortion, both ANC visit and other indicators were included disaggregated by age.

3.3.6. QUALITY OF RH SERVICES

Quality RH service delivery encompasses several aspects including availability of equipment, supplies, guidelines and protocols; knowledge, skills, training, experiences and motivation of health workers; supportive supervision of facilities received; and satisfaction of clients with the care they received. Ethiopia has made a rapid expansion of its healthcare infrastructure through the accelerated expansion initiative that built more than 17,000 health posts, over 3,764 health centers and over 400 hospitals.[87] Yet, the quality of health care in terms of improving patient safety, effectiveness, and patient centeredness, in both public and private facilities in Ethiopia, is often inconsistent and unreliable. As a result, equity and quality transformation has been designed as one of the four pillars of transformation agendas of HSTP. The aim of equity and quality transformation agenda is to consistently improve the outcomes of clinical care, patient safety, and patient centeredness, while increasing access and equity for all segments of the Ethiopian population, by 2020.

Among the initiatives incorporated in the last HSTP, Maternal, Newborn and child health Quality of Care initiative (MNHQoC) was the main initiatives with its primary Goal of the Quality, Equity and Dignity for Maternal and Newborn health initiative is to halve institutional maternal and new-born deaths in health facilities in selected learning districts and improve experience of care over a period of 5 years. It is a country-led initiative which builds on domestic resources and national structures for quality of care.

By the year 2019, the MNH QoC roadmap was operationalized and technical working groups were established at national and regional levels, partners mobilized for a harmonized support to improve MNH QOC, and baseline assessment using the fifteen core indicators of the initiative has been conducted in the 48 learning facilities to guide quality improvement activities. Mentoring and coaching of the facilities were conducted on a monthly basis in collaboration with implementing partners. In addition, one joint supportive supervision was conducted. Prospective data on the core indicators is being collected on monthly basis for progress tracking of the initiative. An annual national level learning session was organized where facilities share experiences amongst themselves.[88]

[87] RH strategic plan 2016-2020

[88] ARM2019

Availability of guidelines is believed to add significant quality in implementing standard procedures in RH services. According to the last EmONC assessment report in 2016, the most commonly available guidelines in all health facilities were family planning (78 %), treatment for infection in young infants (IMNCI) (72 %), neonatal resuscitation (65 %), and PMTCT guidelines (65 %). This availability is different between health centers and higher facilities, as there is less availability as we go more to PHC units like HC.

Quality of AY Health program and services were encompassed nine services standards and fourteen services packages. Quality of AYH program was implemented as learning districts at three regions in selected health and youth centers. Quality of AYH standard tools are included at the quality audit tool, into integrated refresher training manual for Health Extension Workers, clinical catchment based mentorship flagship program at national level. The high impact and targeted interventions designed and under the process of implementation at national level mainly focused; Safe Space program for younger adolescent 10-14yrs, Smart Stat program designed for rural married couples and School Health program.

In this strategic plan, quality of reproductive health services will be given due emphasis by strengthening the already started initiatives like implementing continuous professional development, mentoring and supportive supervision of facilities on catchment bases using appropriate SOP and guidelines.

3.3.7. HEALTH INFRASTRUCTURE DEVELOPMENT

Ministry of health of Ethiopia has been heavily investing on the expansion and standardization of health and health related facilities as one of the major strategies to maintain effective primary health care coverage. At national level; 17,162 health posts, 3,678 health centers and 314 hospitals were functionally available by the end of 2011 EFY (2018/19) while 425 HPs, 86 HCs and 108 hospitals were under construction in the same year. In the same year, the CEMONC functioning facilities were 317 hospitals and 17 health centers. In addition, special purpose facilities, including warehouses, trauma centers, blood banks and Laboratory infrastructures were constructed during HSTP-I.

The ministry had set the strategic objectives in HSTP I and noticeable changes have been seen, including (a) expansion of health facilities to meet the national standard and improve access to quality care; (b) building capacity to maintain and Rehabilitate health facilities; (c) provision of utilities like water supply, toilets, incinerators, placenta pits and power supply; (d) development of designs for health facilities; and (e) applying medical equipment, construction and ICT standards in health facilities.

Despite the remarkable improvements that have been seen, health infrastructure development in Ethiopia is still being challenged by high inflation of construction materials, security problems in

regions, lack of finance and cash flow for capital projects, inefficiency of contractors, and capacity gap at regional and lower levels.

In HSTP II period, the focus areas are upgrading, maintenance and equipping of health facilities, in addition to construction of primary hospitals and other medical infrastructure projects.

3.4. Social determinants of RH health

Social determinants of RH issues such as the low status of women in the society (gender inequality), low socioeconomic status, harmful traditional practices and low female literacy, which have a direct negative impact on reproductive health.

Studies have consistently shown that educational attainment has a strong effect on reproductive behavior, fertility, infant and child mortality and morbidity, and attitudes and awareness related to family health, use of family planning, and sanitation.

Low status of women in the society also leads to economic dependence and force the young women to migrate from rural to urban and engage in different activities that risk their reproductive health. HIV infection is profoundly influenced by gender relations and decision-making power adding to biological vulnerabilities among women (CSA and ORC Macro, 2011).

The role of men in ANC use in a male controlled society like Ethiopia, where women might seek a husband's permission or approval before taking decisions related to care, warrants further studies. The importance of men's education on maternal health issues, as well as the use of ANC, may play a critical role when politically shaping family priorities and health-seeking behaviors. The health of adolescents is strongly affected by social factors at personal, family, community and national levels. Nations present young people with structures of opportunity as they grow up.

Adolescence for example is a critical period of human development with rapid physical, psychosocial, cognitive and emotional development, sexual and reproductive maturation. While biology impacts and wellbeing, social and cultural norms, particularly regarding gender, sexual orientation, disability, determine social behaviors. Early pregnancy and stereotypical attitudes related to masculinities contribute to boys engaging in riskier behaviors such as harmful substances use, greater exposure to interpersonal violence and higher rates of injuries The reproductive health issues among parents, teachers, guardians and other community members and organization recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.

Denial of services

Denying clients, the services they desire such as information, procedures, medications, or contraceptives is clearly the most serious barrier to reproductive health services. To alleviate this challenge, the ministry of health designed and implemented a national compassionate respectful care

program. As a result, the EFY 2011 plan included incorporating CRC principles in pre-service curricula, establishing CRC incubation centers, coordinate volunteer services, establishing consortium with health professional associations, conducting consultative workshops with honorable senior staff, and conduct CRC sub-task force meetings.

Discouraging use of services

Providers either deliberately or carelessly send verbal signals to clients about whether their service needs are reasonable. These signals could involve their manner towards clients, how well they tailor information to clients' concerns, the extent to which they respect clients' privacy and confidentiality, the quality and quantity of supplies they provide, how long they make clients wait, their willingness to answer questions and address sensitive topics, their attention to clients' pain, and their encouragement of clients to return. Even if they do not deny services, providers can use the power of their position to make potential clients reluctant to initiate or return for services.

Adolescents, women with disabilities or who are HIV-positive are often discouraged from obtaining reproductive health services. Due to providers' lack of training in dealing with women with disabilities, and the common misperception that such women are asexual, providers often express surprise or shock when they request contraception or prenatal services.[89]

3.5. Main successes and contributing factors

As indicated in the previous sections, Ethiopia registered a success in reducing mortality and improving the health of women and children. A number of factors within and outside the health care system have synergistically contributed to the success the country has achieved. These factors include: restructuring programs to the regional level, stakeholder engagement for financial and technical supports, regular SMH TWG, active national RAC team, establishing maternity waiting home to reduce maternal mortality, prioritization of and commitment to women's and children's health, monitoring MCH outcomes using evidence, political prioritization of essential health interventions, and focus on addressing health workforce shortages.

These vows have been confirmed by massively expanding access to and utilization of main health care services through HEP, women development agents, pregnant women conferences government's flagship program, and the expansion of primary and secondary level health care through accelerated expansion of health centers and hospitals throughout the country. The country also managed to equip a large proportion of these facilities with basic equipment and supplies along with staffing with trained health workforce.

[89] MoH, CRC training package for health workforce

3.6. Main challenges and contributors (coverage, quality and equity gaps)

- Like the previous ones, the country has witnessed several demand and supply side challenges that continued to hamper implementation of National Strategic Plan.
- Shortage, high turnover and lack of motivation of HEWs. Lack of commitment from leaders of HDTs, week health center health post integration.
- Lack of up-to-date evidences or data for decision making.
- Poor quality of health professionals. In addition to the low ratio of health professionals to population, there is generally poor quality and competency among health professionals. Inequitable distribution of health professionals. The health workforce is inequitably distributed across urban and rural areas, limitation in exercise of decentralized planning. Districts still have inadequate responsibility for their work and financial plans, and very limited autonomy regarding allocation and utilization of financial resources.

Limited supplies, difficulties arise from the lack of medical equipment and medicine, and deficient supply chain management and quality assurance.

3.7. SWOT analysis

Table 4. *SWOT analysis in strength, weakness, opportunity and threat.*

Internal, in the organization	
Strength	**Limitations**
• Expansion of RH service availability and accessibility, particularly to PHC • Increased number of graduates (OB-GY GPs, HOs, Midwives, IESOs, Anesthetists), health workers (availability) and new graduates from new health category of health professionals like OR nurse, neonatal nurse and other ongoing new trainings in community midwifery • CPD implementation initiative for quality of care • Expansion of pre-service education • Demand creation for RH services by HEWs and woman development agent • Suboptimal implementation of CBTC packages	• Interrupted laboratory service and shortage of cartridge • High staff turn over • Low health workforce density (1.7) as compared to Africa (2.3)[90] and the world (9.3) • Weak referral system along the entire health system • Inadequate medical equipment, supply and lab reagents • Inadequate budget allocation for RH pharmaceuticals, medical equipment, supply and commodities • Poor medical device maintenance and service • Low priority given to implementation research • Low data quality and use of data for decision making • Suboptimal quality of services

• Use of new initiatives • Presence of MNHQoC improvement initiatives • Regular mentorship and integrated supportive supervision • Catchment based clinical mentorship initiatives • Increase availability ambulance services • Availability of accredited laboratory and blood bank services in limited health facilities • Presence of various policies, strategies and guidelines • Improving leadership and governance and management at program and facility level • Existence of MPDSR system • Initiation and implementation health care financing reforms (free maternal, newborn family planning, other RH services) • Integrated pharmaceutical logistics system (IPLS) • Improved RH products supply chain management • Improved FP domestic financing in Strategic Direction me regions • Task shifting for FP service provision • HMIS capture age disaggregated data for SRH indicators • The integration of AYH issues in to various strategic documents including catchment based mentorship • Increased job creation opportunities for adolescents and youth	• Mini blood bank not available in all CEmONC facilities • Inadequate health infrastructure • Poor attitude among health managers and providers for sensitive RH services • Working environment is not conducive • Inequitable distribution of health workers • Poor HR planning • Substandard health professional skill mix for RH services • Poor Motivation retention mechanism • Demotivated staff • Inefficient utilization of health resources • Poor efficiency and accountability • Low domestic resource mobilization and allocation for RH services • Unclear maternal health service re-imbursement guideline • Weak supply chain and inventory management system • Weak forecasting, distribution of commodities and supplies • Lengthy RH commodities and supply procurement process • Shortage/unavailability of essential and lifesaving RH medical equipment and supplies (CTG for fetal monitor, U/S, pulse oximeter and patient monitor, anesthesia machine) • Poor capacity of health workers in logistics management information system (LMIS) • Poor cold chain and storage management for heat sensitive health products (oxytocin, ergometrine) • Low procurement of quality assured products and medical equipment (e.g. BP machine) • Inadequate medical device maintenance capacity and inappropriate utilization • Limited capacity for last mile product delivery • Lack of system for end-to-end inventory data visibility

	• Disparity in health care utilization among the population by factors such as regions, residence, level of education and wealth • Poor engagement of private health facilities (follow quality implementation, provision of guidelines) • Lack of adequate RH services including family planning and AC • Poor access of skilled care ANC, delivery and PNC including neonatal complications • Weak FP service integration • Weak quality of FP counseling services • Poor mentorship implementation • Indicate documentation and reporting and low use of data for decision making • Sub-optimal quality of care • Partial exempted reproductive health service • Poor community health seeking behavior • Inadequate male involvement
External, outside the organization	
Opportunity	**Threat**
• Existence of strong government structure up to community level • Government priority for RH services • Strong political will to advocate women leadership • Increase in community demand for high quality of health care • National focus for PHC • Government commitment to SDG • National policies, strategies other than health sector • Multi-sectoral collaboration • Engagement of professional associations and stakeholders • Public private partnership initiative system • High engagement of global and national partners	• Inadequate geographic expansion of RH services • Public health emergencies • Internal and external displacement • Disrupted social network (religious, cultural reasons) • Internal migration from rural to urban setting weak • Low socio - economic status of women • Gender inequality • Shift of global financial support from SRH services to others • Inadequate aid effectiveness • The effect of global economy (rising cost of pharmaceuticals, supplies etc.) • Increasing brain drain (to other sectors and abroad) • Poor quality of pre-service education • Poor facility infrastructure (at all levels)

• Existence of partners in financial and technical support • Global PHC/UHC movement • Expansion of ICT • Expansion medias and communication (Mainstream, social media digital technology expansion) • Strong EPI cold chain system • Expanded pre-service education • Graduated skilled health work force such as GPs, Midwives, HOs • Expansion of health infrastructure • Expansion of road, telecommunication, electricity, water, infrastructure	• Uncertainties of external funding from donors • Lack of SRH services in humanitarian crisis • Community misconceptions and rumors on SRH services • Misperception of religious/cultural influence on family planning use • Low involvement of the youth in the health system program designing and implementation • lack of AYH coordination platform at lower level of the health system (zone, woreda and PHC) • Low involvement of private sectors in health program • Lack of HR structures at zone and Woreda levels to handle AYH issues • Political instability

CHAPTER 4: STAKEHOLDER ANALYSIS

Stakeholders are key players in the health sector and their analysis is crucial to the success of the health program. During the planning process of the health interventions, it is important to take into account the needs and interest of those who have a 'stake' in the health sector. Table 5 below shows the stakeholders analysis of the RH strategic plan III.

Table 5. *Stakeholder analysis.*

Stakeholders	Behaviours we desire	Their needs	Resistance issues	Institutional response
Community	- Participation, engagement Ownership - Service utilization - Healthy life style	- Access to health information and service, empowerment, - Quality of health care Stewardship	- Dissatisfaction - Opting for unsafe alternatives - Underutilization	- Community mobilization, ensure participation - Quality and equitable service and information
Line Ministries (Water, Finance, Labor, Women's Affairs, Agriculture, etc.)	- Inter-sectoral collaboration - Consider RH in all policies and strategies	- Evidence-based plan & reports - Effective and efficient use of resources & coordination - Technical support	- Fragmentation - Dissatisfaction - Considering health as low priority	- Collaboration - Transparency - Advocacy
CPD providers	- Quality, optimum services, training access to all cadres	- Technical, policy support, guidance, coordination	- Curriculum revision - Gap identification advocacy	- Policy and leadership support
Development Partners	- Harmonized and aligned - Participation - More financing - Technical support	- Financial system accountable and transparent - Involved in planning,	- Fragmentation - High transaction cost - Inefficiencies	- Government leadership - Transparency - Efficient resource use

		implementation and M&E		- Build financial management capacity
- ***NGOs, and professional associations***	- Harmonization & alignment - Participation, resource & TA - Participate in licensing and accreditation - Promote professional code of conduct	- Involvement in planning, implementation and M&E Participation	- Dissatisfaction - Fragmentation - Scale down - Withdrawal	- Transparency, Advocacy - Capacity building - Financial support
- ***Diaspora and Private for-profit entities***	- Quality of care; Client oriented; - Knowledge and technology transfer	- Enabling environment for their engagement	- Mistrust - Rent seeking	- Transparency - Accountability - Dialogue
- ***Civil servants***	- Commitment, Participation - CPD compliance	- Conducive environment - Transparency - Incentive - Technology based approach	- Dissatisfaction - Unproductive - Attrition	- Motivation - Involvement

CHAPTER 5: GUIDING PRINCIPLES

The implementation of this strategy is guided by the principles and common values of the national health policy and HSTP II. The key guiding principles include:

• **Good leadership and governance:** The MOH of Ethiopia has the primary ownership and responsibility for establishing good governance and providing effective and good-quality reproductive, maternal, newborn and adolescent health services. The strategy sets strategic priorities and core interventions to enhance the ability to deliver/implement programs effectively at Woreda level as this is the echelon of the MOH's leadership capacity and calls for development partners to align their contributions and harmonize actions.

• **Accountability**: Effective, accessible, inclusive and transparent programme-coverage and impact monitoring mechanisms, independent review and action by all relevant actors are prerequisites for equitable coverage, quality of care and optimal use of resources. Accountability also includes access to processes and mechanisms for remedies. The strategy includes strategic priorities and interventions to enhance effective and efficient program supervision, monitoring and coordination at all levels.

• **Community engagement, empowerment and ownership:** Communities' participation in identifying the major problems, priority setting, planning, implementation and monitoring of policies and programs that affect them is a central feature of leadership and one of the most effective transformational mechanisms for action and accountability for RMNAH/N. The Women Health Development Army (WHDA) in Ethiopia, known as "The Women's Group Approach" in several South Asian countries, is a good example of community engagement, empowerment and ownership.

The main advantages of community-based health promotion and interventions are: to reach to the majority, to bring community behavioral changes in RH issues, and to narrow the gap between the community and the health facilities.

• **Respect for human rights and gender equality:** It includes the right to life, human dignity, equality and freedom from discrimination on the basis of gender, sex, age, disability, health status and social and geographic status. Evidence and practice show the vital importance to health and development of many human rights outcomes. Accordingly, the development of this strategy is guided by the principles and standards derived from international human rights treaties on reproductive, maternal, newborn and adolescent health. The MOH will ensure that this principle is maintained at all phases of the programming process.

• **Excellence in quality improvement and assurance:** As per the HSTP II, quality and safety have been recognized as key issues in establishing and delivering accessible, effective and responsive RH care and services. Working through the process of quality assurance and continuous quality improvement will create an environment for transforming the CH program as a key component of the

health sector and achieving the reproductive health outcome goals described in this strategy. The strategy thus seeks to make improvements in all dimensions of quality related to RH: delivering effective, efficient, acceptable/patient-centered, equitable, safe and timely RH services.

• **Competent, committed and compassionate health fork force:** The strategy outlines that the MOH shall focus on compassionate, respectful and competent health care by ensuring adequate skill mix of human resources at all levels of the health system. The relationship of RH clients with health care providers and the health system should be characterized by caring, empathy, trust, and an enabling environment for informed decision-making. This will as well contribute to guaranteeing quality in RH services.

• **Use of innovation and technologies:** Medical equipment and technologies are vital components of the health care delivery. Innovative thinking and use of available technologies to reach the poorest and most underserved population is one of the new initiatives the ministry is aspiring to.

While more research and development is required to optimize the application of knowledge of which interventions and strategies are most effective, the strategy also proposes the use/scaling up of globally accepted and cost-effective innovations and technologies such as m-health and e-health for RH services in selected areas.

• **Integration:** Providing every woman, newborn, adolescent and youth with good-quality care require integrated service delivery. Effective service delivery integrates the delivery of key interventions across the RMNCAH+N spectrum (continuum of care) by increasing efficiency and reducing duplication, at the same time meeting the health and social needs. The strategy also recognizes that coordinated health system approach involving multiple programs, stakeholders and initiatives across the continuum of RMNCAH+N is included in the guiding principles.

• **Government ownership and leadership in all health planning processes:** It means that the MOH, RHBs, ZHDs, WorHOs at all levels of the health system own the process, have the responsibility to organize and lead the planning sessions. It also ensures all relevant stakeholders (government, development partners, NGOs, CSOs, private sector, the community etc.) will have active roles in the consultation. The plan and budget should also be approved by the relevant local government authority through the formal approval process.

CHAPTER 6: GOAL, OBJECTIVES AND TARGETS

6.1. VISION

To see a healthy, productive and prosperous society.

6.2. MISSION

To promote the reproductive health and well-being of women, newborns, adolescents and youth through providing and regulating a comprehensive package of reproductive health services with the highest possible quality in an equitable manner.

6.3. GOAL

The goal of this strategy is to improve the reproductive health of women, adolescents, and youth, and newborn health of Ethiopians.

6.4. OBJECTIVES

The objectives of the RH 2021-2025 strategic plan are operationally described as high-level result statements that lead to the sector's vision being realized. The overall goal of RH 2021-2025 strategy plan is to improve the population's health status by achieving these four goals:

1. Protect women, newborns, adolescent and youth from reproductive health emergencies
2. Empowering the community and increase reproductive health seeking behaviors
3. Accelerate progress towards universal reproductive health coverage
4. Ensure reproductive health equity and quality

6.5. TARGETS

Impact targets

- Decrease MMR from 401 to 279 per 100,000 live births
- Decrease still birth rate from 15 to 14/1000LB
- Decrease neonatal mortality from 33 per 1000 births to 21 per 1000 births
- Decrease TFR from 4.1 to 3.2
- Reduce mother to child transmission rate of HIV from 13.4% to less than 5%

Outcome Targets

- Increase proportion of pregnant women with four or more ANC visits from 43% to 81%
- Increase deliveries attended by skilled health personnel from 50% to 76%
- Increase early Postnatal Care (PNC) coverage from 34% to 82%
- Increase cesarean section rate from 4% to 8%
- Increase PNC 24 hour stay and care by 25% from 2020 baseline
- Increase syphilis testing coverage for pregnant women from 55% to 85%
- Reducing adolescent pregnancy rate by 75% from its 2020 baseline
- Increase proportion of asphyxiated newborns resuscitated and survived from 11% to 50%
- Increase proportion of newborns with neonatal sepsis/Very Sever Disease (VSD) who received treatment from 30% to 45%
- Decrease prevalence of anemia in women of childbearing age from 24% to 18%
- Increase contraceptive prevalence rate (CPR) among married women from 41% to 50%
- Decrease unmet need for family planning among married women from 22% to 19.1%
- Increase the long-acting reversible method coverage from 10.3% to 15%
- Increase permanent contraceptive methods use from 0.3% to 0.5%
- Reduce adolescent family planning unmet need among adolescent and youth: from 20% to 10%
- Increase proportion of health facilities providing youth friendly services from 45% to 80%
- Reduce teenage pregnancy from 12.5% to 7%
- Reduce Anemia prevalence in girls aged from 10-19: 28% to 14%
- Increase Percentage of pregnant, laboring and lactating women who were tested for HIV from 84% to 96%
- Increase ARV coverage for HIV positive pregnant, laboring and lactating women from 81% to 95%
- Increase enhanced postnatal dual prophylaxis coverage for all HIV exposed infants (HEI) from 53% to 90%
- Increase early infant diagnosis (EID) coverage for HIV exposed infants (HEI) from 75% to 90%

CHAPTER 7: STRATEGIC DIRECTIONS DESCRIPTION AND MAJOR INITIATIVES

The strategic plan for RH 2021-2025 identifies 13 strategic directions that are detailed here below in figure 6.

Figure 6. *Strategic directions for RH 2021-2025.*

7.1. Enhance provision of equitable and quality reproductive, maternal, new born, adolescent and youth health services

Description:

This strategic direction is about the provision of health promotion, prevention of problems, and treatment of reproductive health problems in an equitable and at the highest possible quality of care. The health services provided by organizing services in a continuum of care through the course of life cycle including adolescent health, preconception and pregnancy care, childbirth, Post-natal, child health and nutrition services. The following key interventions/activities will be considered: demand creation (through BCC, advocacy, social mobilization), provision of services through different modalities (static, outreach, mobile…), uninterrupted supply of essential commodities, referral linkage and service integration when appropriate, which can apply for most programs stated below

7.1.1. PRECONCEPTION CARE

Performance measures

- Proportion of health facilities providing preconception care to 25 %
- Proportion of pregnant women receiving preconception care before pregnancy to 25 %

Major Strategic Initiatives

- Develop and use preconception care implementation guideline and training manual
- Provide advocacy, capacity building and preconception care services
- Integrate preconception care with other health services and the curriculum

7.1.2. ANTENATAL CARE

Performance targets by 2025

- Increase early ANC initiation from 20% to 50%
- Increase proportion of pregnant women with four or more ANC visits from 43% to 81%
- Increase proportion of health facilities implementing 8 ANC contacts from 15 % to 45 %

Major Strategic Initiatives

- Develop and implement ANC guideline, training materials including capacity building to providers for 8 ANC contacts
- Strengthen nutritional assessment, counseling and intervention for pregnant women

- Ensure provision of essential ANC services at all levels of health in a respectful and compassionate manner
- Strengthen community mobilization by using existing community platform (HEWs, WDA, 1 to 5…)
- Strengthen maternal waiting home service

7.1.3. DELIVERY AND EMERGENCY OBSTETRICS AND NEWBORN CARE (EMONC) CARE SERVICES

Performance Targets by 2025

- Increase deliveries attended by skilled health personnel from 50% to 76%
- Increase cesarean section rate from 4% to 10%
- Decrease still birth rate from 15 per 1000 to 14 per 1000 live birth
- Increase proportion of asphyxiated newborns resuscitated and survived from 11% to 50%
- Increase proportion of newborns with neonatal sepsis/Very Sever Disease (VSD) who received treatment from 30% to 45%
- Increase met need for EmONC services from 18% to 100%
- Increase provision of BEmONC signal functions from 5% to 100%
- 100% of hospitals provide CEmONC signal services

Major strategic initiatives

- Strengthen and decentralize EmONC service
- Strengthen & expand essential newborn, care low birth weight and preterm baby's services
- Strengthen the referral and triage system
- Strengthen maternity waiting homes at health center level
- Increase community awareness and engagement to increase health seeking behavior
- Ensure respectful maternity care, including birth companion, birthing position and pain management

7.1.4. POSTNATAL CARE

Performance Targets by 2025

- 90 % of women after birth should get 24 hours stay and care

Strategic Initiatives

- Provide high quality postnatal and newborn care
- Strengthen community PNC services
- Increase community demand creation and engagement through HEWs, WDAs…

7.1.5. MATERNAL AND PERINATAL MORTALITY, MORBIDITY AND NEAR-MISS SURVEILLANCE AND RESPONSE

Performance Targets by 2025

- 100% of all maternal and perinatal deaths are identified and notified through Public Health Emergency Management (PHEM).
- 100% hospitals and health centers reviewed maternal and perinatal deaths, and have given appropriate response at all levels 35% to 80% for review and 9% to 50% identified
- 55% of hospitals performed near-miss review

Major Strategic Initiatives

- Improve guidelines and standards on MPDSR
- Increase the capacity of health care providers
- Ensure functionality of MPMMSR in all health facilities and Woreda
- Strengthen maternal and perinatal mortality and morbidity review and response at all levels.
- Strengthen the maternal and perinatal death investigations and verifications at the community level.

7.1.6. COMPREHENSIVE AND SAFE ABORTION CARE

Performance Targets

- Increased proportion of health centers and hospitals providing post abortion care from 43% to 100%.
- Increase proportion of health centers and hospitals providing safe abortion care as per the law and guideline from 43% to 100%.

Major Strategic Initiatives

- Ensure capacity building on SAC and CAC

- Strengthen safe abortion and comprehensive abortion services at all levels (from health center to tertiary level)
- Develop and/or revise appropriate standards (check from the detail activity)

7.1.7. OBSTETRIC FISTULA PREVENTION, CASE IDENTIFICATION AND MANAGEMENT

Performance Targets

- 100% of obstetric fistula cases are treated
- Implement obstetric fistula surveillance and response (OFSR) at all health facilities
- Reduce the number of obstetric fistula cases <1,600

Major Strategic Initiatives

- Ensure Obstetric Fistula prevention
- Ensure early detection and referral system to facilitate early treatment of cases
- Enhance obstetric fistula management services in tertiary hospitals: expand addition treatment facilities
- Strengthen rehabilitation and re-integration of obstetric fistula survivors
- Ensure obstetric fistula and ObF surveillance and response strategies, implementation manual
- Increase community awareness and engagement to increase health seeking behavior
- Implement OFSR at all level

7.1.8. PELVIC ORGAN PROLAPSE PREVENTION, IDENTIFICATION, REFERRAL, AND MANAGEMENT

Performance Targets

- Treat all symptomatic cases of pelvic organ prolapse (POP) in all general hospitals
- All women with POP get access for treatment in the hospitals

Major Strategic Initiatives

- Ensure Pelvic Organ Prolapse prevention strategies are implemented at levels
- Strengthen identification and referral of symptomatic POP at all levels of health facilities
- Ensure treatment for pelvic organ prolapse including pessaries

7.1.9. FEMALE GENITAL MUTILATION (FGM)

Performance Targets

- Prevention, protection and clinical treatment for FGM clients
- Increased access and utilization of appropriate and responsive health services to women and girls

Major Strategic Initiatives

- Ensure appropriate FGM interventions are in place
- Ensure capacity buildings at all levels including community leaders

7.1.10. REPRODUCTIVE ORGAN CANCERS

Performance Targets

- All hospitals should screen and diagnose cervical, prostate and breast cancer
- Health center screening for VIA should increase from 21.6% to 50%.
- Six new oncology centers start providing surgery, chemotherapy, radiotherapy and rehabilitation for reproductive organ cancers

Major Strategic Initiatives

- Ensure community awareness on reproductive organ cancers including breast self-examination (BSE)
- Improve reproductive organ cancers treatment in the country
- Expand the number of health facilities providing screening and diagnosis ROC (Visual inspection with Acetic Acid for precancerous cervical lesion, Pap smear, HPV test, BSE, mammography and biopsy

7.1.11. FAMILY PLANNING SERVICES

Performance targets:

- Increase the long-acting reversible contraceptive use from 10.3 to 15
- Increase permanent contraceptive methods use from 0.3 to 0.5

- All health centers and hospitals offer at least five different type of modern contraceptive methods
- All health posts offer at least four different type modern contraceptive methods
- All hospitals provide postpartum family planning services
- Increase coverage of PPFP service from 40% to 50% in Health centers
- All compressive abortions service providing health facilities provide post abortion family planning service
- Increase CPR by 1% in all regions annually.
- Increase percent demand for FP satisfied with modern methods from 60 % to 68%.

Major Strategic Initiatives

- Ensure the capacity of HCWs and HEWs on family planning
- Improve family planning guide lines, quality standards, policies and job aids
- Improve demand for family planning services through effective social and behavior change communication interventions and male involvement
- Improve the quality and access for family planning services to the community
- Improve adaptation, advocacy, promotion, and implementation of new innovative family planning approaches
- Ensure quality family planning counseling and services for clients including adolescents
- Implement innovative family planning service delivery approached for married adolescents

7.1.12. REPRODUCTIVE HEALTH SERVICES IN HUMANITARIAN SETTINGS

Performance targets:

- All humanitarian settings providing Minimum Initial Service Package for Reproductive health services

Major Strategic Initiatives

- Ensure reproductive health standards, guidelines and services packages in humanitarian settings
- Enhance capacity building to health workers working at humanitarian setting
- Improve all RH components services provision at humanitarian settings
- Strengthen partnership with stakeholders working at humanitarian settings

7.1.13. INFERTILITY

Performance targets:

- All health facilities provide couple counseling on causes and prevention of infertility
- All tertiary hospitals provided infertility workup including hormonal analysis, seminal fluid analysis (SFA), and hystero-salpingography (HSG) and manage non-complicated cases of infertility
- Existing infertility diagnostic and management centers upgraded to provide service with full capacity (laparoscopic tuboplasty, intrauterine insemination (IUI) and In-vitro fertilization (IVF)
- At least three new medical schools initiated training in reproductive endocrinology, infertility and artificial reproductive technology (ART).

Major Strategic Initiatives

- Improve standards, protocols and advocacy materials for the prevention, investigation, and management of infertility
- Ensure community awareness about infertility prevention and management
- Improve the provision of infertility prevention, care and treatment
- Capacity building to strengthen the infertility treatment centers in the country

7.1.14. INNOVATIVE SOCIAL BEHAVIOR CHANGE COMMUNICATION AND REPRODUCTIVE HEALTH OF ADOLESCENTS AND YOUTH

Performance targets

- 80% health centers and hospitals provide quality adolescent and youth-friendly SRH services as per the standard.
- 90% of sexually active adolescents and youth age 10-24 access quality SRH and/or maternity care.
- Reduce Teenage pregnancy from 13% to 7%
- 75% of adolescents and youth have access to comprehensive AYH information
- 60% of vulnerable adolescents and youth reached with targeted interventions
- 90% of adolescents and youth will have comprehensive knowledge on HIV
- 25% of schools integrate school health program and provide correct AYSRH information and education on health and well being

Strategic Initiatives

- Build the capacity of reproductive health service providers to provide comprehensive reproductive health to adolescents
- Enhance reproductive health services to adolescents and youth
- Improve the capacity of AYRH on positive life skill education and communication through positive parenting and teachers support
- Improve multispectral collaboration

7.1.15. YOUTH ENGAGEMENT ON RH PROGRAMS

Performance target

- All youth led organizations and group are represented and engaged in youth related health planning, implementation and M&E activities

Major Strategic Initiatives

- Ensure the engagement of young people in different programs (design, planning, implementation, monitoring and evaluation)
- Build the capacity of youth and adolescents
- Advocate adolescent and youth engagement and ownership at community level

7.1.16. MTCT PREVENTION AND TREATMENT OF HIV, SYPHILIS & HEPATITIS B SERVICE

Performance targets

- Sustain the coverage of HIV and syphilis testing and counseling among pregnant women to ≥95%
- Increase coverage of HBs Ag testing and prophylaxis provision during pregnancy to ≥80%

Major Strategic Initiatives

- Improve community mobilization (SBCC) on HIV, syphilis, and hepatitis B infection prevention and treatment
- Capacity building on HIV, syphilis and HepB infection prevention and treatment
- Ensure services on HIV, syphilis and HepB management and expansion of the services
- Integrate RH/HIV services (FP, STI, TB, OIs) in to PMTCT service

7.1.17. EMTCT OF HIV, SYPHILIS AND "DUAL ELIMINATION" SERVICES TO PREGNANT, AND LACTATING WOMEN AND HIV EXPOSED INFANTS

Performance targets

- Increase ART and syphilis treatment coverage for HIV-positive pregnant women ≥95%
- Reduce new HIV infection due to MTCT to <50 cases per 100,000 live births
- Reduce MTCT of HIV to less than 5%
- Reduce the rate of congenital syphilis to ≤ 50 per 100,000 live births
- Increase viral load suppression by >98%
- Increase the coverage of ARV prophylaxis among exposed infants to ≥ 95%.
- Increasing the coverage of DNA-PCR test done at 2 months to >95%
- Increase the coverage of ART among HIV positive infants to ≥ 95%.

Major Strategic Initiatives

- Enhance ART enrollment and retention of HIV+ pregnant and lactating women
- Improve viral load testing services for HIV+ pregnant and lactating women
- Promote and ensure exclusive breast feeding for all infants born to HIV positive mothers for the first 6 months and gradual shift to complimentary feeding
- Improve service to HEI
- Strengthen treatment of syphilis and HepB for all sero-positive pregnant women
- Scale-up the involvement of mother support group to each PMTCT providing facility
- Strengthen cohort monitoring analysis and scale up in all PMTCT sites

7.1.18. NUTRITION DURING PRE-PREGNANCY, PREGNANCY, LACTATION AND ADOLESCENTS

Performance measures

- Increase proportion of pregnant women who received iron and folic acid supplement at least 90+ from 11% to 60 %
- Proportion of pregnant women who consumed at least one additional meal from 16 % to 50%
- Proportion of pregnant mothers with acute malnutrition from 15% to 2%??
- Reduce the prevalence of anemia among pregnant women from 29 % to 21%
- Increase proportion of pregnant women counseled for nutrition during ANC from 71% to 76%

- Decrease the proportion of lactating mother's positive for acute malnutrition from 20 % to 10%
- Decrease the proportion of lactating mothers with underweight (BMI>18.5) from 22 % to 10%
- Increase the proportion of lactating mothers who consumed at least two additional meals from 16%to 70 %
- Increase the proportion of newborns initiated early with breast feed within one hour from 73% to 86%
- Prevalence of anemia among adolescents aged 10-19 years from 19.9% to 14%
- Proportion of adolescent girls supplemented with iron from 4.5% to 30%
- Increase the proportion of adolescents received folate tablets from 0% to 30%
- Increase the proportion of pregnant women who got pre-conception nutrition services (Folic acid) from 0% to 50%
- Increase the proportion of adolescents with special situations (HIV/AIDS, emergency, obesity, undernourished, substance abuse, mental health and eating disturbances) provided with nutritional services from 0%to 50%

Major Strategic Initiatives

- Improve the nutritional status of pregnant, lactating mothers and adolescents
- Improve/ expand nutrition services provision to mothers and adolescents in special situations
- Improve the capacity of health care providers
- Improve communities understanding on the importance of nutrition

7.2. Enhance good governance, leadership and partnership for RH

Descriptions:

This direction is about guaranteeing responsible and transparent leadership & governance system for effective implementation of strategies. It addresses public accountability on resource management and optimal health service provision. It includes designing and implementing sound regulation mechanisms, building effective teams and institutionalizing appropriate implementation mechanisms and platforms. The components include transparency, accountability, responsiveness, effectiveness and efficiency, participatory, consensus building, equitable and inclusiveness and follow the rule of law.

7.2.1. MONITORING OF RH PROGRAMS

Performance targets

- Program supervisions and coordination meetings are regularly conducted by all RMNCAH programs at all levels.

Major Strategic Initiatives

- Strengthen capacity building to regions, zones and woreda for planning, implementation, monitoring and evaluations of RH for leadership at all levels
- Ensure alignment of strategic directions, plans, performance with all stakeholders of RH at all levels
- Conduct program supervision and coordinating meeting of RH program
- Develop/update guidelines, implementation manuals, training packages, SOPs and job aids for the mangers at different levels and provide training
- Build the capacities of local Faith Based Organizations, Community Based Organizations and other community organizations in demand creation and delivery of RH services

7.2.2. REGULATION OF RH PROVIDERS AND RH RELATED FACILITIES

Major strategic initiatives

- Integrate activities with human resource and quality directorate to regulate reproductive health and health-related facilities, both public and private (enforcing adherence to the Ethiopian health facility minimum standard- for RH related workers and facilities)
- Harmonize and standardize IEC/BCC materials
- Introduce and scale up clinical audits to ensure quality of practice in health facilities in relation with RH services
- Engage private health care facility associations in health regulatory system

7.3. Improve the supply management of pharmaceuticals and medical equipment for consistent availability and rational use of RH commodities and services

Description:

This strategic direction focuses on strengthening the pharmaceutical supply chain, data visibility and culture of data use for RH pharmaceuticals, supply and medical device supply chain management to ensure uninterrupted availability, functionality and accessibility of safe, effective and affordable RH medicines, commodities, medical devices and services that are needed to address RH service.

7.3.1. SUPPLY CHAIN MANAGEMENT FOR RH COMMODITIES AND BASIC EQUIPMENT SUPPLY

Key Performance targets by the end of 2025

- 95% healthcare facilities will have adequate stock of essential RH medicines/commodities
- Increase Mean availability of basic RH medical equipment in HFs from 56[91] to 80%
- Reduce RH pharmaceuticals procurement lead time in days from 252 to 210 in 2025
- Reduce RH pharmaceuticals wastage rate to 2% in 2024 and 1% in 2025

Major Strategic Initiatives

- Strengthen national coordination platform among decision makers for ensuring joint responses to critical supply bottlenecks
- Advance the procurement system through the introduction of e-procurement, establishment of international and regional pooled procurement and long-term fixed price procurement mechanisms
- Develop and implement strategies to reduce RH medicine wastage and to implement RH pharmaceuticals waste management and medical devices decommissioning
- Transform Drug and Therapeutic Committee (DTC)
- Promote the rational use of RH medicines by healthcare professionals and the public
- Scale-up MCH Pharmacies near RH services
- Improve RH commodity integrated supply management, data visibility and culture of data use
- Strengthen capacity building on RH program and pharmaceutical management for health service staff strengthen annual forecasting, and supply planning, pipeline monitoring for RH commodities, including supplies and consumables
- Improve basic medical equipment availability and functionality for RH services (mini-blood bank, delivery coach, BP apparatus, stethoscope, adult/baby weighting scale and thermometer)
- Strengthen medical device maintenance used for RH services
- Strengthen LMIS for end-to-end inventory data visibility

[91]Ethiopia Service Availability and Readiness Assessment (SARA), 2018 final report, Ethiopia, Ethiopian Public Health Institute, May 2018.

7.4. IMPROVE COMMUNITY OWNERSHIP

Description:

It improves community involvement, including men to ensure women's access for RH services through strengthening community forums and improving the knowledge of community on the selected health contents.

7.4.1. COMMUNITY OWNERSHIP IN RH PROGRAM

Performance targets

- 100% women have access to recommended RH care through HEP, religious leaders, WDAs and community leaders
- 100% PHCU organize community forums such as pregnant conference (plan reviews, performance issues, and review and feedback mechanisms)

Major Strategic Initiatives

- Utilize innovative outreach techniques to educate youth and young adult population through an integrated media campaign, in different local languages.
- Capacitate religious leaders, WDA, community leaders to involve in RH for demand creation
- Promote education about importance of post-partum appointment and ongoing reproductive health care for to the community
- Increase education about how to access prenatal care for those who are unable to be insured
- Use the existed community structures to involve the community including key informants in the community

7.4.2. MALE INVOLVEMENT

Major Strategic Initiatives

- Increase couples' communication on fertility and family planning
- Ensure that family planning services address specific needs of men and are male-friendly
- Provide men with information to participate responsibly in RH service use and decision making
- Encourage men to accompany their partners on reproductive health services including family planning

- Support men as responsible adults and parents who prevent unwanted pregnancy and sexually transmitted infections
- Make reproductive health (family planning, and sexually transmitted infections/HIV) information/topics available to men through formal and informal channels (e.g. work and recreation locations)
- Involve men in designing and implementing reproductive services, and allow them to express how they can take more responsibility

7.5. Improve research and evidence for decision-making

Description:

This strategic direction focuses on the generation of quality evidence, research and innovations, culture of evidence-based decision-making and development and use of technology (new and or improved tools). It also promotes use of data from routine, non-routine data sources including new researches supported with appropriate information communication technology (ICT), and using established HIS governance framework. With this strategic direction Strengthen linkage between universities and MoH, RHB to conduct RH related researches in all universities, Improve RH service quality related researches for decision making, and data integration and digitization

7.5.1. RESEARCH AND EVIDENCE FOR DECISION-MAKING FOR BETTER RH CARE

Performance targets

- 100% of health facilities will use appropriate registration and complete documentation
- RAC team produce at list 20 policy brief, issue brief and technical brief on key RH issues
- 50 % of hospitals and 10% of HCs will have a knowledge resource center for RH
- 100% of facilities will use local data for improved services.

Major Strategic Initiatives

- Strengthen linkage between universities, and MoH and RHB to conduct RH related researches in all universities
- Improve RH service quality related researches for decision making
- Promote research on gender-based violence, health system and other social determinants of RH

7.6. Enhance use of technology and innovation

Description:

This strategic direction mainly focuses on digitization of family information through eCHIS, and networking health facilities at different levels. Digital technologies provide concrete opportunities to tackle health system challenges, and thereby offer the potential to enhance the coverage and quality of health practices and services.

7.6.1. TECHNOLOGIES AND INNOVATION FOR BETTER RH OUTCOMES

Performance targets

- Family information managed with eCHIS implement with HEP
- All tertiary hospitals have utilized telemedicine and tele-education technologies for RH services to support other facilities.
- Ensure data integration and digitization

Major Strategic Initiatives

- Strengthen collaboration with HIT directorate to implement and monitor the innovations, including m-health technologies
- Strengthen the use of technology in the community health services: to implement self-care health services

7.6.2. PROVIDER SUPPORTED SELF-CARE

Description

Self-care interventions are evidence-based health promotions, testing and treatment of problems, which can be provided fully or partially outside of formal health services and can be used with or without the direct supervision of health care personnel. This approach would help to sustain essential reproductive health services at the mid COVID-19. It also has cost implications and people empowering capacity.

Major Strategic Initiatives

- Advocate country context self-care through health extension workers, community volunteers
- Self-care on selected reproductive health components (HIV self-test, self-management of medical abortion, self-administered injectable contraception (depot medroxyprogesterone acetate in its subcutaneous))

7.7. ENHANCING DEVELOPMENT AND MANAGEMENT OF HUMAN RESOURCE FOR RH

Description:

This direction entails human resources planning, development and management (training, capacity building, performance management and motivation) to ensure the presence of motivated, competent, compassionate and committed health professionals in adequate number and skill mix. It focuses on improving the quality of pre-service training and continuous professional development. Promoting ethics and professionalism in the pre-service education and in-service training programs will be given a critical attention. It also includes leadership development with due attention to the involvement of women in leadership positions.

7.7.1. MOTIVATED, COMPETENT AND COMPASSIONATE PROVIDERS

Performance measure

- All health centers will be staffed with at least 5 midwives or professionals with midwifery skill
- Level "A" HCs with basic emergency and obstetric care infrastructure staffed with at least 1 IESO and/or MSc clinical midwife and 1 anesthesia professional
- All primary hospitals will be staffed with 2 integrated emergency surgical officers and or MSC clinical midwife, 2 anesthesia professionals and 4 BSC midwives
- All general hospitals will be staffed with at least 2 obstetrician-gynecologists, 13 anesthesia professionals and 13 midwives

Major Strategic Initiatives

- Ensure that all health facilities are staffed with the national HR standards
- Ensure motivational mechanism to health workforce

7.8. IMPROVE HEALTH INFRASTRUCTURE FOR RH SERVICES

Description:

This strategic direction aims to improve running water, telephone and an electric /solar power supply with backup generator, space for ANC, delivery, postnatal, FP, adolescent health services, maternity waiting homes, and neonatal intensive care unit (NICU).

7.8.1. HEALTH INFRASTRUCTURE FOR RH SERVICES

Performance targets

- 100% HCs and hospitals will have constant running water, telephone and an electric /solar power supply with backup generator
- All health facilities have space for ANC, delivery, postnatal and FP services
- 75% of health centers will have maternity waiting homes
- 95% of hospitals and 100% of health centers have a neonatal intensive care unit (NICU) and radiant warmer, respectively

Major Strategic Initiatives

- Mobilize resources to procure and distribute backup power sources and ambulances as per identified gaps
- Revise facility standard for the appropriate provision of RH services (including design, number of beds, cleanness and access to other services).
- Renovate facilities as per revised facility design standards
- Ensure that newly constructed facilities fulfill revised facility standards
- Improve access for the community to health facilities: Road, ambulance, insurance
- Improve multi-sectoral participation and dialogue in policy making and implementation
- Improve health care financing policy

7.9. ENHANCE POLICY AND PROCEDURES

Description:

This strategic direction aims to have health facilities standardized, protocols for fee-exempted lifesaving services including EmONC functions, FP, VIA screening for precancerous cervical lesion and vaccination for HP. It also aims to ensure private sector, non-governmental organizations (NGOs) and charity-based organizations (CBOs) participate in policy development, and RH implementations engagements, ensuring existing and new protocols, guidelines and standard checklists are properly applied for quality RH service provision.

7.10. ADDRESS THE SOCIAL DETERMINANTS OF RH

Description:

This strategic direction aims to improve women's participation in decision-making related to reproductive health matters; build partnership with all relevant ministries and sectors; build the capacity of RH women leaders through: advocate for the implementation of existing laws that protect reproductive health such as family health law, abortion law, and laws related to harmful traditional practices; mobilize the community and raise their awareness about the existing laws related to RH rights; build community active participation in the implementation of the laws and amending community norms that promote HTPs, organizing sensitization and advocacy workshops for law enforcement bodies (ministry of justice, police and others) and work closely with them in protecting the reproductive rights and taking corrective measures against the perpetuators and rehabilitative care for the victims.

7.10.1. ADVOCACY AND PARTNERSHIP TO IMPROVE WOMEN'S DECISION MAKING POWER ON RH MATTERS.

Performance target by 2025:

- Increase women's decision-making on RH matters

Major Strategic Initiatives

- Improve women's participation in decision-making related to reproductive health matters
- Build partnership with all relevant ministries and sectors
- Build the capacity of women to lead RH issues

7.10.2. LEGAL FRAMEWORKS TO ADVANCE INDIVIDUALS RH RIGHTS

Performance targets

- Age at marriage will be >18 years.
- Decrease the incidence of female genital cutting (FGC) to <1%.
- Reduce prevalence of FGC among 15 to 19 age group from 47 % to 20 %
- Provide reproductive health services to all without age and sex discrimination

Major Strategic Initiatives

- Advocate for the implementation of existing laws on RH such as family health law, abortion law, and laws related to harmful traditional practices
- Mobilize the community and raise their awareness about the existing laws related to RH rights and build their active participation in the implementation of the laws and amending community norms that promote HTPs

- Distribute the necessary framework documents (family health law, abortion law and guidelines) to all responsible bodies and offices.
- Design, develop and implement targeted and context-specific IEC/BCC messages and materials for community members (men, women, adolescents) on specific HTPs.

7.11. ENHANCE QUALITY IMPROVEMENT AND ASSURANCE ARE INTEGRATED IN RH PROGRAMS

Description:

This strategic direction aims to improve proportion of RMNCYH focal personnel represented in the quality team at all levels; proportion of RH service areas having adequate basic water, electric supply and equipment as per the quality standards; develop, adapt or adopt RH guidelines, standards compatible with current scientific knowledge and following standard knowledge translation approaches; strengthen onsite support systems for quality improvement, data systems for quality of care improvement in RH; use district based collaborative learning as a regular means of face to face learning between facilities and stakeholders in the woreda; and scale up best practices and change packages from existing quality improvement initiatives such as MNH QOC learning districts initiative, MPDSR, some other initiatives in newborn health.

7.11.1. QUALITY CARE PROVISION IN RH

Performance measures

- Proportion of RMNCYH focal personnel represented in the quality team at all levels
- Proportion of RH service areas having adequate basic water, electric supply and equipment as per the quality standards

Major Strategic Initiatives

- Strengthen governance structures for quality care provision in RH program (represent RMNAYH focal persons in existing quality structures at national, regional and district and facility levels)
- Integrate quality and safety in RH plans across all levels of the health care system with allocation of dedicated budget, HR and other resources
- Fulfill basic water, electric supply and equipment requirements of facilities for provision of quality and safe RH services
- Revise infrastructural design and facility standards for provision of quality, safe and dignified RH services

7.11.2. EVIDENCE BASED RH CARE PROVISION

Major Strategic Initiatives

- Develop, adapt or adopt RH guidelines, standards compatible with current scientific knowledge and following standard knowledge translation approaches
- Strengthen onsite support systems for quality improvement such as catchment based clinical mentorship and district-based QI coaching
- Strengthen data systems for quality of care improvement in RH including development of indicators that measure quality in processes and outcomes of care including users' experience of care; and tracking key quality indicators through dashboard at all levels of the health care system for continuous improvement and learning
- Use district based collaborative learning as a regular means of face to face learning between facilities and stakeholders in the woreda
- Scale up best practices and change packages from existing quality improvement initiatives such as MNH QOC learning districts initiative, MPDSR, some other initiatives in newborn health
- Strengthen RAC to for technical, policy and issue briefs

7.11.3. SAFE AND PATIENT CENTERED CARE IN RH SERVICE PROVISION

- Ensure continuity of comprehensive care through the life course by effectively integrating services, strengthening coordination and referral linkages
- Improve consistent implementation of respectful and dignified care, effective communication, and emotional support in RH service provision
- Advocate and implement midwifery led care to improve maternal and newborn health outcomes and reduce over medicalization of care
- Address equity in RH service provision especially of vulnerable and disadvantaged populations through generating evidence/equity analysis and designing context specific service modalities
- Improve enforcement of HCF reforms that allow free RH services
- Regularly measure RH clients' experience of care and use for QI

7.12. STRENGTHENING RESOURCE MOBILIZATION FOR RH SERVICE IMPLEMENTATION

Description

This strategic direction describes how to mobilize resources at different levels (domestic and outside funding sources) to implement reproductive health services at different levels to alleviate the high out of pocket expenditure for health and the progressively declining bilateral and multilateral funding sources through increasing the government's health expenditure and expanding the health insurance schemes, communicating the strategy to stakeholders and national and international funders and donors.

7.12.1. FUNDING DIVERSIFICATIONS FOR RH COMMODITY PROCUREMENT TO BRIDGE FINANCIAL GAP

Key Performance targets by the end of 2025:

- Reduce level of funding gaps from 25%[92] to 10% for RMNCH priority commodities
- Reduce level of funding gaps from 100%[93] to 50% for non-funded RH medicines, supplies and consumables

Major Strategic Initiatives

- Initiate maternal health trust fund
- Increase visibility: showcase and exhibit at high impact and crowd pulling exhibition platforms or forums, strategic communication through newsletter, website, social media platforms and local media
- Plan alignment with responsible partners to secure funding opportunities
- Increase evidence based budget allocation by MoFED
- Plan alignment with responsible partners to secure funding opportunities
- Strengthen donor coordination for funding and advocacy efforts for mobilizing adequate resources
- Improve domestic finance allocation and budget lines for RH commodities
- Advance Reproductive Health Commodity Security (RHCS)

[92] MOH annul budget allocation record
[93] MOH annul budget allocation record

CHAPTER 8: SERVICE DELIVERY MODALITIES

One of the most important steps to improving reproductive, maternal and newborn health is the adoption of a comprehensive approach to service delivery.

8.1. Community-based interventions

Ethiopia has demonstrated that basic health services can be made accessible to a large proportion of the population through cost-effective community based government led health delivery platform.

Building on the existing government flagship, priority will be given to scaling-up of community-based reproductive, maternal and newborn health interventions through HEWs and HDAs. The main objective is to achieve universal health coverage with community-based promotive, preventive and curative interventions and to strengthen the capacity of HEWs and HDA networks, and health care providers at different levels.

8.2. Population-oriented outreach services

In a country like Ethiopia where geographical access presents major barrier, population- oriented outreach preventive and promotive interventions provide an avenue for community action and expanded access, and creates the required linkages between community services and health facilities. The RH strategy will provide population-oriented scheduled services by health workers during regular outreach services, campaigns. This may be delivered through routine and scheduled outreach or in a health facility in a scheduled manner. When scheduling outreach services, attention will be given to variations in access to services within the community.

8.3. Individual-oriented clinical services

This service-delivery mode requires HEWs, health workers (nurses, midwives, health officers and physicians) trained in emergency obstetric, newborn and adolescent and youth health care, and is available on a permanent basis. It addresses individual-specific clinical services required by newborns, children, adolescents and pregnant women who are sick or giving birth. Although preventive and promotive services are important in reducing maternal and neonatal morbidity and mortality, ending preventable deaths requires back-up facility-based services for sick children and pregnant women who require emergency obstetric care and have complications.

To ensure sustainability of having adequately skilled health staff in RH services, the pre-service education programs should be strengthened, including incorporation of high-impact RH interventions in the training curricula so that the graduates qualify with the required skills for these services.

CHAPTER 9: MONITORING AND EVALUATION FRAMEWORK

The successful implementation of the national RH strategy relies on robust monitoring and evaluation system carried out as an integral part of the strategy. Continuous monitoring of progresses and evaluations of outcome and impacts will provide the required evidences for decisions that foster effective, efficient and synergistic implementation of programs. Moreover, it will be integrated into knowledge management efforts that will help document lessons and sharing of experiences both nationally and at the international arena.

The National RMNCAYHN coordination platform under the chairpersonship of the MOH/MCH will lead the coordination of partners involved in RH service. As some of the RH interventions are very much intertwined with child health interventions, there should be strong integration of partners working on maternal and newborn health and child health. In addition, the TWG should work closely with the Policy Planning Directorate of the MoH, EPHI, Universities and other agencies engaged in health research to ensure regular measurement of the progress made in the implementation of the strategy.

A set of high-priority indicators and operational targets will be objectively measured (ANNEX 2) and used for monitoring and evaluation purposes to understand the scale and outcomes of implementation, to provide evidence-based guidance for actions/decisions and to improve accountability at all levels of the health system. The HMIS, while continuing to be vigorously strengthened, remains the main source of data for routine tracking of the performance of most of the interventions of the strategy.

See table -6 below a Monitoring and Evaluation template.

Table 6. *Monitoring and Evaluation template.*

	INDICATOR	DEFINITION How is it calculated?	BASELINE What is the current value?	TARGET What is the target value?	FREQUENCY How often will it be measured?	Source of data	Data collection	Analysis & synthesis	Communication and use
Input	Key Indicators	Numerator/ Denominator	Average baseline data	Average target	Every month/ 3-5 years	Routine Information System: HMIS, CHIS, HRIS HCMIS, LIS, RIS, Vital Statistics, Insurance Information Systems and others Facility Assessments: SARA, SPA	Routine Information System: HMIS, CHIS, HRIS HCMIS, LIS, RIS, Vital Statistics, Facility Assessments : SARA, SPA	Data Quality Assurance; Triangulation of Data from different sources; Comparison of performance against benchmarks (Targets, baselines, standards and international and national commitments.. .)	Regular reporting, review by performance monitoring teams, regular review at JSC, ARM and other forums; midterm and final evaluation, Global reporting, share information products by different platforms
Outputs/outcome/impact indicators	Indicators	Numerator/ Denominator.	Average baseline data	Average target	Every month/ 3-5 years	Routine Information System: HMIS, CHIS, HRIS HCMIS, LIS, RIS, Vital Statistics, Insurance Information Systems and others Facility Assessments: SARA, SPA	Routine Information System: HMIS, CHIS, HRIS HCMIS, LIS, RIS, Vital Statistics, Insurance Information Systems and others Facility Assessments : SARA, SPA		

9.1. Regular performance tracking system

9.1.1. SUPERVISION

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

9.1.2. REVIEW MEETING

Review meetings will be conducted on a regular basis at all levels of the health system to review progress. Review meetings will be held at the national, regional, Woreda and PHCU levels at different time intervals. During these meetings, performance of plans and targets will be reviewed; opportunities, challenges and solutions will be identified; and successes, best practices and lessons learnt will be shared. The F, RHBs, zonal health departments, Woreda health offices and the PHCU will lead the organization of the review meetings at their respective levels.

9.1.3. HEALTH INFORMATION SYSTEM

Services and facilities should generate reliable data routinely at various levels. The data should be primarily utilized by generating unit for local decision-making and passed to the next level without delay. To ensure quality control in M&E, an independent verification system will be established.

Effort will be made to improve data use for program improvement at different levels along with using independent data quality-monitoring mechanisms. HMIS data will be used to fathom progress of activities of those indicators that are tracked by the system on regular basis. Information not captured through HMIS will be tracked through building a national database system integrated from various sources including joint and regular supervision checklist, and performance review meetings and training databases.

9.2. Operational research, surveys and evaluation

Research and surveys will also be used to assess the progresses made in the implementation of interventions, outcomes and impacts. Equally, the necessity of research in RH is also to inform the implementation of the strategy and triangulate data collected routinely in the health information system.

The existing national surveys and evaluations that can be used to review the performance of the national RH strategy include EDHS, Ethiopia Service Provision Assessment (ESPA+) surveys, EmONC surveys, Immunization Coverage Surveys and other program-specific studies such as CBNC evaluations will be used to review progress. The MOH will also strengthen its partnership with local

and international health research centers and universities and work jointly on facilitating bilateral information sharing on current demands for evidence. To this end, RMNCAHN research advisory council under the MCH Directorate has been established. While institutionalizing health research in RMNCAHN, the council plays both leadership and technical roles including advocating for increased financing for research and for building research capacities of institutions and individuals; ascertaining the feasibility of studies in terms of composure of findings and their validity and relevance to pressing needs and demands.

Enhancing and consolidating the scope and organizational arrangement of the newly established RMNCAHN research and advisory council as an important governance platform helps greatly to improve the research and evaluation capacity of the MOH.

CHAPTER 10: COSTING

10.1. Introduction

In order to determine the cost proposed in the RH strategy, it is important to understand how much the intervention, supplies and medicine, and program cost. As part of the HSTP-II planning, the HSTP-II technical working group and the program owners have done costing exercise to determine the costs of program and health services delivery at different levels of health facilities and administration. The RH strategy also needs to be costed in same manner and aligned with costing methods and inputs used for HSTP-II costing with the help of One Health tool.

10.2. Costing Methods

This costing section foresees providing guidance to the effort of estimating the investment of the RH strategy as accurately as possible. The costing begins by outlining targets set for the RH strategy, which will determine the investment items and scope of costing. The One Health tool was used to estimate the cost of implementing the strategy. The targets set out in the strategy should be used to drive the cost estimates. The costing exercise should put the inputs specific to the program management costs, medicines and medical supplies as well as program interventions that are required to translate the RH strategy in to action. The cost for medicines and medical supplies and health intervention costs were extracted from the One Health tool estimate of HSTP II. In the program management costs, the HR cost reflects program specific estimated salaries and benefits as well as training and capacity building intervention costs. The infrastructure cost estimate should also capture construction cost for upgrading of health centers and hospital for some expansion of RH specific program, ensuring availability of equipment, power, water and sanitation services as well as digitalization and technology development at health facility level. All the unit costs for each of the interventions to be used for this costing (Cost estimates for 2021-2025) are extracted from the One Health too l.9.3.

10.3. Determining the RH strategy target and coverage

The costing was made by outlining coverage of key interventions, including baseline coverage and the coverage intended to be reached at the end of the RH strategy period. This is followed by setting specific targets for each of key indicators.

10.4. Component of RH strategy costing

In the costing process it was included all inputs required for provision of services envisioned for the program, particularly program specific HR, infrastructure, medicines and medical supplies and inputs related to program specific management and administration costs are incorporated and aligned with HSTP-II intervention and other related costs.

10.5. Cost of Drugs and Supplies

The computation of the cost of drugs and supplies is to identify the types and quantities of drugs and supplies needed for RH strategy that will depend on the type and list of services/ interventions to be provided through this strategy. The type and list of interventions will be disaggregated for each type of Health Facilities.

Types and quantities of drugs and supplies required for the strategy: quantities of all types of drugs and supplies required for the implementation of RH strategy are defined based on the list of interventions envisioned to be provided by each type of Health Facility. Type and quantities of drugs and supplies are defined in One Health tool once interventions are identified in the tool.

Unit cost of each drug and supply: cost of medicine and medical supplies are generated from the One Health tool, which uses cost data from EPSA. Here, it is important to ensure that a comprehensive list of drugs and supplies required for each intervention/ service in the strategy are included.

10.6. Costing Summary

Based on the above assumptions and One Health tool pre-defined as well as customized intervention list, the total cost of the RH strategy is estimated. The five-year total cost from 2021-2025 is 2,379,306,124 US dollar. From the total cost of the strategy 1,816,872,463 (76.36%) US dollar is for the drugs and supplies cost and the rest of 562,433,661(23.63%) US dollar is for program management cost.

The total cost in this strategy shows that the sum of service delivery/ intervention costs and the program management cost of RH strategy. In addition to this, the total cost of the strategy excluded newborn health, child health and nutrition.

The intervention coverage/targets, the number of service delivery package, detailed cost of drug and supplies, program management's costs are indicated in the following tables below (tables 7-9).

Table 7. *Summary intervention, drug and supply and program costs.*

Summary cost in $ (USD)						
	2021	***2022***	***2023***	***2024***	***2025***	***Total***
Family Planning						
Service package cost	5,525,152	6,733,651	7,037,006	6,738,976	7,495,101	***33,529,886***
	Maternal health					
	33,404,886	34,425,862	6,853,274	45,700,377	61,284,220	***241,008,386***
	Other sexual and reproductive health					
	33,404,886	34,425,862	6,853,274	45,700,377	61,284,220	***241,008,386***
	PMTCT					
	76,144,571	85,944,316	95,859,217	106,086,137	116,764,879	**547,125,033**
Drug and supply cost	***Family planning***					
	19,940,152	23,313,531	23,646,475	24,858,283	26,857,156	***118,615,597***
	Maternal health					
	20,511,453	225,058,017	234,202,802	264,712,194	313,603,989	***1,473,172,912***
	PMTCT					
	31,670,316	35,987,974	39,741,151	43,580,853	47,849,421	***225,083,954***
Program cost	***Family planning***					
	20,148,505	18,793,647	18,666,647	18,651,647	11,682,647	***87,943,092***
	Maternal Health					
	53,214,902	57,614,107	59,960,082	57,451,434	50,238,286	***278,478,811***
	PMTCT					
	3,502,062	2,790,594	2,794,634	2,524,877	2,436,226	***14,048,394***
	Adolescent					
	5,226,774	62,260,605	5,184,635	4,798,114	4,493,236	***181,963,364***
Total cost						**$ 562,433,661**

Table 8. *Number of service package for each program.*

Total number of service package						
Total number of services by service package, Family Planning						
	2021	***2022***	***2023***	***2024***	***2025***	***Total***
Family Planning						
Pill - Standard daily regimen	823,481	883,818	913,651	958,337	982,395	4,561,682
Condom - Male	130,633	146,172	151,425	156,370	157,733	742,332
Injectable - 3 month (Depo Provera)	213,781	246,964	980,614	1,429,593	1,891,700	4,762,653
IUD - Copper-T 380-A IUD (10 years)	83,804	89,252	250,307	228,001	250,236	901,601
Implant - Implanon (3 years)	781,167	835,347	485,842	542,538	447,003	3,091,898
Implant - Jadelle (5 years)	145,274	154,941	584,002	537,739	613,466	2,035,422
Female sterilization	22,489	164,643	7,834	14,990	10,882	220,836
Male sterilization	103,063	755,019	647,114	16,174	542,660	2,064,031
Periodic abstinence	613,611	658,570	563,977	526,970	471,550	2,834,678
Withdrawal	920,417	987,856	845,965	790,454	707,325	4,252,017
Traditional (not specified)	690,313	740,892	689,814	681,485	653,882	3,456,385
Other contraceptives	997,118	1,070,177	916,462	856,326	766,268	4,606,351
Total	***5,525,152***	***6,733,651***	***7,037,006***	***6,738,976***	***7,495,101***	***33,529,886***
Total number of services by service package, Maternal health						
	2021	***2022***	***2023***	***2024***	***2025***	***Total***
Maternal health						
Pre conception care	433,243	432,484	451,944	610,344	1,236,225	3,164,240
Management of ectopic pregnancy care						
Ectopic case management	30,327	32,119	33,729	35,129	36,263	195,944
Pregnancy care – ANC						
Tetanus toxoid (pregnant women)	1,388,423	1,396,001	1,397,467	1,392,393	1,395,061	8,344,242
Syphilis screening (pregnant women)	3,076,027	3,383,157	3,668,019	3,926,205	3,939,438	20,743,251

Antenatal Care (ANC): at least four visit	3,223,330	3,301,790	3,364,459	3,409,599	3,502,639	19,932,038
Early ANC <16 weeks	869,700	879,603	993,995	1,446,497	1,913,014	6,976,392
Antenatal Care - First visit	3,208,786	3,189,060	3,250,594	3,595,577	3,993,038	20,468,068
Hepatitis (B and C) testing and treatment (pregnant women)	433,243	432,484	451,944	610,344	1,236,225	3,164,240
Screening & treatment of mental health problem in pregnant and postpartum women	1,083,108	1,075,914	1,091,944	1,279,536	2,060,376	6,590,878
Prevention of maternal alcohol use during pregnancy	1,083,108	1,075,914	1,091,944	1,279,536	2,060,376	6,590,878
Pregnancy care - Treatment of pregnancy complications						
Hypertensive disorder case management	208,997	214,809	219,575	223,174	228,694	1,297,468
Management of pre-eclampsia (magnesium sulphate)	188,097	193,328	197,618	200,856	205,824	1,167,722
Management of other pregnancy complications	481,286	478,128	486,081	533,137	588,067	3,051,347
Deworming (pregnant women)	649,256	691,730	1,001,920	2,165,612	3,339,290	8,495,035
Screening and management of GDM	108,311	130,920	157,614	188,931	230,357	816,133
Childbirth care - Facility births						
Parenteral administration of uterotonics	3,231,995	3,443,112	3,634,290	3,802,220	3,857,023	20,972,255
Labor and delivery management	3,162,676	3,340,332	3,499,375	3,636,906	3,683,952	20,291,930
Pre-referral management of labor complications	325,199	323,121	329,705	384,989	512,401	2,202,844
Parenteral administration of anti-convulsants	170,785	180,378	188,966	196,393	198,933	1,095,764
Neonatal resuscitation	70,183	77,095	83,558	89,490	95,528	478,746
Treatment of local infections (Newborn)	280,732	277,540	273,464	268,469	268,672	1,651,892

Management of obstructed labor	276,766	296,044	313,747	329,623	348,835	1,821,115
Kangaroo mother care	231,933	240,955	248,904	255,636	258,839	1,458,195
Feeding counseling and support for low-birth-weight infants	312,124	309,823	313,936	354,457	451,292	2,056,091
Parenteral administration of antibiotics	75,898	75,521	77,551	87,823	99,335	492,539
Manual removal of placenta	44,974	46,684	48,183	49,443	51,770	284,126
Removal of retained products of conception	22,359	23,152	23,842	24,417	25,519	140,760
Blood transfusion	41,617	41,297	41,681	44,635	48,270	259,414
Childbirth care - Home births						
Clean birth environment	954,586	828,671	703,441	579,893	494,506	4,641,111
Childbirth care – Other						
Antenatal corticosteroids for preterm labor	68,626	102,779	135,590	166,636	196,214	703,374
Antibiotics for preterm or prolonged PROM	202,180	214,124	224,860	234,195	261,618	1,326,158
Induction of labor for pregnancies lasting 41+ weeks	63,233	85,903	107,633	128,187	141,026	565,820
Cesarean section	26,171	26,966	33,589	58,893	84,612	256,450
24 hour stay PNC	9,641	69,323	452,316	1,859,781	3,266,591	5,658,970
Early PNC	3,647,908	3,631,541	3,600,562	3,554,249	3,618,020	21,702,021
Postpartum care - Treatment of sepsis						
Maternal sepsis case management	134,999	138,709	141,746	144,030	145,298	835,447
Postpartum care – Other						
Mastitis	218,540	217,251	221,749	246,097	274,702	1,398,488
Treatment of postpartum hemorrhage	173,404	172,069	173,670	185,978	201,126	1,080,891
Obstetric fistula	162	150	156	239	380	1,264
Management of uterine prolapse	496,840	521,604	579,105	810,378	1,293,606	4,178,679

Safe abortion						
Safe abortion	649,970	641,975	629,531	612,585	599,809	3,787,447
Management of abortion complications						
Post-abortion case management	4,584	4,685	4,749	4,772	4,801	28,039
Other sexual and reproductive health						
Treatment of urinary tract infection (UTI)	372,219	369,931	377,069	417,087	463,192	2,374,296
Cervical cancer screening	961,813	1,051,595	1,470,954	3,663,264	8,428,310	16,493,524
Identification and management of infertility	133,684	144,750	200,378	493,669	1,123,317	2,224,442
Treatment of PID (Pelvic Inflammatory Disease)	573,840	621,340	860,125	2,119,075	4,821,837	9,548,418
Total	***33,404,886***	***34,425,862***	***36,853,274***	***45,700,377***	***61,284,220***	***241,008,386***
Total number of services by service package, PMTCT						
	2021	**2022**	**2023**	**2024**	**2025**	**Total**
PMTCT						
Testing for PMTCT (Testing for pregnant women)	3,858,080	3,887,402	3,883,634	3,913,590	3,997,544	23,243,007
ART for PMTCT	25,687	25,147	24,429	23,850	23,668	148,488
NVP + AZT prophylaxis for HEIs	16,957	18,792	20,348	21,875	23,668	116,330
EID by DBS for HEI	17,477	18,526	19,349	20,189	21,301	112,860
POC (Point of Care testing) for EID using Gene xpert machine	728	869	994	1,114	1,246	5,515
Cotrimoxazol for HEI	25,463	24,984	24,324	23,799	23,668	147,663
Confirmatory test for HEI (ab test)	15,613	17,814	19,721	21,571	23,668	111,383
Cotrimoxazol for HIV positive women	13,991	16,294	18,308	20,255	22,422	102,570
IPT (INH preventive therapy) for HIV positive women	12,592	14,664	16,477	18,229	20,180	92,313

Testing for partners of pregnant women	687,472	1,034,295	1,357,986	1,680,145	2,019,811	7,097,089
Screen HIV+ pregnant and lactating women for TB	20,706	21,182	21,447	21,774	22,422	127,306
Nutrition supplements for HIV positive pregnant, lactating and HIV exposed infants	3,296	4,334	5,268	6,157	5,606	26,808
Screening for syphilis in pregnancy	3,177,769	3,386,086	3,557,855	3,753,335	3,997,544	20,737,816
Treatment of syphilis in pregnancy	74,252	76,649	78,316	80,591	83,948	463,183
Condom distribution for HIV positive pregnant and lactating women.	12,983	14,338	15,484	16,609	17,938	88,652
Viral load test for HIV positive pregnant and lactating women	18,971	20,259	21,290	22,331	23,668	123,751
CD4 test for HIV positive pregnant and lactating women	22,105	22,540	22,755	23,040	23,668	135,295
Exclusive breast feeding	67,073,415	75,465,481	84,118,421	93,035,040	102,247,050	480,899,407
Hepatitis B screening	984,661	1,715,030	2,400,480	3,078,578	3,787,146	12,186,299
Hepatitis B prophylaxis	40,282	79,155	115,737	151,820	189,357	576,352
Hepatitis B treatment	42,072	80,475	116,595	152,242	189,357	582,945
Total	**76,144,571**	**85,944,316**	**95,859,217**	**106,086,137**	**116,764,879**	**547,125,033**

Table 9. *Cost of drugs and supplies for the specific program interventions.*

Total Drug and Supplies Cost in $(USD)						
Drugs and supplies cost, Family Planning, US$						
	2021	***2022***		***2024***	***2025***	***Total***
Family Planning						
Pill - Standard daily regimen	5,682,021	6,098,342	6,304,190	6,612,522	6,778,527	31,475,603
Condom - Male	1,026,773	1,148,910	1,190,198	1,229,069	1,239,783	5,834,733
Injectable - 3 month (Depo Provera)	750,373	866,843	3,441,956	5,017,872	6,639,868	16,716,913
IUD - Copper-T 380-A IUD (10 yrs)	107,738	114,569	320,819	291,785	319,751	1,154,662
Implant - Implanon (3 years)	11,005,771	11,769,110	6,844,971	7,643,755	6,297,774	43,561,382
Implant - Jadelle (5 years)	1,070,670	1,141,914	4,304,095	3,963,137	4,521,246	15,001,062
Female sterilization	105,107	769,507	36,613	70,060	50,858	1,032,145
Male sterilization	191,698	1,404,336	1,203,632	30,083	1,009,348	3,839,097
Total	***19,940,152***	***23,313,531***	***23,646,475***	***24,858,283***	***26,857,156***	***118,615,597***
Drug and supply costs, Maternal Health, US$						
	2021	***2022***	***2023***	***2024***	***2025***	***Total***
Maternal and Newborn						
Pre conception care	492,633	511,181	554,468	776,196	1,627,639	3,962,116
Management of ectopic pregnancy care						
Ectopic case management	444,410	470,664	494,261	514,781	531,390	2,871,344
Pregnancy care – ANC						
Tetanus toxoid (pregnant women)	192,435	198,093	202,912	206,770	211,770	1,198,004
Syphilis screening (pregnant women)	1,482,030	1,630,005	1,767,252	1,891,646	1,898,021	9,994,098

Antenatal Care (ANC): at least four visit	13,632,650	14,416,336	15,150,389	15,820,260	16,731,293	88,561,414
Early ANC <16 weeks	819,978	829,315	937,166	1,363,797	1,803,643	6,577,538
ANC - First visit	36,301,377	35,326,588	35,242,092	38,134,871	41,409,241	223,728,527
Pregnancy care - Treatment of pregnancy complications						
Hypertensive disorder case management	31,349	32,221	32,936	33,476	34,304	194,620
Management of pre-eclampsia (Magnesium sulphate)	5,689,764	5,848,005	5,977,760	6,075,727	6,226,001	35,322,538
Management of other pregnancy complications	18,848,514	18,724,848	19,036,325	20,879,171	23,030,377	119,499,410
Deworming (pregnant women)	25,970	27,669	40,077	86,624	133,572	339,801
Screening and management of GDM	452,940	547,489	659,119	790,082	963,320	3,412,950
Childbirth care - Facility births						
Parenteral administration of uterotonic	743,359	791,916	835,887	874,510	887,115	4,823,619
Labor and delivery management	39,411,516	41,625,373	43,607,270	45,321,103	45,907,367	252,866,792
Pre-referral management of labor complications	9,752,227	9,689,899	9,887,369	11,545,253	15,366,133	66,059,987
Parenteral administration of anti-convulsant	8,222,116	8,683,975	9,097,443	9,454,987	9,577,295	52,753,618
Neonatal resuscitation	370,161	406,614	440,706	471,989	503,835	2,525,010
Treatment of local infections (Newborn)	6,212,457	6,141,822	6,051,614	5,941,087	5,945,573	36,555,502
Management of obstructed labor	10,758,229	11,507,600	12,195,729	12,812,856	13,559,637	70,788,931

Feeding counseling and support for low-birth-weight infants	2,247,290	2,230,724	2,260,339	2,552,089	3,249,301	14,803,854
Parenteral administration of antibiotics	1,561,000	1,553,249	1,595,005	1,806,265	2,043,028	10,130,101
Manual removal of placenta	535,196	555,538	573,373	588,378	616,069	3,381,101
Removal of retained products of conception	65,736	68,067	70,096	71,785	75,026	413,834
Blood transfusion	376,801	353,128	335,448	336,769	339,918	2,142,640
Childbirth care - Home births						
Clean birth environment	1,307,783	1,135,279	963,714	794,453	677,473	6,358,322
Childbirth care – Other						
Antenatal corticosteroids for preterm labor	116,664	174,725	230,503	283,282	333,563	1,195,736
Antibiotics for preterm or prolonged PROM	727,057	770,007	808,613	842,183	940,800	4,768,970
Induction of labor for pregnancies lasting 41+ weeks	663,318	901,127	1,129,067	1,344,680	1,479,360	5,935,448
Cesarean section	1,579,083	1,627,017	2,026,644	3,553,391	5,105,177	15,473,238
24 hour stay PNC	17,837	128,248	836,784	3,440,595	6,043,194	10,469,095
Postpartum care - Treatment of sepsis						
Maternal sepsis case management	5,767,995	5,926,546	6,056,276	6,153,862	6,208,037	35,695,594
Mastitis	6,599,911	6,560,989	6,696,822	7,432,126	8,296,002	42,234,326
Treatment of postpartum hemorrhage	4,656,863	4,621,008	4,664,003	4,994,536	5,401,326	29,027,873
Obstetric fistula	3,079	2,497	2,218	2,833	3,606	17,998

Management of utrine prolapse	11,906,633	12,500,094	13,878,095	19,420,487	31,000,895	100,140,860
Safe abortion						
Safe abortion	16,155,086	15,956,365	15,647,084	15,225,867	14,908,318	94,137,483
Management of abortion complications						
Post-abortion case management	223,185	228,129	231,248	232,360	233,779	1,365,296
Other sexual and reproductive health						
Treatment of urinary tract infection (UTI)	8,593,200	8,540,374	8,705,163	9,629,036	10,693,445	54,813,944
Identification and management of infertility	390,458	422,778	585,253	1,441,879	3,280,916	6,497,017
Treatment of PID (Pelvic Inflammatory Disease)	3,133,166	3,392,517	4,696,280	11,570,152	26,327,229	52,134,360
Total	***220,511,453***	***225,058,017***	***234,202,802***	***264,712,194***	***313,603,989***	***1,473,172,912***
Drugs and supply costs, PMTCT, US$						
	2021	***2022***	***2023***	***2024***	***2025***	***Total***
PMTCT						
Testing for PMTCT (Testing for pregnant women)	12,500,178	12,595,183	12,582,975	12,680,032	12,952,041	75,307,341
ART for PMTCT	125,315	122,028	117,909	114,498	113,009	718,846
NVP + AZT prophylaxis for HEIs	43,036	47,441	51,095	54,633	58,791	292,478
EID by DBS for HEI	346,674	365,526	379,728	394,077	413,536	2,218,966
Cotrimoxazole for HEI	344,360	334,432	322,243	312,010	307,019	1,967,429
Confirmatory test for HEI (ab test)	55,084	62,208	68,155	73,774	80,092	385,628
Cotrimoxazole for HIV positive women	1,184,611	1,365,546	1,518,565	1,662,514	1,821,036	8,518,852

IPT (INH preventive therapy) for HIV positive women	14,808	17,069	18,982	20,781	22,763	106,486
Testing for Partners of pregnant women	2,326,406	3,481,438	4,546,537	5,594,882	6,689,616	23,718,602
Nutrition supplements for HIV positive pregnant, Lactating and HIV exposed Infants	66,303	87,181	105,957	123,857	112,755	539,241
Screening for Syphilis in Pregnancy	10,324,489	10,889,047	11,323,473	11,821,190	12,457,798	66,220,041
Treatment of Syphilis in Pregnancy	497,575	511,039	519,503	531,870	551,185	3,078,758
Condom distribution for HIV positive pregnant and lactating women.	7,404	8,135	8,740	9,328	10,022	50,105
Viral load test for HIV positive pregnant and lactating women	1,115,509	1,179,048	1,226,302	1,272,863	1,334,865	7,152,219
CD4 test for HIV positive pregnant and lactating women	27,355	27,752	27,874	28,080	28,697	166,111
Hepatitis B screening	1,226,858	2,119,143	2,941,285	3,740,319	4,562,035	14,866,532
Hepatitis B prophylaxis	64,662	125,767	181,995	236,248	291,557	900,228
Hepatitis B treatment	1,399,691	2,649,990	3,799,833	4,909,897	6,042,604	18,876,088
Total	***31,670,316***	***35,987,974***	***39,741,151***	***43,580,853***	***47,849,421***	***225,083,954***
Grand total cost for drugs and supplies						**1,816,872,463**

Table 10. *Program management cost for the specific individual programs.*

Program costing summary US $-Family planning						
	2021	***2022***	***2023***	***2024***	***2025***	***Total***
Program specific human resources	474,000	474,000	474,000	474,000	474,000	2,370,000
Training	6,394,805	5,228,947	5,088,947	5,088,947	5,088,947	26,890,592
Supervision	113,900	113,900	113,900	113,900	113,900	569,500
Monitoring and evaluation	41,000	27,000	25,000	25,000	41,000	159,000
Communication, media & outreach	300,000	130,000	130,000	130,000	145,000	835,000
Advocacy	12,769,800	12,769,800	12,784,800	12,769,800	5,769,800	56,864,000
General program management	25,000	20,000	20,000	20,000	20,000	105,000
Other	30,000	30,000	30,000	30,000	30,000	150,000
Total	***20,148,505***	***18,793,647***	***18,666,647***	***18,651,647***	***11,682,647***	***87,943,092***
Program costing summary US $- Maternal health						
	2021	***2022***	***2023***	***2024***	***2025***	***Total***
Program specific human resources	758,000	756,000	756,000	756,000	756,000	3,782,000
Training	906,383	2,359,308	2,550,283	2,353,475	1,235,487	9,404,936
Supervision	747,000	747,000	747,000	747,000	747,000	3,735,000
Monitoring and Evaluation	50,000	-	2,100,000	50,000	-	2,200,000
Infrastructure and Equipment	46,102,197	46,102,197	46,102,197	46,102,197	46,102,197	230,510,985
Communication, media & outreach	3,754,720	248,000	239,000	119,160	264,000	4,624,880
Advocacy	765,602	570,602	715,602	515,602	710,602	3,278,010
General program management	23,000	23,000	23,000	108,000	223,000	400,000
Other						-
New ANC Guideline for Positive pregnancy Experience	54,000	-	-	-	-	54,000

Revise safe abortion technical and procedural guideline	-	27,000	-	-	-	27,000
Revise postnatal care guideline	-	-	27,000	-	-	27,000
Revision of catchment based clinical mentoring	-	27,000	-	-	-	27,000
Revision of obstetric referral guideline	27,000	-	-	-	-	27,000
Revision of maternity waiting home guideline	27,000	-	-	-	-	27,000
Respectful Maternity Care Guideline	-	54,000	-	-	-	54,000
COVID response PPE for Maternal Health Service	-	-	-	-	-	-
Portable Ob U/S	-	6,500,000	6,500,000	6,500,000	-	19,500,000
NASG		200,000	200,000	200,000	200,000	800,000
Total	***53,214,902***	***57,614,107***	***59,960,082***	***57,451,434***	***50,238,286***	***278,478,811***
Program costing summary US $ -PMTCT						
	2021	***2022***	***2023***	***2024***	***2025***	***Total***
Programme-specific human resources	288,000	288,000	288,000	288,000	288,000	1,440,000
Training	1,274,933	1,223,120	1,211,315	1,132,403	1,082,907	5,924,679
Supervision	561,664	561,664	561,664	561,664	561,664	2,808,320
Communication, media & outreach	810,000	260,000	320,000	365,000	160,000	1,915,000
Advocacy	165,000	168,000	38,000	38,000	168,000	577,000
General program management	252,465	139,810	175,655	139,810	175,655	883,395
Other(viral load machine)	150,000	150,000	200,000	-	-	500,000
Total	***3,502,062***	***2,790,594***	***2,794,634***	***2,524,877***	***2,436,226***	***14,048,394***

Program costing summary US $-Adolescence Health						
Program cost	***2021***	***2022***	***2023***	***2024***	***2025***	***Total***
Programme-specific human resources	2,076,000	2,076,000	2,076,000	2,076,000	2,076,000	10,380,000
Training	1,099,202	1,615,629	984,396	665,196	434,796	4,799,219
Supervision	659,290	659,290	659,290	659,290	659,290	3,296,450
Monitoring and evaluation	-	78,489	-	-	-	78,489
Communication, media & outreach	436,650	156,796,750	379,200	284,400	284,400	158,181,400
Advocacy	594,420	599,420	594,420	594,420	593,420	2,976,100
General programme management	23,712	23,712	23,712	23,712	23,712	118,560
Other (Total Cost)	*337,500*	*411,315*	*467,617*	*495,096*	*421,618*	*2,133,146*
Generate best practice for experience sharing	12500	12500	12500	12500	12500	62,500
Initiate AYRH MNHQI network at quality directorate		2136	23214	17340	24211	66,901
MOH/RHB AYH staff capacity building	75000	75000	75000	75000	75000	375,000
Established AYH services within 300 catchment mentors Hospital	250000	321679	356903	390256	309907	1,628,745
Total	***5,226,774***	***162,260,605***	***5,184,635***	***4,798,114***	***4,493,236***	***181,963,364***
Grand total cost for program management						***562,433,661***

ANNEXES

Annex 1: Implementation plan

Strategic Direction 1: Enhance provision of equitable and quality reproductive maternal , new born , adolescent and youth health services										
Strategy1: Initiate implementation of preconception care										
			Year of Intervention							
Strategic initiatives		**Activities**		**2021**	**2022**	**2023**	**2024**	**2025**	**Base line**
1.	Enhance use of preconception care implementation guideline and training manual	Develop preconception care implementation guideline							
		Develop training manual							
		Use preconception care implementation guideline and training manual							
2	Ensure community and health care providers awareness and capacity on preconception care services	Provide advocacy session for leaders and stakeholders							
		Create community and awareness for community and HCWs							
		Provide capacity building to HCWs							
		Implement preconception service							
	Integrate preconception care with other health services and to the curriculum	Integrate preconception care with other health services							
		Integrate preconception care to the curriculum							
Strategy 2: Improve equitable access to quality antenatal care (ANC) services										
1	Ensure ANC guideline and training materials including capacity building to providers for 8 ANC contacts	Develop and implement the ANC guideline							
		Provide cascade training to all level of ANC providers and managers							
		Train midwives on limited obstetric ultrasound							

2	Strengthen nutritional assessment and counseling and intervention for pregnant women,	Provide micronutrient supplementation (iron, folate and multiple micronutrient) to pregnant women								
		Introduce calcium supplementation to prevent preeclampsia and eclampsia								
3	Ensure provision of essential ANC services at all levels of health in a respectful and compassionate manner	Pregnant mothers have access to high quality 8 ANC contacts according to the national guideline								
		Provide Ultrasound scanning for all pregnant mothers								
		Conduct ANC clinical audit								
Strategy 3: Improve equitable access to quality and utilization of delivery and emergency obstetrics and newborn care (EmONC) care services										
1	Strengthen and decentralize EmONC service	Decentralize CEmONC services through upgrading health centers and training of CEmONC provides,								0
		Upgrade health posts to provide BEmONC services								0
		Strengthen existing CEmONC centers to provide the 10 CEmONC functions								
2	Strengthen & expand essential newborn care, low birth weight and preterm baby's services	Institute Kangaroo Mother Care (KMC) and Kangaroo Father Care (KFC)								
		Provide thermal radiant at all HCS								
		Establish ICU care service at all hospitals								3
		Expand and strengthen health facilities providing essential newborn care								
		Strengthen preterm care feeding and care								
		Conduct CEmONC clinical audit								
		Birth preparedness and complication readiness plan established at each kebele								
		Referral protocol guideline revised and implemented								

		At least one ambulance per HC availed							
4	Improve community awareness and engagement to increase health seeking behavior	Increase community awareness about importance of institutional delivery through different platforms							
		Implement community score cards for institutional delivery							
5	Ensure respectful maternity care, including birth companion, birthing position and pain management	Ensure all maternal health care professionals are trained with at least 5 CEU course on RMC							
		Avail pain management options in all facilities and epidural in hospitals							
		Provide ultrasound scanning for all pregnant mothers							
Strategy 4: Improve equitable access and utilization of quality postnatal care									
1	Provide high quality postnatal and newborn care	Expand postnatal mental health problems management							
		Ensure provision of early postnatal care services for mothers and newborns as per the standard							
		Ensure provision of PNC 24 hour stay and care for mothers and newborns as per the standard in 90% health facilities							
		Ensure postnatal counseling on danger signs for mothers and newborns and health education on family planning, vaccination, sunlight exposure and breast feeding							
		Expand and strengthen maternity waiting homes at health centers and primary hospitals							
		Revise maternity waiting home guideline that addresses pastoralist regions and implement							
		Conduct PNC clinical audit							
2	Strengthen community PNC services	Engage community and religious leaders for postnatal care using various means (media and IEC/BCC materials)							

		Introduce PNC kit for community postnatal care services								
Strategy 5: Strengthen Maternal and Perinatal Mortality and Morbidity (Near-miss) Surveillance and Response										
1	Ensure functionality of MPMMSR in all health facilities and Woreda	Strengthen MPDSR committee for at all level of the health system								
		Conduct regular MPMMSR supportive supervision to keep its functionality								
		Conduct regular mentorship for PHEM to keep its functionality								
		Submit timely and complete maternal and perinatal death and response report at woreda level								
		Collaboration with blood bank and establish Mini blood bank and blood products in response to MPMM at hospitals								
		Conduct MPDSR clinical audit								
2	Strengthen maternal and perinatal mortality and morbidity review and response at all levels	Review and response maternal near miss								
		Identification review and response maternal deaths at all facility level								
		Integrate birth defect surveillance and response into MPMMSR								
3	Strengthen the maternal and perinatal death investigations and verifications at the community level	Create awareness within the community on the importance of maternal and perinatal deaths, notification and response,								
		Conduct Maternal and perinatal death tracing and report at the community level in the form of verbal autopsies and maternal and perinatal deaths summaries or reviews and response								
Strategy 6: Increase access and quality of comprehensive and safe abortion care service										
1	Ensure capacity building on SAC and CAC	Value clarification training (VCAT) towards CAC								
		Conduct CBCM								
		Introduce SOJT for CAC & SAC								

		Whole site (Cross section of Hospital personnel) VCAT								
2	Strengthen safe abortion and comprehensive abortion services are provided at all levels (from health center to tertiary level)	Revise safe abortion technical and procedural guidelines								
		Integrate FP, preconception care, STI/HIV, nutrition and psychosocial support in to CAC and SAC								
		CAC and SAC provided at HCs and hospitals								
		Second trimester medical abortion provide at hospital level								
		Second trimester surgical abortion provide at general and tertiary hospitals								
		Conduct onsite and regional review meetings								
		Conduct community awareness on the risks of unsafe abortion								
		Conduct clinical audit for CAC and SAC								
		Maintain Record Keeping & Report								
Strategy 7: Improve obstetric fistula prevention, case identification, referral and management										
1	Ensure Obstetric Fistula prevention	Increase community sanitization(organize events) the prevention of FGM, Early marriage, Fistula treatment								
		Accessing quality of emergency obstetrics and newborn care EmONC) and family planning services								
		Accessing quality family planning services								
		Develop IEC/ BCC Materials								
		Disseminate IEC/ BCC Materials & Use of local media								
2	Ensure early detection and referral system to facilitate early treatment of cases	Create awareness for HDA, Volunteers, HEW regarding warning signs, about fistula								
		Train HCPs and health leaders on early detection and organizing the HWF								

		Arrange means of transport for referral							
		Conduct regular Surveillance and Response							
3	Enhance obstetric fistula management services in tertiary hospitals: Expand addition treatment centers	Train Surgeon and OBGYN in fistula repair treatment							
		Equip fistula repair OR theater center with supplies and equipment							
4	Strengthen rehabilitation and re-integration of obstetric fistula survivors	Conduct awareness creation and , sensitization workshop (involve religious leaders , Husband & partners)							
		Create networking with fistula survivors for knowledge and experience transfer							
		Provide Psychosocial support / PSS to fistula survivors							
5	Ensure obstetric fistula and OBF surveillance and response strategies, implementation manual	Revise Obstetric fistula and obstetric fistula surveillance and response strategic plan							
		Follow the implementation of the strategic plan							
		Develop Implementation manual							
		Disseminate Implementation OBF manual							
		Continuous monitoring & Evaluation							
		Integrate appropriate recording and reporting formats in to routine PHEM and DHIS 2 reporting system							
		Conduct Sensitization orientation for HCPs on the new integrated documentation and reporting							
Strategy 8: Improve pelvic organ prolapse prevention, identification, referral, and management									
1	Ensure Pelvic Organ Prolapse prevention strategies are implemented	Conduct community sensitization/ awareness Events (Birth spacing, Avoid grand multi para)							
		Strengthen family planning service provision							
		Strengthen skilled birth attendance							

		multi-sectoral collaboration in the prevention and management of POP								
2	Strengthen identification and referral of symptomatic POP at all levels	Provide training to health care workers to identify and refer POP cases to a higher level								
		Conduct community sensitization workshop including religious leaders , HDAs, Husband & partners								
3	Ensure treatment for pelvic organ prolapse including pessaries	Train for HCWs								
		Avail Kit & Supplies , Equip OR theater								
		Exchange experience sharing within & between the facility								
		Increase number of health facilities treating POP								
Strategy 9: Strategy 9: Strengthening prevention, and clinical management of FGM										
1	Ensure appropriate FGM interventions are in place	Update FGM management guidelines and protocols								
		Conduct biannual review meetings at selected FGM prevent regions								
		Strengthening partnerships around FGM and maternal health								
		Supply & Logistic support								
2	Ensure capacity buildings at all levels including community leaders	Provide trainings to Health care providers to manage FGM survivors								
		Provide mentoring to service to FGM affected areas								
		Provide capacity building to community leaders								
Strategy 10: Improve access to screening and management for reproductive organ cancers Strategic interventions:										
1	Ensure community awareness on reproductive organ cancers including breast self-examination	Develop standardized national and local communication materials (SBCC , Media messages)								
		Educate adolescent &young girls on ROC including cervical cancer at school & out of school								

		Educate women to be aware on BSE and practice the examination								
2	Improve reproductive organ cancers treatment in the country	Provide basic trainings to mid-level health care providers to screen cervical cancer								
3	Expand the number of health facilities providing screening and diagnosis ROC (Visual inspection with Acetic Acid for precancerous cervical lesion, **Pap** smear for HPV test, BSE, mammography an biopsy	Conduct facility readiness Assessment								
		Train health care providers Conduct Integrated screening								
		Avail necessary equipment for the new facility to capacitate and able provide the treatment								
		Support the new facility to start ROC treatment								
		Conduct mentoring and supportive supervision								
Strategy 11:Improve demand, access and utilization of quality Family Planning services										
1	Ensure the capacity of HCWs and HEWs on family planning	Conduct training needs assessment with CPD providers : Value Clarification and Attitude Transformation (VCAT), SOJT								
		Develop national service integration training packages as per the gap identified								
		Conduct ToT trainings								
		Conduct basic training to HCPs								
		Conduct post training follow-up and mentoring								
2	Improve family planning guide lines, quality standards, and policies	Develop family planning guide lines, policies and Job aids								
		Follow the implementation of its implementation								
		Develop and implement family planning clinical audit								
3	Improve demand for family planning services through effective social and behavior change communication interventions	Develop tailored FP communication materials for different segment of the community and monitor their utilization at all levels								
		Conduct family planning promotion using different platforms (Mass media and print media interventions								

		Involve male involvement in family planning services utilization							
		Conduct communication and facilitation skills training to HEWs and other community level health agents							
		Involve parliamentarians, political leaders, NGOs, community leaders and champions to advocate family planning services							
4	Improve the quality and access for family planning services to the community	Expand family planning services including LARCs to hard to reach areas through mobile clinic and outreach services to reduce unmet need for family planning							
		Conduct Family planning clinical audit							
		Follow the provision of client-centered and compassionate family planning counseling services before pregnancy, during ANC and latent phase of labor, post-partum and abortion care service and ensure male involvement in the FP service							
		Conduct mentoring and SOJT services to the facility							
		Provide postpartum and post abortion family planning services at all health facilities							
		Integrate family planning service into maternal and newborn continuum of care							
		Work with the RAC team to identify the root causes of FP discontinuation rate							
		Provide family planning services for youth groups at universities, and people with special needs, disable, and vulnerable Youths							
5	Improve adaptation, advocacy, promotion, and implementation of new	Identify new family planning innovation areas							
		Adapt the new innovation approach							
		Pilot the new innovation approach							

	innovative family planning approaches	Train providers, leaders, based to implement							
Strategy 12: Improve access to and utilization of Reproductive Health services in humanitarian settings									
1	Ensure reproductive health standards, guidelines and services packages in humanitarian settings	Adapt RH guidelines for humanitarian settings							
		Develop protocols for humanitarian settings							
		Develop job aids for humanitarian settings							
		Follow the implementation of guidelines, protocols and job aids at the humanitarian settings through mentorship and supportive supervision							
		Adopt adolescent youth tailored guidelines and toolkits in humanitarians setting							
2	Enhance capacity building to humanitarian health workers	Conduct competency based trainings to providers at the humanitarian settings							
		Collaborate with organizations working at humanitarian settings to provide supportive supervision and mentoring							
3	Improve all RH components services provision at humanitarian settings	Provide all MISP package to humanitarian settings							
		Conduct on site mentoring and supportive supervision to HCWs at humanitarian settings							
4	Strengthen partnership with stakeholders working at humanitarian settings	Engage humanitarian setting actors in different RH TWGs							
		Include of RH services in a disaster management plan/policy at national and regional levels							
		Conduct community empowerment in crisis affected areas							
Strategy 13: Improve access to prevention, investigation, and management of infertility									
1	Improve standards, protocols and advocacy materials for the prevention, investigation,	Develop standards, guideline and protocols for the prevention, investigation, and management of infertility							

	and management of infertility	Develop IEC/BCC materials that provide clear information on infertility for the community							
		Follow the implementation of standards and guidelines							
2	Improve the provision of Infertility prevention, care and treatment	Strengthen STI, unsafe abortion, and chronic disease prevention							
		Promote healthy life style for the prevention of infertility health promotion programs to reduce the incidence and prevalence of infertility							
3	Capacity building to strengthen the infertility treatment centers in the country	Provide Support to strengthen the infertility treatment centers							
		Facilitate experience sharing and coordination with relevant stakeholders, including universities, and treatment centers							
		Support the existing infertility centers with appropriate equipment							
		Support the existing infertility centers with training and follow up to provide service with full capacity							
		Conduct onsite mentorship and supportive supervision with experts							
Strategy 14: Improve innovative social behavior change communication and reproductive health of Adolescents and youth									
1	Build the capacity of reproductive health service providers to provide comprehensive reproductive health to adolescents	Provide trainings to health care providers working for adolescents and youth							
		Conduct onsite mentorship and supportive supervision to health care providers while on duty							
2	Enhance reproductive health services to adolescents and youth	Design targeted teenage pregnancy prevention spot messages and disseminate through TV and/or radio,							
		Provide trainings to media professionals on health literacy and health reporting on topics of AYRH issues							
3	Improve the capacity off AYRH on positive life skill	Train adolescent teachers' on how to empower adolescent and youth							

	and communication through positive parenting and teachers support	Promote positive parenting skills and communication skills to parents							
		Promote adolescents to delay the in initiation of sexual practices: Design targeted teenage pregnancy prevention spot messages and disseminate through TV and/or radio.							
		Expand youth friendly services, and youth centers to advocate positive life experience							
		Strengthen peer education program to improve young people's reproductive and sexual health outcomes							
	Improve meltosectoral collaboration	Integrate life skills, family life and education for health and wellbeing into school curricula,							
		Support the implementation of school health program through HEPs in collaboration with MoE							
Strategy 15: Enhance youth engagement and ownership of health programs									
1	Ensure the engagement of young people in different programs (design, planning, implementation, monitoring and evaluation)	Establish a youth led advisory panel that represent various adolescent groups							
		Involve youth in program design, planning, implementation, monitoring and evaluation and research activities.							
		Involve youth in health related technical working groups							
2	Build the capacity of youth and adolescents	Provide trainings to adolescent and youth to increase knowledge, skills and attitude that promote competence, confidence, connection, and caring others							
		Organize national and regional a periodic youth-related event/forum to address adolescent and youth related health/ development issues.							
Strategy 16: Ensure prevention of mother to child transmission of HIV, Syphilis & Hepatitis B infection through improving access to care									
1	Improve community mobilization(SBCC) on HIV,	Create community awareness through radio , TV and other means							

	syphilis, and hepatitis B infection prevention and treatment	Creating awareness by involving community and religious leaders							
2	Capacity building on HIV, syphilis and HepB infection triple prevention and treatment	Develop training material, strategies , protocols for HIV, syphilis and HepB triple elimination							
		Conduct ToT and basic trainings on HIV, syphilis and HepB triple elimination							
		Conduct on the job mentoring and supportive supervision							
3	Ensure services on the HIV, syphilis dual management and expansion of the services	Initiate HIV, Syphilis co-testing (dual testing) and Hepatitis B for better coverage							
		Integrate PMTCT services on FP, STI, TB, OIs screening and prophylaxis treatment/PrEP with RMNCH plat form							
		Conduct HIV testing for pregnant women, laboring and lactating women and their partners							
		Expand HIV testing services to health posts for pregnant women and link to care							
Strategy 17: Provide integrated quality EMTCT of HIV, syphilis and Hepatitis B "Triple elimination" services to pregnant, and lactating women and HIV exposed their infants									
1	Improve ART enrollment and retention of HIV+ pregnant and lactating women	Expand viral load testing services for HIV+ pregnant and lactating women							
		Engage mother support group to each facility to PMTCT services to scale up the service							
2	Promote and ensure exclusive breast feeding for all infants born to HIV positive mothers for the first 6 months and gradual shift to complimentary feeding	Conduct refresher training to health care providers on exclusive breast feeding and complementary feeding to HEI							
		Provide counseling and awareness on exclusive BF to the women							
3	Improve service to HEI	Expanding POC sites for EID services improvement							
		Strengthen the use of mother baby cohort registration and analysis of HEI cohort							

		Strengthen enhanced postnatal prophylaxis for all HIV exposed infants.								
		Conduct PMTCT clinical audit								
Strategy 18: Improve the Nutritional status of Mothers during pre-pregnancy, pregnancy, lactation and adolescents										
	Strategic intervention	**Detailed activity**		**Performance**						
				2021	2022	2023	2024	2025		
1	Improve the nutritional status of pregnant, lactating and adolescents	Provide iron and folic acid to pregnant women								
		Provide de-worming for pregnant women in the second and third trimester of pregnancy.								
		Provide micronutrient (iron, folate, zinc, calcium, MNP) supplementation for pregnant women Provide nutrition services through mobile health and nutrition teams for pastoralist and hard to reach communities								
		Avail nutrition commodities and supplies in sustainable way								
		Monitor weight gain during pregnancy								
		Promote of consumption of bio fortified foods (orange fleshy sweet potato, quality protein maize, ion rich bean).								
2	Expand nutrition services outlets to Mothers and adolescents in special situations	Provide iron supplementation for adolescent girls at schools and health facilities								
		Provide nutritional assessment and counseling services to lactating mothers								
		Provide biannual de-worming for school and out of school adolescents.								
		Provide nutrition services through mobile health and nutrition teams for pastoralist and hard to reach communities								
		Conduct nutritional assessment and counseling at to pregnant women								
		Provide nutritional assessments and nutritional counseling services to adolescents at different contacts								

		Provide folic acid supplementation for adolescent girls at schools and health facilities							
3	Improve the capacity of health care providers to improve nutritional service to the community	Provide Training on maternal and adolescent nutrition for health workers							
		Provide mentorship and supportive supervision							
4	Improve community understanding on the importance of nutrition	Promote healthy and active lifestyle such as promoting exercise for preventing adolescent obesity.							
		Community mobilization on the prevent food taboos, use of substances, alcohol, which contribute to intergenerational malnutrition							
		Advocacy for least one diversified and nutrient dense additional meal							
		Promote early initiation of ANC and nutrition service provision							
		Promote consumption of diversified and nutrient dense two additional meals during lactation							

Strategic Direction 2: Enhance good governance, leadership and Partnership for RH									
Strategy 19: Enhance coordination and effective monitoring of RH programs									
1	Capacity building to regions, zones and woreda for planning, implementation, monitoring and evaluations of RH for leadership at all levels	Provide orientation to develop an aligned annual and yearly planning							
		Provide a regular follow-up (mentoring, SS) to implement the regional planes							
		Provide support to implement regional plan with strategic directions							
		Support the regions to align plans with the regional stakeholders every year							
2	Build the capacities of local Faith Based Organizations, Community based Organizations and other community organizations in demand creation and delivery of RH services	Develop/adapt training manuals to train Faith Based Organizations, Community based Organizations and other community organizations in demand							
		Develop/update guidelines, implementation manuals, training packages, SOPs and job aids for the mangers at different levels and provide training							
		Provide trainings to Faith Based Organizations, Community based Organizations and other community organizations in demand on community demand creation and how to improve health seeking behaviors							
Strategic direction 3: Improve Regulatory System for RH									
Strategy 20: Improve the standards of premises, products, practice and professionals for provision of RH services									
1	Ensure facility standards for RH service delivery and to ensure that health facilities are renovated and newly constructed per the revised facility standard	Follow human resources are fulfilled as per the standard							
		Provide regular support as the communication tools (IEC/BCC) materials are organized and updated							
		Provide a regular follow up as the training packages are need based that satisfies the need of the providers and ensure the quality of service							

		Provide regular support as health care providers are required to comply with the CPD standards							
Strategic Direction 4: Improve supply chain management and medical equipment fulfillment for consistent availability of RH commodities and services									
Strategy 21: Strengthen coordination and capacity of supply chain management for RH commodities and basic equipment supply									
1	Strengthen national coordination platform among decision makers for ensuring joint responses to critical supply bottlenecks	Conduct high level tripartite meetings among MOH, EPSA and EFDA							
		Provide supportive guidance to RHBs to review respective EPSA branches and implementing partners							
		Implement linkage among technical working groups of MoH and EPSA							
		Conduct biannual stakeholder review meetings							
2	Improve RH commodity integrated supply management, data visibility and culture of data use	Support EPSA to strengthen integrated management (reporting, requesting and distributions) of RH commodities through the IPLS system							
		Develop and implement SOP/guideline to ensure cold chain maintenance for temperature sensitive RH products (oxytocin/ergometrine) across the supply chain levels							
		Enhance stock status data generation, aggregation, and reporting of information through the Procurement Planning and Monitoring Report							
		Collaborate with EPSA and implementing partners to conduct regular RMNCH end use verification assessment on essential lifesaving medicines							
		Conduct monthly follow-up of national RH commodity stock status for commodity security and responding promptly to improve stock status situations.							

3	Strengthen capacity building on RH program and pharmaceutical management for health service staff	Coordinate stakeholders to provide training on RMNCH program pharmaceutical supply management							
		Support for institutionalizing IPLS training onto pre-service training curricula							
		Conduct biannual mentoring/supportive supervision to HFs, RHBs/ Zones/ WorHOs and EPSA branches (to assess stock availability, supply management capacity and contextual supply management challenges)							
4	Strengthen annual forecasting, and supply planning, pipeline monitoring for RH commodities, including supplies and consumables	Support team establishment for quantification exercise							
		Support consumption, service statistics and demographic data gathering process							
		Coordinate quantification exercise workshops							
		Coordinate supply planning validation and review workshops							
		Conduct pipeline monitoring for RH commodities							
5	Improve basic medical equipment availability and functionality for RH services (mini-blood bank, delivery coach, BP apparatus, Stethoscope, adult/baby weighting scale and thermometer)	Support assessments on RH medical equipment availability and functionality							
		Estimate national demands for basic medical equipment							
		Advocate for equipping health facilities with basic equipment to ensure RH service readiness							
		Coordinate procurements of basic medical equipment with ministry's medical service directorate, EPSA and other relevant stakeholders.							
		Monitor procurement of equipment for mini-blood bank							
		Support mini-blood bank equipment distribution and installations to selected hospitals							
Strategic 22: Improve funding diversifications for RH commodity procurement to bridge financial gap									

1	Strengthen donor Coordination, funding, and advocacy efforts for mobilizing adequate resources	Conduct funding gap analysis							
		Advocate for existing funding shortfalls through advocacy briefing and/or workshops							
		Organize donor coordination platform to meet periodically							
2	Improve domestic finance allocation and budget lines for RH commodities	Conduct assessment on the existing financing and reimbursement protocol							
		Conduct policy dialog and advocacy through organizing meetings and other events at central and regional levels for decision-makers and authorities/leaders for increased budgetary allocation for RH commodities and supplies.							
		Design and implement programmatic logistics coordination protocol including innovative strategies for improving domestic finance allocations							
3	Advance Reproductive Health Commodity Security (RHCS)	Establish task team for Reproductive Health Commodity Security (RHCS)							
		Conduct RHCS situation analysis							
		Develop RHCS strategic plan							
		Advocate for multi-stakeholder plan alignment and implementation							
		Monitor RHCS plan implementation							
Strategic Direction 5: Improve Community Participation and Engagement									
Strategy 23: Improve community engagement in RH program									
1	Scale up the existing social and community health insurance schemes	Promote the participation of satisfied users and clients on RH services							
		Conduct regular community forums on health insurance							
		Involve religious and other influencers, particularly in the pastoralist and semi pastoralist communities							
		Ensure mechanisms to reimburse for essential RH services							
Strategic Direction 6: Improve Research and Evidence for Decision-Making									
Strategy 24: Improving use of research and evidence for decision-making for better RH care									

1	Strengthen linkage between universities and MoH, RHB to conduct RH related researches in all universities	Conduct capacity building to researchers and MoH, RHB staffs on the concept of operational research								
		Allocate research funds for universities to undertake RH service quality researches								
		Establish knowledge and capacity building resource centers at selected health facilities								
		Advocate for adequate allocation of research funds at national and regional levels								
		Conduct operational and survey researches on the quality of RH services								
2	Improve RH service quality related researches for decision making	Conduct basic trainings in research institutions								
		Conduct operational and survey researches on the quality of RH services								
		Develop policy briefs, policy issues and technical briefs with the national RAC team on selected RH issues								
		Ensure the use of data for decision making at the national and local levels								
		Train HEWs and orient Woreda council and Kebele management on community health Information System (CHIS) and implement it in all health posts								
3	Improve data integration and digitalization	Ensure data integration and digitalization								
Strategic Direction 7: Enhance use of Technology and Innovation										
Strategy 25: Improve use of technologies and innovation for better RH outcomes										
1	Strengthen collaboration with HIT directorate to implement and monitor the innovations, including m-health	Work closely with the HIT stakeholders to new products, processes, services, technologies or ideas to transform reproductive health								
2	Strengthen the use of technology in the community	Initiate the application of m-health services (referral services and for consultation) by the users and HEWs in								

	health services: to implement self-care health services	all kebeles with particular emphasis to the remote and hard-to-reach areas							
		Initiate toll free line for ambulance/ referral/ emergency service/ awareness creation in all kebeles							
		Avail tele-medicine and tele-education in all tertiary hospitals and sensitize professionals to utilize them							
Strategic Direction 8: Development and management of Human Resource for RH									
Strategy 26: Improve availability, motivation and retention of motivated competent and compassionate RH care providers.									
1	Ensure that all health facilities are staffed as per the standard	Develop a recognition scheme for facilities maintaining the standards of care with human resource and other requirements							
		Follow hospitals and health centers function 24 hours a day and 7 days a week							
		Provide need-based in-service trainings to health care providers (SOJT, SS, mentorship)							
2	Ensure motivational mechanism to health workforce	Design motivation and incentive package in hard-to-reach areas of the country							
		Maintain and improve competency of RH care providers through continuing professional development							
		Avail recognition platforms to improve the availability of motivated competent and compassionate HR for RH							
		Support the new MSc. and specialty trainings in obstetrics and gynecology							
Strategic Direction 9: Improve health infrastructure for RH services									
Strategy 27: Improve health infrastructure as per the standard of RH service requirement									
1	Improve telephone, water and electricity supply and other infrastructures in the health facilities	Organize intersectoral forums to improve telephone, water and electricity supply problems in health facilities							

		Mobilize resources to procure and distribute backup power sources and ambulances as per identified gaps.							
		Renovate facilities as per revised facility design standards.							
		Fulfill the newly constructed facilities with the revised facility standards							
2	Improve health care access to the community	Work with the road authority for a better road accessibility mainly on the in the hard to reach areas							
		Mobilize the community to involve in health insurance							
		Implement self-care health service at the urban settings							
Strategic direction 10: Enhance policy and procedures									
Strategy 28: Ensure availability of enabling policy environment for RH services									
1	Improve multi-sectoral participation and dialogue in policy making and implementation:	Engage private sector, NGOs and CBOs in policy making and implementation to improve RH services delivery							
2	Improve health care financing policy	Enforce the mechanism to implement exempted services for selected RH services							
Strategic Direction 11: Address the social determinants of RH									
Strategy 29: Improving advocacy and partnership to improve women's decision making Power on RH matters.									
1	Improve women's participation in decision-making related to reproductive health matters	Conduct at least one national gender focused health forum advocacy every year on gender and RH.							
		Maximize the utilization of mass-media, to promote the importance of women empowerment on health issues							
		Conduct annual forum with families, teachers, girls and other communities working on gender and sexual and reproductive health							
2	Build partnership with all relevant ministries and sectors.	Collaborate with the Ministry of Women, Children and Youth Affairs							

		and other partners working on gender related activities							
3	Build the capacity of RH women leaders	Provide leadership trainings for women reproductive health services leaders							
Strategy 30: Enhance the enforcement of the implementations of the legal frameworks that protect and advance women's RH rights									
1	Improve the implementation of laws and regulations to protect reproductive health of the community	Develop and implement targeted and context-specific IEC/BCC messages and materials for community members (men, women, adolescents) on specific HTPs.							
		Conduct advocacy for the implementation of existing laws that protect reproductive health such as family health law, abortion law, and laws related to harmful traditional practices							
		Conduct awareness creation community mobilization on the existing laws related to RH rights and build their active participation in the implementation of the laws and amending community norms that promote HTPs							
		Conduct sensitization and advocacy workshops to law enforcement bodies (ministry of justice, police and others)							
		Work closely with law enforcement bodies in protecting the reproductive rights and taking corrective measures against the perpertrators and rehabilitative care for the victims.							
2	Promote research on gender-based violence, health system and other social determinants of RH	Conduct research on GBV and other RH determinants							

Annex II: M and E: Indicators and Targets

The indicator matrix includes the name of the indicator, its category, type, data source, baseline and targets of RH SP 2021-2025.

N0	Indicator	Type of indicator	Level of data collection	Data Source	Frequency of data collection/ Analysis	Base line	Mid-term Target 2021	Target (2024/ 25)
	Improving health status							
1	Maternal mortality rate - Per 100,000 live birth	Impact	Population	EDHS	5 years	401		279
2	Decrease still birth rate /1000 LB	Impact	Facility	HMIS	Monthly	15	14.5	14
3	Neonatal mortality rate - per 1,000 LB	Impact	Population	EDHS/ MDHS	5 years/ 2-3 yrs	33	28	21
4	Decrease TFR	Impact	Population	EDHS/ MDHS	5 yrs	4.1		3.2
	Improving access to quality RH services							
5	Teenage pregnancy rate (%)	Impact	Population	EDHS	5 years	12.5%	10.0%	7%
6	Reduce mother to child transmission rate of HIV	Impact	Population	Modeling /Spectrum	2-3 years	13.4%		<5%
7	Contraceptive Prevalence Rate (CPR)	Outcome	Population	EDHS	5 years	41%	45%	50%
8	Reduce adolescent family planning unmet need	Outcome	Population	EDHS	5 years	20%		10%
9	Decrease unmet need for family planning among married women	Outcome	Population	EDHS	5 years	22%		19.1%
10	Proportion of health facilities providing preconception care	Outcome	Facility	Special report	Monthly	0%		25%
11	Proportion of pregnant women receiving preconception care before pregnancy	Outcome	Facility	Special report	Monthly	0%		25%
12	Proportion of pregnant women with four or more ANC visits	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 years	43%	60%	81%
13	Increase proportion of health facilities implementing 8 ANC contacts	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 years	25 %		50 %

14	Proportion of deliveries attended by skilled health personnel	Outcome	Facility / population	HMIS/ EDHS	Monthly/ 5 years	50%	62%	76%
14	Early ANC initiation	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 years	20%		50%
15	ANC 1 coverage	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 years	74%		90%
16	Early postnatal care coverage,	Outcome	Facility /population	HMIS/ EDHS	Monthly/ 5 years	34%	53%	82%
17	PNC 24 hour stay and care	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 years			25 %
18	Cesarean section rate	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 Years	4%	6%	10%
19	Increase provision of BEmONC signal functions	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 years	5%		100%
20	Hospitals provide CEmONC signal functions	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 Years	??		100%
21	Proportion of asphyxiated newborns resuscitated and survived	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 Years	11%	29%	50%
22	Proportion of health centers and hospitals providing post abortion care	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5Years	43%		100%
23	Proportion of health centers and hospitals providing safe abortion care as per the law and guideline	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5Years	43%		100%
24	Proportion of newborns with neonatal sepsis/Very Sever Disease with treatment	Outcome	Facility/ population	HMIS/ EDHS	Monthly/ 5 years	30%	37%	45%
Family planning								
25	Long acting reversible methods	Outcome	Facility/ Community	HMIS/ EDHS		10.3%		15%
26	Permanent contraceptive methods use	Outcome	Facility/ Community	HMIS/ EDHS		0.3		0.5
27	Health centers and hospitals offer at least five different type of modern contraceptive methods	Outcome	Facility/ Community	HMIS/ EDHS				100%
28	Health posts offer at least four different type modern contraceptive methods	Outcome	Facility/ Community	HMIS/ EDHS				100%
29	Hospitals provide postpartum family planning services	Outcome	Facility/ Community	HMIS/ EDHS				100%
30	Coverage of PPFP service in health centers	Outcome	Facility/ Community	HMIS/ EDHS		40%		50%

31	Compressive abortions service providing health facilities provide post abortion family planning service	Outcome	Facility/ Community	HMIS/ EDHS				
32	Increase CPR in all regions annually by 1 %	Outcome	Facility/ Community	HMIS/ EDHS				5 %
33	Percent demand for FP satisfied with modern methods	Outcome	Facility/ Community	HMIS/ EDHS		60 %		68%.
Nutrition								
34	Proportion of pregnant women who received iron and folic acid supplement at least 90+	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	11%		60%
35	Proportion of pregnant women who consumed at least one additional meal	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	16 %		50%
36	Proportion of pregnant mothers with acute malnutrition	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	15%		2%
37	Prevalence of anemia among pregnant women	Outcome	population	EDHS	5 years	29 %		21%
38	Proportion of pregnant women counseled for nutrition during ANC	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	71%		76%
39	Proportion of lactating mother's positive for acute malnutrition	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	20 %		10%
40	Proportion of lactating mothers with underweight (BMI>18.5)	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	22 %		10%
41	Proportion of lactating mothers who consumed at least two additional meals	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	16%		70 %
42	Proportion of newborns initiated early breast feed within one hour	Outcome	population	EDHS/ special assessment	3-5 years	73%		86%
43	Prevalence of anemia among adolescents aged 10-19 years	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	19.9%		14%
44	Proportion of adolescent girls supplemented with iron	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	4.5%		30%
45	Proportion of adolescents received folate tablets	Outcome	Population	EDHS	5 years	0%		30%
46	Proportion of pregnant women who got pre-conception nutrition services (Folic acid)	Outcome	Population	EDHS	5 years	0%		50%
Infertility								

47	Health facilities provide couple counseling on infertility and prevention of infertility	Outcome	Population	EDHS	5 years	NA		100%
48	Tertiary hospitals provided infertility workup including hormonal analysis, seminal fluid analysis (SFA), and hysterosalpingography (HSG) and manage non-complicated cases of infertility	Outcome	Population	EDHS	5 years	NA		100%
49	Infertility diagnostic and management centers upgraded to provide service with full capacity (laparoscopic tuboplasty, intrauterine insemination (IUI) and Invitro fertilization (IVF)	Outcome	Population	EDHS	5 years	NA		100%
50	Facilities conducted maternal and perinatal deaths review	Outcome	Facility	PHEM Registers	Monthly	155		100%
51	Facilities providing appropriate response for the identified MPDSR review cases	Outcome	Facility	PHEM Registers	Monthly	9%		50%
52	Facilities providing appropriate response for the reviewed MPDSR cases	Outcome	Facility	PHEM Registers	Monthly	35%		80%
Obstetric fistula and POP								
53	Obstetric fistula cases treated	Outcome	Facility/ population	Survey reports	2-3 years	NA		100%
54	Obstetric fistula surveillance and response (OFSR) at all levels	Outcome	Facility/ population	Survey reports	2-3 years	NA		100%
55	Number of obstetric fistula cases	Outcome	Facility/ Population	Special survey	2-3 years	NA		<1,600
Maternal near miss review								
56	Hospitals performed near-miss review	Outcome	Facility	PHEM report	Monthly	25%		55%
Syphilis testing								
57	Syphilis testing coverage for pregnant women	Outcome	Facility/ population	HMIS/ EDHS	Monthly / 5 years	55%		85%
Adolescent health								
58	Reducing adolescent pregnancy rate	Outcome	Facility/ Population	DHSI2/ EDHS	Monthly /5 year			by 75% from its 2020 base line

59	Sexually active adolescents and youth age 10-24 access quality SRH and/or maternity care.	Outcome	Population	EDHS	5 year			90%
60	Teen-age pregnancy rate	Outcome	Facility/ Population	DHSI2/ EDHS	Monthly /5 years	13%		7%
61	Adolescents and youth have access to comprehensive AYH information	Outcome	Population	EDHS	5 years			75%
62	Vulnerable adolescents and youth reached with targeted interventions	Outcome	Population	EDHS	5 years			60%
63	Adolescents and youth will have comprehensive knowledge on HIV	Outcome	Population	EDHS	5 years			90%
64	School health program integration and provide correct AYSRH information and education on health and well being	Outcome	Population	EDHS	5 years			25%
65	Increase proportion of Health facilities providing Youth friendly services	outcome	Population	EDHS	5 year	45%		80%
66	Reduce Anemia prevalence in girls aged 10-19	outcome	Population	EDHS	5 year	28%		14%
67	Prevalence of anemia in women of childbearing age	outcome	Population	EDHS	5 year	24%		18%
PMTCT								
68	Percentage of pregnant, laboring and lactating women who were tested for HIV	Outcome	Facility	HMIS	Monthly	84%		96%
69	ARV coverage for HIV positive pregnant, laboring and lactating women	Outcome	Facility	HMIS	Monthly	81%		95%
70	Postnatal dual prophylaxis coverage for all HIV exposed infants (HEI)	Outcome	Facility	HMIS	Monthly	53%		90%
71	Early infant diagnosis (EID) coverage for HIV exposed infants (HEI)	Outcome	Facility/population	HMIS/ EDHS	Monthly / 5 years	75%		90%
Reproductive Health services in humanitarian settings								
72	Humanitarian settings providing MISP for Reproductive health services	Outcome	Humanitarian setting	Special report from humanitarian settings	Monthly	NA		100
Rh standards								

74	Health facilities implemented the RH clinical practice protocols	Outcome	Facility	Admin report	Every year			100%
Commodities and basic equipment								
75	Healthcare facilities will have adequate stock of Essential RH medicines/ Pharmaceuticals	Input	Facility	LMIS/ Special study	Monthly	NA		95%
76	Mean availability of basic RH medical equipment in HFs	Input	Facility	LMIS/ Special study		56 %		80%
77	RH pharmaceuticals procurement lead time in days	Input	Facility	LMIS/ Special study report		252		210
Funding for RH commodity								
78	Funding gaps for RMNCH priority commodities	Input	Facility	Admin report		25%		10%
79	Funding gaps for non-funded RH medicines, supplies and consumables	Input	Facility	Admin report		100%		50%
Research and evidence for decision-making for better RH care								
80	Health facilities using appropriate registration and complete documentation	Input	Facility	Special report	Annual/ 2-3 Years			100%
81	Number of policy brief, issue brief and technical brief on key RH issues	Input	Facility	Special report	Annual/ 2-3 Years	5		20
82	Hospitals HCs having a knowledge resource center for RH	Input	Facility	Special report	Annual/ 2-3 Years			50% & 10%
83	Facilities using local data to improved services	Input	Facility	Special report	Annual/ 2-3 Years			100%
Health infrastructure								
84	HCs and hospitals having constant water source , telephone and an electric /solar power supply with backup generator	Input	Facility	Admin. Report/ SPA+/ Special facility survey	Annual/ 2-3 Years			100%
85	Health facilities have space for ANC, delivery, postnatal and FP services	Input	Facility	Admin. Report/ SPA+/ Special	Annual/ 2-3 Years			100%

				facility survey				
86	Health centers having maternity waiting homes	Input	Facility	Admin. Report/ SPA+/ Special facility survey	Annual/ 2-3 Years			75%
87	Hospitals and health centers have a neonatal intensive care unit (NICU) and radiant warmer, respectively	Input	Facility	Admin. Report/ SPA+/ Special facility survey	Annual/ 2-3 Years			95% & 100%
Policy and procedures								
88	Health centers and hospitals with fee-exempted services for life saving services: EmONC functions, FP, VIA screening for precancerous cervical lesion and vaccination for HPV	Outcome	Facility	Special report				100%

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Solomon Worku(Dr.)	MoH/CIRTH
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Teshome Fekadu	MoH, HRDD
Wasie Tsehay (Dr.)	MoH/ EH
Wogen Shiferaw (Dr.)	WHO
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Yayeh Negash(Dr.)	UNICEF
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Natnael Nigussie	EFDA
Shamil Abdurhman	HRHB
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Genet Deres	MOH
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Abdifarah Ahmed	SRHB
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Liknesh Lemma	MoH
Lydia Yohannis	PMED
Luwam Teshome (Dr.)	PSIE
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Elisabeth Kasahun	MoH, PSC-PSM
Emiamerew Sisay	PSI
Sintayehu Abebe	AMREF
Gukiklat Teshome	PSC- PSM
Tibebu Alemayehu(Dr.)	Engender Health
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Tesfaye Hurisa (Dr.)	SPHMMC
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Tamirat Shiferwa	EMwA
Melaku Tamire	EMwA
Melese Tekele	ISO
Efrem Regasa	ORHB
Takele Yeshiwas	MoH/ MSIE
Nibret Eyasu	ARHB
Melaku Tamire	EMwA

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