NATIONAL REPRODUCTIVE HEALTH STRATEGY

2020 - 2016



FEDERAL
DEMOCRATIC REPUBLIC OF ETHIOPIA
MINISTRY OF HEALTH

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Preface

The Government of Ethiopia is committed to improve and maintain the reproductive health status of women, men and young people in Ethiopia. To materialize this and other health issues, the national Health Policy as a governing guide has been revised very recently. As a vehicle for the implementation of the revised health policy, the 20-Year Health Sector Visioning document and comprehensive Health Sector Transformation Program (HSTP) have been formulated. Taking into account the Growth and Transformation Plan (GTP-2), the HSTP is a five year strategic framework based on the concepts and principles of equity and universal access to primary healthcare. In line with the existing and new high-impact interventions and the long-term vision of the country, the revision of the current reproductive health strategy was imperative to consolidate the encouraging .gains and accelerate progress to end all preventable maternal and child deaths

The current National Reproductive Health Strategy is developed for the years 2016-2020 in response to the need to provide guidance for implementing the new national HSTP pertaining reproductive health issues. This strategy reaffirms the Ministry's commitment to take the momentum forward by setting forward targeted and measurable agenda. It builds on a past of numerous activities and ongoing initiatives and readily assimilates new and emerging developments, proven to serve the .health needs of all Ethiopians with high impact

Building on the commitments of the MDGs, the global Sustainable Development Goals (SDGs) are newly proposed by the United Nations to address domestic and global inequalities by 2030. Proposed Goal 3 aims to "ensure healthy lives and promote well-being for all at all ages." Sub-target 3.1 further states that by 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births; and target 3.7 states by 2030, ensure universal access to sexual and reproductive health services, including information and education, and the integration of reproductive health into national strategies and programmes. The goal of this strategy is therefore, built on the momentum occasioned by the SDGs to harvest the multi-faceted support needed to meet the reproductive and .sexual health needs of our culturally diverse population

It is also important to note that the revised National RH Strategy follows a logical approach. It stepped up the implementation of the three component strategic plans-maternal and newborn health, family planning and fertility, and adolescent and youth reproductive health-contingent upon the implementation of the HSTP. The complementary role of NGOs, partners and other stakeholders .will remain crucial in the actual execution of the activities of the strategic plans

Finally, on behalf of the Ministry of Health, I would like to take this opportunity to express my gratitude to all of our partners in health and development for their continued support to apprehend success in our undertaking of this strategy and to use this National RH Strategy as a guiding framework for their .future endeavor to the realization of the sexual and reproductive health SDGs in Ethiopia

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Acknowledgments

The National Reproductive Health Strategy for Ethiopia (2016-2020) had been prepared in consultation with a wide range of individual and institutional stakeholders at national and sub-national levels. The strategy is built on the evidence provided by an extensive situational analysis from the incorporation of inputs of program managers and implementers at the different directorates and agencies, the Regional Health Bureaus (RHBs), Non-Governmental Organizations (NGOs), and other members of the reproductive health community. The national Safe Motherhood Technical Working Group (SM-TWG) closely engaged and monitored the review and development of the strategy, supported by the management of the Maternal and Child Health Directorate and three national consultants. The Ministry of Health is extremely grateful and appreciative of all individuals and organizations that .contributed to the development of the strategy

As this is the turn of the MDG era, the Ministry forwards extensive gratitude and admiration to its development partners who have renewed their commitment and invites their support towards ending preventable maternal and child deaths through enduring their commitment to the implementation of .the Revised National Reproductive Health Strategy in the post-2015

Finally, the MOH would like to acknowledge the World Health Organization, USAID's Integrated Family Health Program and the Clinton Health Access Initiative (CHAI) for their financial and technical support in realizing the development of this strategy; and expresses its appreciation to the members of the RH Task Force, particularly to members of the Coordinating Committee and the working group .established to as¬sist in the initial sketch of the strategy

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
AYH	Adolescent and Youth Health
AYRH	Adolescent and Youth Reproductive Health
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BPCR	Birth Preparedness and Complication Readiness
CS	Cesarean Section
CAC	Comprehensive Abortion Care
CBHI	Community Based Health Insurance
CBNC	Community Based Newborn Care
CBO	Community Based Organization
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHERG	Child Health Expert Reference Group
CHIS	Community Health Information System
COC	Certificate of Competence
CPD	Continued Professional Development
CPR	Contraceptive Prevalence Rate
CQI	Continuous Quality Improvement
CSA	Central Statistical Agency
DBS	Dry Blood Sample
DHS	Demographic and Health Survey
EDHS	Ethiopian Demographic and Health Survey
EHAQ	Ethiopian Hospital Alliance for Quality
EHRIG	Ethiopian Hospital Reform Implementation Guidelines
EID	Early Infant Diagnosis
EMDHS	Ethiopian Mini-Demographic and Health Survey
eMTCT	Elimination of Mother To Child Transmission
EPI	Expanded Program of Immunization
ESPA+	Ethiopian Services Provision Assessment Plus
FANC	Focused Antenatal Care
FDRE	Federal Democratic Republic of Ethiopia
FGAE	Family Guidance Association of Ethiopia
FGC	Female Genital Cutting
FMHACA	Food, Medicine and Healthcare Administration and Control Agency
MOH	Ministry of Health
FP	Family Planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GTP	Growth and Transformation Plan
HDA	Health Development Army
HC	Health Centre
HCF	Health Care Financing
HEP	Health Extension Program
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
HPV	Human Papiloma Virus
HRC	Human Rights Council
HRH	Human Resource for Health
HSDP	Health Sector Development Plan
HSTP	Health Sector Transformation Plan
HTP	Harmful Traditional Practice
ICCM	Integrated Community Case Management
ICT	Information Communication Technology
ICU	Intensive Care Unit
IEC	Information, Education and Communication
IESO	Integrated Emergency Surgical Officer
IPLS	Integrated Pharmaceuticals Logistics System
IRT	Integrated Refreshment Training
ISS	Integrated Supportive Supervision
IST	Inter-Country Support Team
KMC	Kangaroo Mother Care
LARC	Long Acting Reversible Contraceptive
LMIS	Logistics Management Information System
MBP	Mother Baby Pair
MCH	Maternal and Child Health
MDG	Millennium Development Goal
M-DHS	Mini- Demographic and Health Survey
MDSR	Maternal Death Surveillance and Review/Response
MgSO4	Magnesium Sulphate
mHealth	Mobile Health
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn/Neonatal and Child Health
MNH	Maternal and Newborn/Neonatal Health
MOE	Ministry of Education
MOH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Review/Response
MTCT	Mother to Child Transmission
MOWCYA	Ministry of Women, Children and Youth Affairs
NFFS	National Family and Fertility Survey
NGO	Non-Governmental Organization

PBF	Performance-Based Financing
PDR	Perinatal Death Review
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
PLMU	Pharmaceutical Logistic Management Unit
PMA	Performance Monitoring and Accountability
PMR	Perinatal Mortality Rate
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Car
PPP	Public Private Partnership
RH	Reproductive Health
RHB	Regional Health Bureau
RHCS	Reproductive Health Commodity Security
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RMNCAHN	Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition
ROC	Reproductive Organ Cancer
SDP	Service Delivery Point
SNNP	Southern Nations, Nationalities, and Peoples
SNNPR	Southern Nations, Nationalities, and Peoples' Region
SO	Strategic Objective
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
SWOT	Strength, Weakness, Opportunity and Threat
SDG	Sustainable development goals
TFR	Total Fertility Rate
THE	Total Health Expenditure
TT	Tetanus Toxoid
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Education Fund
UN-IAG	United Nations Inter Agency Group
UN-IAGME	United Nations Inter-Agency Group for Mortality Estimation
USAID	United Stated Agency for International Development
VDRL	Venereal Disease Research Laboratory
VERA	Vital Events Registration Agency
WHDA	Women Health Development Army
WHO	World Health Organization

Executive summary

Ethiopia is among the countries with a good progress in reducing maternal mortality. According to the Ethiopian Demographic and Health Surveys (EDHS), Maternal Mortality Ratio (MMR) has dropped from 871 in 2000 to 676 in 2011 per 100,000 live births. According to estimates by the UN Inter-Agency Group (UN-IAG), substantial declines in maternal deaths have been achieved over the last two decades. According to their estimate, the MMR had declined from 1250 to 353 maternal deaths per 100,000 live births between 1990 and 2015. The absolute number of women who died during pregnancy or childbirth had also decreased nearly by 70%, from 31,000 in 1990 to around 13,000 in 2013. Based on this achievement, Ethiopia is acknowledged as one of the countries in progress towards MDG5 MMR target of 267 per 100,000 live births. According to the 2014 Countdown report, the majority of maternal deaths occur during the intrapartum and immediate postpartum periods due to hemorrhage (25%), pre-eclampsia/eclampsia (16%), and infection (10%). Unsafe abortion accounted for 10% of avoidable maternal deaths.

Child mortality has also declined significantly. The under-five mortality rate had dropped from about 205 per 1,000 live births in 1990 to 59 per 1,000 live births in 2015. Despite remarkable success in improving child health and declaring achievement of MDG4 three years before the deadline, the neonatal mortality rate (NMR) is still in the high range. The most recent estimate by the UN-Inter-agency Group revealed that the NMR in the country in 2013 was 28 per 1,000 live births. The perinatal mortality rate also had not shown significant change between 2000 and 2011.

Among other remarkable changes, the total fertility rate has declined from 5.5 in 2000 to 4.1 children per woman in 2014; the contraceptive prevalence rate has increased from 8% in 2000 to 42% in 2014; and the prevalence of anemia among pregnant women decreased from about 27% in 2005 to about 17% in 2011. The 90% of pregnant women attending antenatal care being counseled and tested for HIV in 2014 is another big success. However, only 69% of HIV-positive women have received antiretroviral treatment (ART) and 59% of HIV-exposed newborns received ARV prophylaxis. In 2015, the ANC4+ visits coverage and skilled persons who attended delivery increased to 67% and 60%, respectively. Adolescent pregnancy rate has decreased from 17% in 2010 to 12% in 2014. Findings of equity analysis in the HSTP indicated that social determinants affected RMNCH indicators and influenced equity.

The most recent national Reproductive Health (RH) Strategy of Ethiopia is through its final year of implementation. The strategy was designed in line with the broader strategic framework and context of the Health Sector Development Programme (HSDP) and aligned with the lifespan of the third and fourth plans of the HSDP. It aims at building on the momentum occasioned by the Millennium Development Goals to garner the multi-sectoral support needed to meet the reproductive and sexual health needs of our culturally diverse population.

While the current strategy provided the means for reducing mortality and morbidity and improving the health of mothers and newborns, several global and national developments had happened during the last ten years. This has necessitated revision to prepare a comprehensive and up-to-date strategy that incorporates these developments to be used as one of the policy tools to potentiate transformation in the health sector and accelerate national progress towards ending preventable maternal and child deaths. Such new interventions as community-based management of neonatal sepsis and "Option B+" for PMTCT had already been introduced and being largely scaled up.

There is also a need to scale up existing high-impact interventions whose population coverage lags behind the target such as skilled birth attendance and antiretroviral prophylaxis for neonates born to HIV infected mothers. The revision of the current strategy is imperative to consolidate the encouraging gains in maternal, newborn, child and adolescent survival and the long-term vision of .the country to end all preventable maternal and child deaths by 2035

The development of the national RH strategy 2016-2020 was informed by a comprehensive situational analysis that provided an in-depth view of the current status of the health of Ethiopian mothers and their children resulting from interventions provided in the past strategy. The strategy provides an overall guidance and reflects on the core targets and priority actions for the implementation of three five-year national strategic plans: maternal and newborn health, family planning and fertility, and adolescent and youth reproductive health presented as the strategic foundations of the national RH strategy. The strategy also outlines the key approaches for addressing reproductive organ cancers .and the social determinants of reproductive health with emphasis on gender

This RH strategy encompasses 12 strategic objectives catered under core thematic areas of: improving maternal and newborn health (MNH), improving family planning, improving adolescent and youth reproductive health, prevention and management of reproductive organ cancers, addressing the social determinants of reproductive health, and prevention and treatment of pelvic organ prolapse. It provides an overall guidance and reflects on the main targets and strategic interventions for the implementation of these strategic objectives pooled around 23 strategies. Seven of the objectives relate to improving equity and access to quality RH services, enhancing good governance, improving the regulatory system for RH, improving the logistics and supply chain management of RH commodities, improving community participation and engagement for RH, improving financing and resource mobilization and improving research and evidence for decision making. Four are related to capacity building and include enhancing the use of technology and innovations, improving development and management of human resources, improving health infrastructure and enhancing policy and procedures. The remaining one strategy addresses the .social determinants of reproductive health

While implementing this strategy, the service delivery modalities shall give due emphasis to the continuum of care approach where essential services for mothers, newborns, children, adolescents and youth will be delivered in an integrated package at critical points in the life cycle, in a dynamic .health system

The implementation of this strategy is also contingent upon the execution of the Health Sector Transformation Plan and the 20-Year Health Sector Visioning under the overarching umbrella of the revised National Health Policy of Ethiopia. The strategy aligns with the vision of the HSTP for the next five years to reducing maternal mortality to 199 per 100,000 live births and neonatal mortality to 10 per 1,000 live births by scaling up RMNCAH services. In line with this, Ethiopia has committed to increasing contraceptive prevalence to 55 percent among married women, thereby reducing total fertility rate to 3, reducing adolescent pregnancy rate to 3 percent, increasing coverage of skilled care at birth to 90 percent and increasing ART treatment of HIV-positive pregnant women to 95 percent. In order to have coordinated efforts and effective courses of action, the Ministry of Health will coordinate the implementation of the national RH strategy and assume responsibility for its execution, supervision and monitoring in collaboration with key stakeholders/partners and the .broader membership of the RH community

1 INTRODUCTION

The vision of the health policy of Ethiopia entails improving the health of women, children, adolescents and youth through access and quality reproductive health services; integrated with the prevention and control of sexually transmitted infections including HIV, reproductive organ cancers; which in turn requires trained and caring providers, community-based health extension agents, good clinical services, a steady flow of life-saving and health-promoting commodities; and also measures that .build social and economic participation

The previous reproductive health strategy was developed for the period of 2006-2015 and has already ended. It provided the platform and the means for achieving the acknowledged successes in maternal and neonatal mortality reduction. Simultaneously, global and national developments have brought new evidence-based interventions to be included in the existing package of interventions. Changes in population dynamics, urbanization, double burden of communicable and non-communicable diseases, malnutrition, industrialization, globalization, climate change and advancement in technologies have continually changed Ethiopia's landscape. In turn, this may .require modification of the traditional service delivery approach

In light of the new high-impact interventions, change in priority target groups, service delivery approaches as well as aligning Ethiopia's RH policies and strategies with the new global commitments-the sustainable development goals related to reproductive health-and the strong political commitment to consolidate the encouraging gains and the long-term vision to end preventable maternal, neonatal, child and adolescent mortality, it is compulsory to develop a comprehensive follow-up reproductive .health strategy

There is also a need to scale up existing high-impact interventions for which population coverage lags behind the target such as skilled birth attendance, and antiretroviral prophylaxis for neonates born to HIV-infected mothers. Thus, the revision of the current strategy was imperative to consolidate the encouraging gains in maternal, newborn, child and adolescent survival and the long-term vision .of the country to end all preventable maternal and child deaths

The new RH strategy fine-tunes, contextualizes and incorporates selected high-impact reproductive health interventions and service delivery models that have gained global acceptance, keeping the primary healthcare unit at the core. The service delivery model will be based on life cycle approach and ensuring continuum of promotive, preventive and curative care across time: pre-pregnancy, pregnancy, childbirth, postpartum and neonatal period and through reproductive age. This approach is based on the sound premise that the health of an individual across the life stages and levels of .delivery are interlinked

The development of this strategy is informed by an extensive situational analysis that provided an in-depth view of the current status of the health of Ethiopian mothers, children, adolescents and youth and identified the critical success factors, bottlenecks and solutions for formulating new targets and priority actions. The strategy fosters multi-sectoral and interdepartmental collaborations and partnership of all stakeholders that share common goals and vision for improved health outcomes with emphasis on the most vulnerable and underserved sections of the population and the developing regional states. This strategy is built and aligned with strategies and visions of the HSTP, GTP II and .other programmatic strategies of other related sectors

2 BACKGROUND

Geography.2.1

Ethiopia is located in the horn of Africa covering an area of approximately 1.14 million square kms. It is boarded by Sudan and South Sudan on the West, Somalia and Djibouti on the East, Eritrea on the North and Kenya on the South. It is known for its diverse topography characterized by rugged mountains, flat-topped plateaus, deep river canyons, rolling plains and lowlands. The country is administratively sub-divided into nine regional states: Tigray, Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, Southern Nations, Nationalities, and Peoples (SNNP), Gambela and Harari, and two Administrative councils: Addis Ababa and Dire Dawa. The regions are divided into zones, woredas, and kebeles, which are the lowest level of administration. The woreda is the local government structure, acting as the basis for most administration and management. Currently, there are 956 woredas, representing around 100,000 people each and 16,541 kebeles with average .(catchment population of about 5,000 people each (MOH, 2014

Demography.2.2

Projection from the 2007 population and housing census estimates the total population for the year 2015 to be 90 million (CSA, 2015). With this, Ethiopia is the second most populous country in Africa. According to the Ethiopian Mini-Demographic and Health Survey (M-DHS) (CSA, 2014), the country is characterized by a young population with 42% of its population being in the age range of 10-29 years. Women of child bearing age account for about 57% of the female population and 30% of the total population. Children under the age of 15 years account for nearly half (45%) of the total population, while only about 4% of Ethiopians are over age 65. Thus, to have productive society, improving the Reproductive Health (RH) status of all the people in general and mothers, children .and adolescents in particular and keeping it as one of the policy priorities is very fundamental

Education.2.3

Ethiopia has given due emphasis to change the education status of its citizen evidenced by massive expansion of primary, secondary and tertiary level teaching institutions. There were about 21.2 million children in 30,800 primary and 2,333 secondary schools in 2013/14 academic year (MOE, 2014). As the result, net primary school enrolment (Grade 1-6) reached 99% in 2014; this is a fivefold increase from the 1990 rate of 19%. In 2014, more than 1.7 million youth were attending higher education in 1312 TVETs and 33 universities. More than 3.5 million adults benefited from the adult education program and 6.6 million are currently in the program. Proportion of girls enrolled in primary and secondary education has exceeded 45% in 2014 as a direct result of the government's .policy to empower women through enhancing girls' education

Education is the main instrument for socioeconomic development and one of the social determinants of health. Studies have revealed that people are observed to have differences in health status, exposure to health risks, access to health services and health-seeking behaviour because of their differences in educational status (WHO, 2012). Educational attainment by women has a strong effect on reproductive behaviour, fertility, infant and child mortality and morbidity, and attitude and awareness related to family health, use of family planning, and sanitation. In principle, education and the health of women are inseparable. In addition to its synergistic effect with income, education also empowers women to make informed decisions in their lives and increases their sexual and .reproductive health literacy

The Ethiopian mini-DHS (CSA, 2014) showed that there is improvement in female education in the country but it is still low as compared to other parts of the world. In the same report, 42% have only some primary education, 3% completed primary education and did not attend secondary school. Only 4% of females have attended but not completed secondary education, and an additional 3% of females have completed secondary or higher education. Significant disparities in education also exist between urban and rural women. About one in four urban women and one in two rural women have no education (CSA, 2014). Hence, promoting female education and narrowing the equity gap is very crucial in the coming transformation plan, thereby contributing to the improved health status .of women and their children

Socio-economy.2.4

Over the last decade (2003/4 -2013/14), Ethiopia's economy has registered rapid growth with a 10.9% annual average growth rate of Gross Domestic Product (GDP). The Government of Ethiopia has also implemented a comprehensive economic reform program over the past decade. Cognizant of this, the health sector has been playing its part as a means of the economic growth while benefiting from the economic growth. Among the important features of the economic reform in Ethiopia is empowering women by creating an enabling environment for equal opportunity for women in the participation of the economic development of the country which is enshrined in the constitution. The Ethiopian constitution recognizes the principle of equality of access to economic opportunities, employment and property ownership for women. Following this, the government has formulated a national gender policy, which recognizes equality between the sexes and sets up mechanisms for the improvement of women's conditions, such as the establishment of the Ministry of Women's Affairs, now called Ministry of Women's and Children's Affairs and Ministry of Youth and Sports . The main strategies employed to implement the national policy include gender mainstreaming in sectoral development programs, advocacy and capacity-building initiatives. Despite all these efforts, bringing gender equality at all levels for decision making power in all their reproductive health matters still requires continuous work in improving their socio-economic status in the coming .transformation plan

The MOH is committed to strengthening gender mainstreaming at all levels of the health care system through the development of the Gender Mainstreaming manual whose implementation is underway in all major health programs and initiatives. The Health Extension Program (HEP) is an important gender-oriented program that delivers cost-effective basic services mainly to women and children, and is underpinned by the core principle of community ownership. At the center of community ownership efforts, empowering women is the means to ensure the health of family members. The Women Development Army (WDA) works through organizing and mobilizing families (mainly women) to scale-up best practices from the HEP. This mechanism has empowered women to participate in community health, seek for services and decide on the best alternatives for their health and their families. As a result, promising momentum has been shown in leaping the RH services. Nevertheless, maternal mortality and morbidity (such as fistula) are still very high as a consequence of harmful traditional practices such as early marriage, sexual violence and use of unlawful traditional healers. Thus, improving women's socio-economic status requires continuous work to ensure gender equality at all levels and women's full decision-making power in all matters .related to their reproductive health

Health System Organization.2.5

The health service of Ethiopia is structured into three tier system: primary, secondary and tertiary levels of care.

Primary level health care is composed of a health centre (HC), five satellite health posts (HP) and a Primary Hospital (PH). A health center is supposed to have 20 staff on the average and the catchment population to be served ranges from 15,000-25,000 people for the rural health centre and 40,000 people for the urban health centre. The health centers are expected to provide both preventive and curative services and serve as referral centers and practical training site 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. Specific to RH, The following health center activities are among others:

- Providing focused antenatal care (ANC), delivery and postnatal care (PNC), including prevention of mother-to-child transmission (PMTCT) of HIV services.
- Prevention and treating pregnancy-related complications.
- Arranging referral and transportation for emergencies
- Family planning services, including providing long-acting contraceptives
- Providing safe abortion and post-abortion care.
- Adolescent and Youth Friendly RH services

Health post is the lowest level of Ethiopian health care system staffed by two HEWs each per Kebele and expected to serve a catchment population of 3000 – 5000 people. The health post is supposed to serve the following reproductive health services.

- Basic ANC, including treatment of anaemia, malaria, and hook worm in pregnancy.
- Immunization of mothers and children.
- PNC with counselling on nutrition and family planning.
- Promotion of maternal and child nutrition, growth monitoring, Vitamin A and iron supplementation, and demonstration.
- Family planning counselling and services.
- Adolescent and youth RH (AYRH) services, including counselling on sexuality, HIV infection and harmful traditional practices.

A primary hospital provides inpatient and ambulatory services to an average population of 60,000 - 100,000. In addition to what a health center can provide, a primary hospital provides rape clinical management and emergency surgical services, including cesarean section, blood transfusion (all the 9 CEmONC signal functions), and clinical management for cases of sexual assault. It also serves as a referral center for health centers under its catchment areas, a practical training center for undergraduate students. A primary hospital has an inpatient capacity of 25-50 beds.

Secondary level health care comprises a general hospital which provides inpatient and ambulatory services to an average of 1 million – 1.5 million people. With an average of 234 staff, serves as a referral center for primary hospitals and as a practical training center for both undergraduate and postgraduate programs in medicine and other health sciences.

Tertiary level health care is composed of a specialized hospital that serves an average of 3.5 million - 5 million people, has a standard staffing of 440 health workers and serves as a referral center to general hospitals. According to the 2014 MOH of Ethiopia report, there were about 16,281 health posts, 3,335 health centers and 263 public hospitals (133 Primary, 122 General and 8 Specialized) in 2013. In addition, there are about 65 private/NGO hospitals making a total of 325 hospitals in the country.

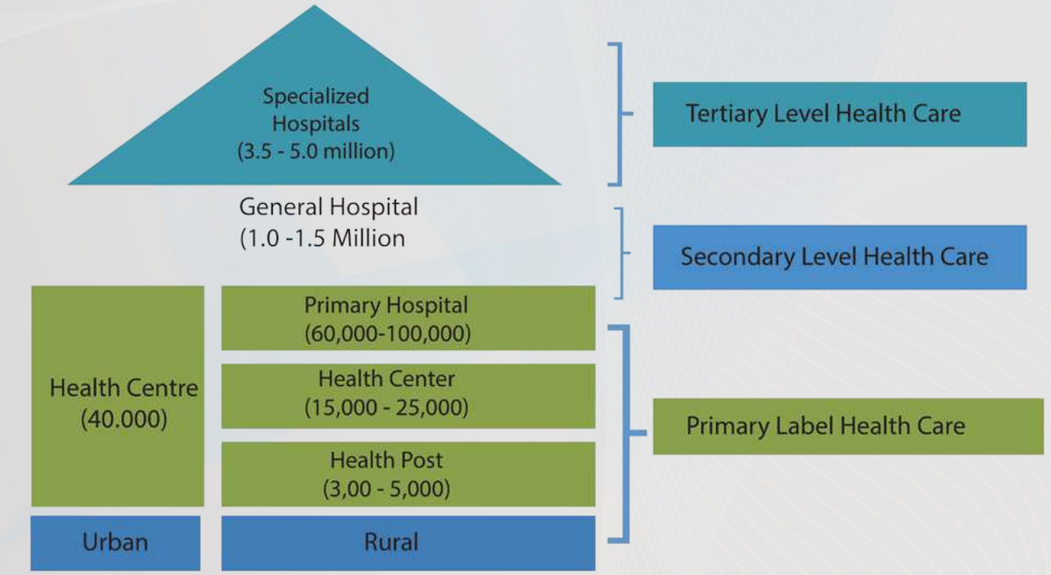


Figure 1: The three tier health system of Ethiopia

The Health Sector Plan and Vision.2.6

The newly revised health policy of Ethiopia recognizes the constitutional rights of women and children for health. It shades light on reproductive, maternal and child health as it distinguishes the constitution's guidance on women's rights to be protected from harm arising from pregnancy and child birth and women's rights to access to family planning, education, information and capacity to safeguard their health (Constitution: Article 35.9); as well as every child's right to life and not to be subject to exploitative practices which may be hazardous and harmful to his or her health (Constitution Article 36: 1&3). Preceding the development of the new national health policy, the MOH prepared the 20-year health sector vision. The vision defines a framework for strategic actions that enable Ethiopia to achieve the health outcomes commensurate with lower-middle-income countries by 2025 and upper-middle-income countries by 2035.

It focuses on primary health care as a critical element of a cost-effective health system and the principal means to advance towards universal health coverage (including reproductive, maternal, newborn, child and adolescent health services) while also addressing broader issues of secondary and tertiary care necessary to ensure a continuum of quality clinical care with strong linkage to primary health care (MOH, 2014). Ethiopia's health sector transformation plan (HSTP 2016-2020) derives from the health sector strategic recommendations defined in the 20-year vision and goals of the health sector. One of the key strategic objectives of the HSTP is to improve equitable access to quality maternal, newborn, child and adolescent health services-ensuring the minimum essential health services package at the primary health care unit for individuals, families and communities, at optimal coverage levels and with protection from catastrophic out-of-pocket expenditure (MOH, 2015).

3. SITUATIONAL ANALYSIS

3.1.Impact analysis (mortality, morbidity and fertility)

3.1.1. Maternal mortality

Ethiopia is among the countries with good progress in reducing maternal mortality. According to the Ethiopian Demographic and Health Surveys (EDHS) maternal mortality ratio (MMR) has dropped from 871 in EDHS 2000 to 676 in EDHS 2011 per 100,000 live births. The MMR reported in EDHS 2005 and 2011 were almost similar (CSA and ORC Macro, 2000, 2005 and 2011). However, the 2015 estimates of maternal mortality for Ethiopia by the UN Inter Agency Group (UN-IAG) indicates a substantial decline in maternal deaths over the last twenty-five . According to this report, the MMR had shown 5% annual rate of decline; from 1250 to 353 per 100,000 live births between 1990 and 2015, a 71.8% decline. As a result, the country was labeled as one of the countries making progress to achieve the 2015 MDG target. The proportion of deaths among women of reproductive age that are due to maternal causes (PM) had also reduced significantly from 40% in 1990 to 18.7% in 2005. However, the decline in the last ten years was slow with the level of 16.7% in 2015 (WHO et al, 2015) (Figure 2).

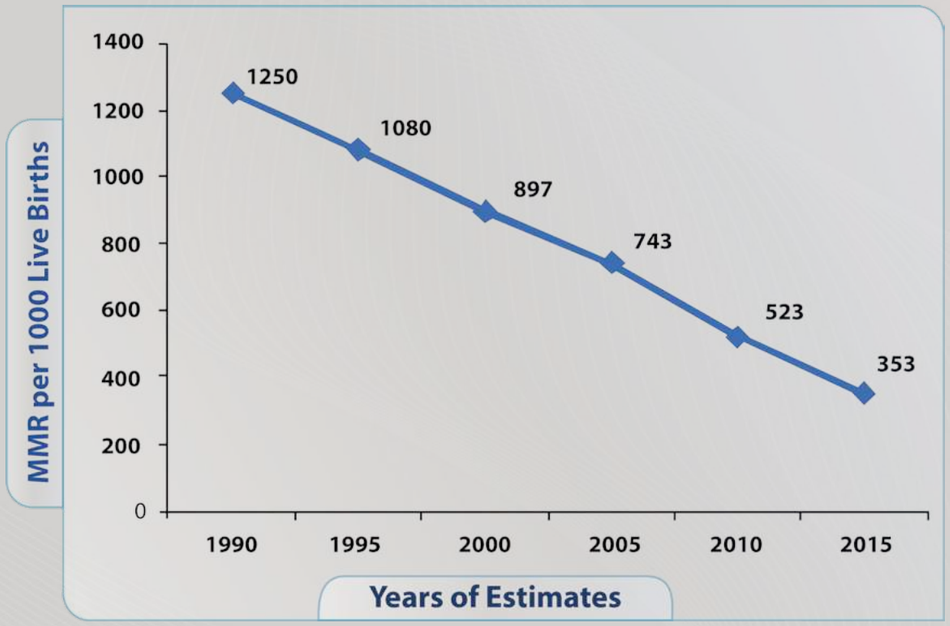


Figure 2: Trends in maternal mortality in Ethiopia, 1990-2015 (Source: UN-IAG, 2015).

Despite significant decline in MMR nationally, disparities exist between regions. The in-depth analysis of EDHS 2000-2011 conducted by the United Nations Population Fund (UNFPA), shows that five out of the eleven regions (Somali, Afar, SNNP, Amhara and Oromia) estimated to have higher maternal mortality burden than the national average. There were also significant variations between urban and rural women as well as different socioeconomic status (wealth quintiles), where the women in the rural residences and the lowest wealth quintile had a high risk of maternal death (UNFPA, 2012).

According to the facility-based report of the Ministry of Health (MOH, 2003), fifteen years ago , abortion was the leading cause of maternal mortality in Ethiopia accounting for 32%. Similarly, according to the systematic review and meta-analysis done by Berhan et al (2014), abortion was the leading direct cause of maternal mortality during 1980-1999 accounting for 31%. For the period from 2000-2012, however, the top five direct causes of maternal mortality were obstructed labor (36%), hemorrhage (22%), hypertensive disorders of pregnancy (19%), infection (13%) and abortion (10%). According to recent estimates in the Countdown 2014 report (WHO et al, 2014), the majority of maternal deaths occur during the intrapartum and immediate postpartum period from hemorrhage (25%), pre-eclampsia/eclampsia (16%), and infection (10%). Unsafe abortion accounted for 10% of avoidable maternal deaths (WHO et al, 2014). Hence, addressing the top four leading causes can avert about nine in ten of the maternal deaths.

3.1.2.Neonatal mortality

In Ethiopia, child mortality has declined significantly in the last 25 years. The under-five mortality rate had reduced from about 205 per 1000 live births in 1990 to 59 in 2015, 71% reduction. The Infant mortality rate has also declined from about 122 to 41 per 1000 live births in the same period. Consequently, Ethiopia was declared by the international community to have achieved MDG4 in 2013.

Despite Ethiopia's remarkable success in improving child health, mortality is not being reduced uniformly across the different childhood age groups as the rate of reduction in neonatal mortality is relatively slow. The neonatal mortality rate (NMR) in EDHS 2000, 2005 and 2011 were 49, 39 and

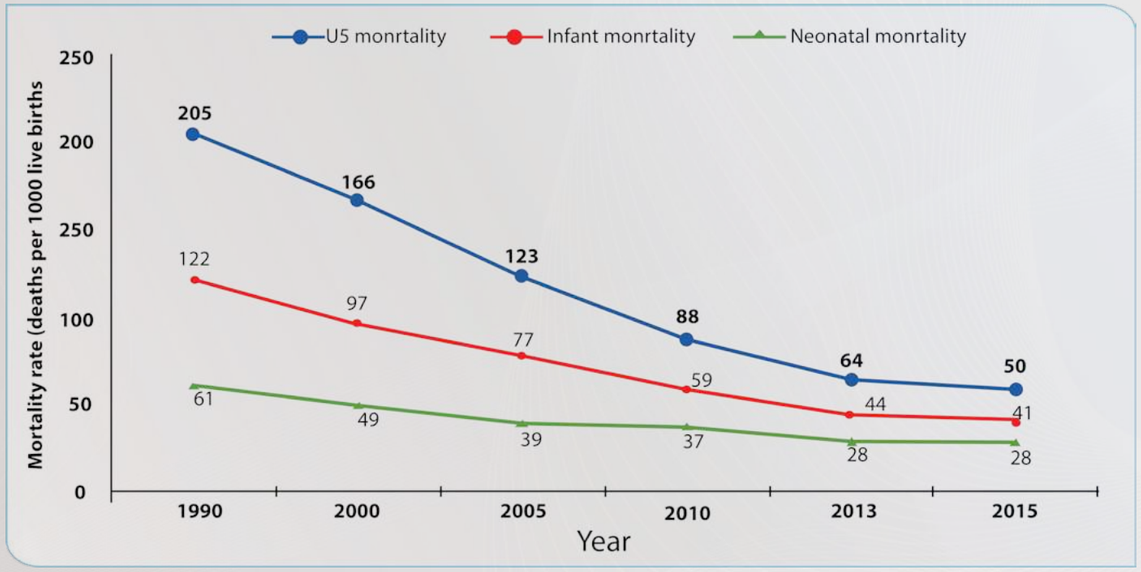


Figure 5: Trends in Total Fertility Rate (TFR), unmet need and Contraceptive Prevalence Rate (CPR) in Ethiopia, 2000-2014. Sources: EDHS, 2000, 2005, 2011 and 2014.

Like that of the maternal mortality, significant disparities in the NMRs exist between regions. According to EDHS 2011, NMRs ranged from as low as 21 per 1,000 live births in Addis Ababa to as high as 62 per 1000 live births in Benishangul-Gumuz. Six regions (Benishangul-Gumuz, Amhara, Tigray, Oromia, Gambela and SNNP) had NMRs above the national average. Similarly, low maternal education and being in the lowest wealth status were directly related to poor health care seeking behavior of mothers during pregnancy, delivery and postpartum, which in turn contributed to increased neonatal mortality.

The three leading causes of newborn deaths in Ethiopia were asphyxia (33%), complications of preterm birth (26%) and sepsis (21%). All of these causes can be significantly prevented or managed through increased investment in the quality of care around the time of birth. According to the UN-IGME (UNICEF et al, 2014) report, in 1990, the share of neonatal death from under-five deaths was 27%, which had increased to 43% in 2013. The most recent report in the Countdown 2014 report for Ethiopia also revealed that 43% of the causes of under-five deaths were neonatal deaths, suggesting the need for particular attention to neonatal health.

Perinatal mortality .3.1.3

Perinatal mortality Rate (the rate of stillbirths and early neonatal deaths per 1000 pregnancies lasting seven months or more), which is an indicator of the quality of pregnancy and intra-partum care, is also slowly declining in Ethiopia. It was 52, 37 and 46 per 1000 total births lasting seven months or more in the EDHS 2000, 2005 and 2011, respectively. The status of still birth of 18 per 1000 pregnancies lasting 7 months or more is also unacceptably high. High maternal deaths are also directly related to high perinatal and neonatal mortality rates, mostly occurring within the first 24 hours after birth, which in turn are directly associated with the availability and quality of obstetric services. This also points to improving the provision of quality care during late pregnancy, labor and delivery, and early postnatal period.

3.1.4. Contributing factors to maternal and newborn mortality

Timing is critical in preventing maternal death and disability. Although post-partum hemorrhage can kill a woman in less than two hours, for most other complications, a woman has between 6 and 12 hours or more to get life-saving emergency care. Similarly, most perinatal deaths occur around

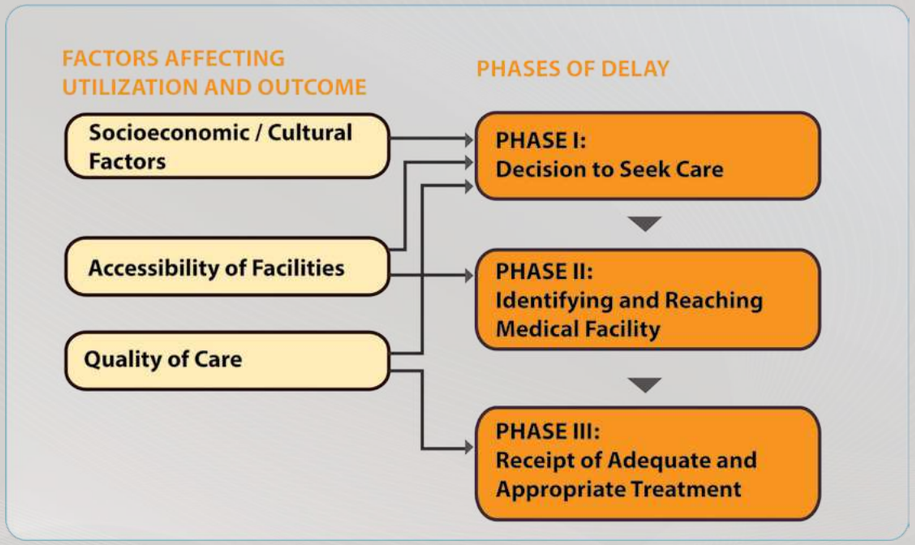


Figure 4: The 'three delays' model. Source: UNFPA, 2014

The first delay often happens when a woman, or her family, put off seeking health care. The second delay can occur when she tries to reach appropriate health care. Both of these delays relate to the issue of access to care, involving factors such as family and community beliefs, awareness, affordability of care, availability of transport and distance to health care. Improved awareness in the community and use of new communications technologies – including mobile phones – can address the first delay. Improved transport services and reduced transport costs can also address the second delay.

The third delay is a delay in receiving care at health facilities. This involves factors within the health facility, including organization, quality of care, and availability of staff and equipment. Recently, a "fourth delay" that results when patients are not timely referred to the next higher level of care due to delay in making referral decisions by providers is getting attention. Addressing these issues is an essential component of ensuring quality emergency obstetric care.

Obstetric fistula .3.1.5

Many women who survived delivery-related death are prone to develop long term complications, such as fistula, uterine prolapse, chronic pelvic pain, depression, anemia and exhaustion. Although there are multiple factors, deliveries unattended by a skilled person are considered as the major reason for the high prevalence of obstetric fistula (Muleta, 2004; CSA and ORC Macro, 2005). Among survivors of obstructed labor, obstetric fistula is especially common in Ethiopia, primarily due to the high rate of adolescent pregnancy combined with neglected prolonged and obstructed labor. The USAID fistula situation analysis in Ethiopia has estimated approximately 3,500 obstetric fistula cases annually (MOH, 2013), and the MOH report has also shown that about 37,500 women were living with untreated fistula across the country (MOH, 2010). Compared to 2003 WHO annual estimates of 9,000 new cases, the USAID finding indicates marked reductions in the incidences of obstetric fistula. The future strategy of the MOH is to expand services in public and non-public healthcare facilities to treat more women living with fistulae and to transform their lives and restore their dignity, and to prevent its occurrence in future deliveries. The Ethiopian government has also expressed its commitment to eliminate obstetric fistula by 2020, under the theme "Ending Fistula and Transforming Lives by 2020."

Fertility .3.1.6

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 4.8 children in 2011 and then further to 4.1 children in 2014 with a one child drop in the past one decade and a decline of 1.4 children observed over the past 14 years (Figure 4). This substantial decline in fertility has taken place both in urban areas (from 3.3 to 2.2) and rural (from 6.4 to 4.5). However, the TFR in rural areas exceeded the TFR in urban areas by more than two children per woman. Moreover, there were substantial differences in the TFR among the regions, ranging from 1.7 children per woman in Addis Ababa to 7.3 children per woman in Somali. Fertility levels were higher than the national average in Somali, Afar, Benishangul-Gumuz, Gambela, Tigray and SNNP. The level of fertility was inversely related to women's educational attainment, decreasing from 5.1 children among women with no education to 1.7-1.9 children among women who have a secondary or higher education. Women in the lowest wealth quintile had a TFR of 5.6, more than twice as high as women in the highest wealth quintile, at 2.4 (CSA and ORC Macro, 2000, 2005, 2011, CSA, 2014). As an indirect indicator of the fertility control, the contraceptive prevalence rate has

increased from 8% in 2000 to 42% in 2014. The contraceptive unmet need has also reduced from 36% in 2000 to 25% in 2011 (the detail is described below).

Despite the recent gain, Ethiopian population is still growing with annual rate of 2.6%. If unchecked, the growth of the Ethiopian population will be faster and the doubling time will further decrease to less than 25 years. These imply the need for thoughtful planning to properly exploit this huge demographic resource for national development and at the same time curtail uninvited consequences ahead of their occurrence.

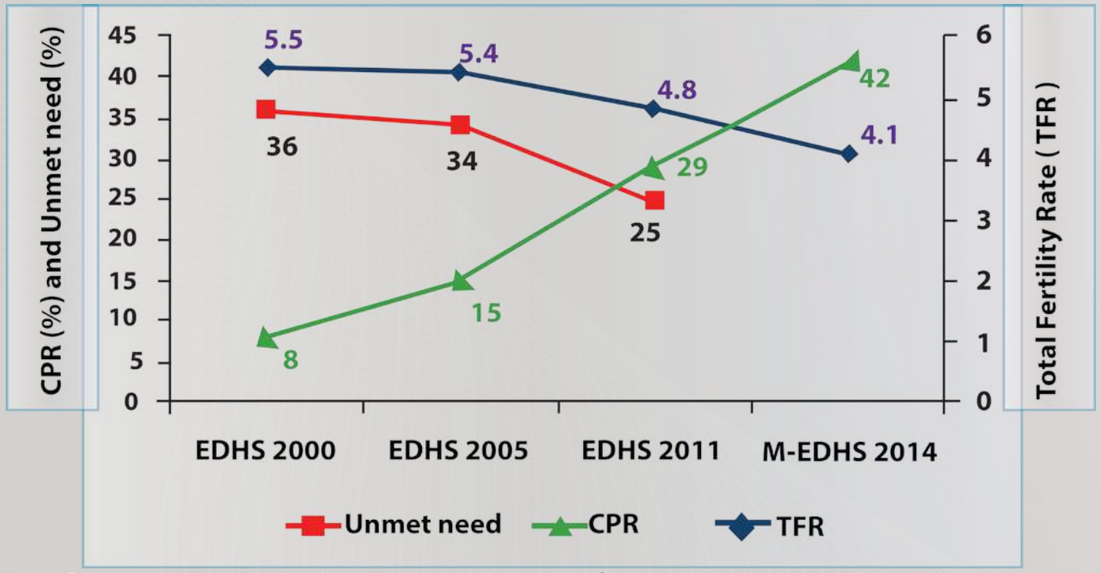


Figure 5: Trends in Total Fertility Rate (TFR), unmet need and Contraceptive Prevalence Rate (CPR) in Ethiopia, 2000-2014. Sources: EDHS, 2000, 2005, 2011 and 2014.

Maternal, newborn and adolescent nutrition .3.1.7

The importance of ensuring good nutrition from adolescence through pregnancy and early childhood (the first 1,000 days) is being increasingly recognized as a priority for sustainable development. Poor nutritional status harms woman's own health and is a risk factor for intrauterine growth restriction and other poor obstetrical outcomes. Based on the 2014 child health expert reference group (CHERG) estimates, under nutrition is a major underlying cause contributing to nearly half of childhood deaths in Ethiopia. Even though child nutrition has shown improvement with declines in underweight, stunting and wasting by 39%, 31% and 25%, respectively during the last 15 years, the current prevalence of stunting (40%), underweight (25%) and wasting (9%) is still very high.

The prevalence of under-nutrition among Ethiopian women did not change between 2005 and 2011 EDHS reports, 26.5% and 26.9%, respectively. The 1993-2005 estimation of iron deficiency anemia in women of reproductive age of Ethiopia was 52% (WHO, 2008). A large scale study on women of reproductive age in nine regions of Ethiopia reported that the prevalence of anemia was about 29% (Haidar et al, 2009). However, according to EDHS, the anemia prevalence among pregnant women decreased from about 27% in 2005 to about 17% in 2011. Reproductive, maternal, newborn and child health is inextricably interconnected: improving maternal health and nutrition will reduce newborn and young child deaths. In turn, reducing stunting, improving child health and lowering adolescent and total fertility rates will reduce the risk of a maternal death among the next generation of women.

3.1.8. Sexually Transmitted Infections (STIs) including HIV

The 2011 Ethiopian Demographic and Health Survey (EDHS) has shown that the national HIV prevalence among women and men aged 15-49 years was 1.5%, with the highest prevalence 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.

The STIs prevalence in Ethiopia is not known. According to the 2011 EDHS, 3% women and 2% men had abnormal genital discharge and about 1% each genital sore in 12 months period prior to the survey. Among the high risk group, however, the STIs prevalence was reported to be in the range of 3.5% to 12% (MOH, 2014).
Preventing the transmission of STIs including HIV, is with no doubt the best. Effective treatment of STIs is therefore 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 to be an integral component of all reproductive and sexual health services. Similarly, the prevention, testing and early initiation of antiretroviral treatment for HIV infection is an important strategy to reduce the HIV-related morbidity and mortality, and by large, to prevent the synergic effect of STI and HIV on the overall health of the carrier. 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.

(Reproductive organ cancers (ROCs .3.1.9

Although there are limited data estimating the national prevalence of reproductive organ cancers (ROCs) in Ethiopia, breast and cervical cancers in women and penile and prostate cancers in men are thought to be the most common. Due to delay in reporting, lack of mass screening for precancerous lesions, lack of radiotherapy and chemotherapy for the majority, breast and cervical cancers are also contributing much to women's morbidity and mortality. Surgical treatment services are also available in a few hospitals.
According to the International Agency for Research on Cancer (IARC) estimation, the number of breast, female genital organ and male genital organ cancers in Ethiopia in 2012 was 12,956, 10,181 and 1,427, respectively. The same agency estimated the number of cervical cancers as 7,095. The Addis Ababa population-based cancer registry also showed that breast and cervical cancers were on the top list, 22.6% and 10.8%, respectively. Data from the hospital-based registry also showed that cervical cancer accounted for 30% of all cancer cases.

This much high prevalence of breast and cervical cancers is despite the fact that they give an opportunity for prevention and early detection because of 1) easily accessible nature of the organs for inspection and palpation, 2) the long period of transformation from precancerous to cancerous lesion (10-20 years in case of cervix), and 3) presence of effective screening methods. Among others, the "See and Treat" technology such as visual inspection of the cervix with acetic acid (VIA) or lugol's iodine (VILI) and providing immediate treatment (cryotherapy or loop electrosurgical excision procedure) is ideally suited for large scale interventions in a low resource setting like Ethiopia. Breast self-examination, timely reporting and referring suspected breast lesions, mammography examinations and microscopic examination of fine needle

aspirations are also effective methods of preventing the morbidity and mortality due to breast cancers. Mammography can detect 80%-90% of breast tumors up to two years ahead before they can be felt.

There are also potentially preventable risk factors for breast cancer, such as nulliparity, failure to breastfeed, early menarche (childhood obesity), adulthood obesity, giving first birth at early or late age and use of alcohol. Similarly, since nearly 100% of cervical cancers are attributed to the persistent human papilloma virus (HPV) infection, several of the factors increasing the persistence of HPV infection and development of cervical cancer [early sexual debut, teenage pregnancy, multiparity, co-infection with other sexually transmitted infections (STIs) such as HIV, herpes simplex virus (HSV) type 2 and Chlamydia trachomatis] are also potentially preventable. Avoiding HPV infection and its persistence is also an advantage to prevent about 90% of anal cancers, 40% of genital cancers (vulva, vagina and penis), and 12% of oropharyngeal cancers, which are also thought to be caused by persistent HPV infection (WHO, 2007).

Another method of preventing cervical cancer is providing the HPV vaccine for girls and boys at age 9-13 years, which is known to offer the best protection from cervical cancer in their later age. Currently, there are three types of HPV vaccines to prevent cervical cancer; bivalent vaccine (Cervarix) for genotypes 16 and 18 (responsible for 70% of cervical cancers), quadrivalent vaccines (Gardasil, and Gardasil 9) for genotypes 6, 11, 16 and 18. The latter two vaccines are also effective in protecting other HPV-related female genital cancers (vulvar and vaginal), anal cancer and genital warts in both men and women.

Unfortunately, due to myriad reasons, single radiotherapy center with limited capacity has been established in Addis Ababa at Tikur Anbessa hospital. The chemotherapy services again with limited capacity are also available in the same hospital and few private health facilities. Currently, however, 5 oncology centers are under establishment in different regional states basing university hospitals. Due to few numbers of gynecologists and surgeons across the country, the surgical therapy for ROCs is still not optimal. With the ongoing scale up specialty training, the surgical treatment of ROCs is expected to markedly improve in the years to come.

In short, improving the early detection and treatment of precancerous and cancer lesions, and the establishment of oncology centers will benefit women with any type of ROC. The experience of Ethiopia in precancerous cervical lesion screening using VIA for HIV-positive women in 25 health facilities (hospitals and clinics) has shown that it is possible to scale up this procedure to reach to the most vulnerable group at the national level and reduce the incidence of cervical cancer. Similarly, the feasibility of HPV vaccination in Ethiopia in the coming five years is higher taking into account the good experience of other countries, the low cost of three-dose vaccines, the WHO strong recommendation to start this vaccination in low income countries and the commitment of Ethiopian's government to launch it. In parallel, the planned national cancer surveillance and registry need to be strengthened.

3.1.10. Pelvic organ prolapse

Pelvic organ prolapse (POP) is one of the common gynecologic problems that usually becomes symptomatic later in life. Anatomically, a loss of normal attachment and support results in descent of the pelvic organs into the vaginal canal. It is estimated that more than half women aged 50 years and above develop POP. In Ethiopia, the exact prevalence of POP is unknown. Because of the presence of multiple risk factors (early marriage and delivery, high fertility, high proportion of home delivery, high incidence of obstructed labor, high prevalence of malnutrition,

the majority of rural women engagement in heavy physical work), the prevalence of POP in Ethiopia is expected to be among the highest in the world. Other factors contributing to the high prevalence are: its painless nature, low awareness of women about its treatability, probably being embarrassed to disclose it and the limited number of gynecologists treating this disorder. As a result, unpublished survey has shown that the prevalence of POP in some areas of Ethiopia was about one in ten women.

With improving family planning and obstetric services in this country, the risk of developing POP due to obstetric risk factors is expected to be low in the years to come. However, the prevalence of POP among older women may cause POP to continue being a public health problem. With that understanding, the current RH strategy primarily aims to clear the backlog by identifying women with POP, and linking them with hospitals to get the treatment. In parallel, preventive actions will be promoted by integrating with other RH schemes.

3.2.Outcome and output analysis

Improving maternal, newborn and adolescent health depends on the collective ability of the government and development partners to work together effectively to reach women, newborns, children and adolescents with essential and effective interventions along with the continuum of care. Therefore, this situational analysis tried to address the outcome/services use in line with this continuum of care.

3.2.1. Family planning

The history of family planning in Ethiopia starts with the establishment of the Family Guidance Association of Ethiopia (FGAE) in 1966 in one clinic in Addis Ababa. Despite this long years of history, access to family planning was limited to major urban areas. The Ministry of Health (MOH) integrated family planning with a national mater¬nal and child health (MCH) program in the early 1980s in public health facilities. Since then, the family planning service coverage increased largely as a result of a significant increase in access to health facilities.

As seen in Figure 5 above, although started at a slow pace, Ethiopia has contin¬uously experienced an increase in contraceptive prevalence in the last two decades. According to the first National Family and Fertility Survey (NFFS) in 1990, only 4% of the women in their reproductive ages were using some family planning methods, of which, only 3% were using modern contraceptive methods (CSA, 1991). The contraceptive prevalence rate has doubled between the periods 1990 and 2000 and by the year 2000 it was esti¬mated at 8.2%. The increase has been rapid and unprecedented after 2000. The subsequent DHS surveys in 2005 recorded a twofold increase in contraceptive prevalence rate (CPR) and put the rate at 14.7%. With the trend continuing, CPR reached at 41.8% by the year 2014 (CSA, 2014).

There was also an increasing trend of CPR by area of residence. In the urban areas, CPR showed an increase of 7.1% age points in 2014 from the 2011 CPR level. In rural areas, the percentage point increase in CPR was 5.6 in the three years between 2011 and 2014. Although family planning service has been showing an improvement in method mix over the years, the use of injectable contraceptives has still remained to be the dominant method (CSA, 2014). The current CPR is estimated at 42%.

With regard to the unmet need for family planning, there has been encouraging changes over the past years. In the year 2000, the country had an unmet need level of 36% among currently married women, which has declined to 34% in 2005 and further to 25% in 2011. Unmet need is higher among rural women as compared to that of urban women (27.5% Vs 15.0%) (EDHS, 2000, 2005, 2011). Furthermore, low coverage of LARC and permanent methods is well noted.

Hence, more effort is required to increase the CPR and reduce the unmet need with particular focus on long-acting reversible and permanent contraceptive methods. This is because despite Ethiopia's track record in consistently increasing FP uptake, the growth has not been uniform across the various methods. Among others, the utilization of long-acting reversible and permanent methods is extremely low. As a result, the majority of family planning users still depend on short-acting methods, particularly injectable methods (EDHS, 2011). As the country continues its efforts to increase FP uptake through a rights-based approach, it will be essential to improve the quality of FP counselling and services and bring about a well informed decision-making process on method choice. As a result, every couple will be aware of the options available for delaying, spacing, and limiting pregnancy.

3.2.2. Antenatal, delivery and post-natal care

Ethiopia has been implementing main maternal and newborn health interventions and has achieved significant improvements in the coverage. However, coverage for the basic service delivery packages varies across the continuum of care. Services that can be scheduled, notably antenatal care (ANC) have relatively high coverage with 98% of pregnant women making at least one ANC visit (MOH, 2014). However, only 20% have made their first ANC visit before 16 weeks (L10K, 2015) with median duration of pregnancy at first visit of 4.9 months (EMDHS, 2014) and the prevalence of those going for at least four visits increased to 67% (MOH, 2015). According to EMDHS 2014, of women with ANC, only one out of six (16%) received all four components of ANC services (information on pregnancy complications, blood pressure measurement, blood sampling and urine sampling); 30% received three components and the majority (36%) received two or less.

Arguably, interventions that require 24-hour curative services and that rely on strong health system, such as skilled birth attendance have shown marked improvement. Nationally, 60% of births are attended by skilled personnel (MOH, 2015). However, only 20% of BEmONC facilities provided anticonvulsants and the proportion of CEmONC facilities with effective blood transfusion and cesarean delivery services was 4% and 5%, respectively (MOH, 2014). Furthermore, though the coverage value (89.9%) of routine postnatal care for mothers is relatively high (MOH, 2015), its timeliness and quality are debatable.

Equitable care involves providing care to all families according to need, rather than according to income or other background. Large disparities exist between rich and poor people, rural and urban, and among regions. Even for some primary health interventions with high coverage, it is lower for poorer families. Marked urban-rural difference in ANC service indicates a major access problem for women in rural areas; 45.3% of women in rural areas have no antenatal visit compared to 17.5% in urban areas; urban women are more likely than rural women to make four or more ANC visits (66% versus 27%); women in urban areas make their first ANC visit more than a month earlier (4.1 months) than rural women (5.2 months). Also, the likelihood of receiving ANC during pregnancy varied with wealth indices; only 44% of women in the poorest quintile received ANC, compared to

For clinical and curative care, the gap between access to care in the richest and poorest households, specifically skilled attendance during childbirth, is 11-fold higher for the richest than the poorest families. Similarly, urban women have 7-fold more access to skilled birth attendance than rural women. The available CEmONC facilities are not distributed within easy reach of all the women and newborns who need them. Disparity in the distribution and utilization of BEmONC and CEmONC facilities, particularly pastoralist areas are among the major challenges.

Regional variations are still wide: skilled attendance at birth varies from 4% in Afar to 96% in Harari, and postnatal care is 12 times higher in Harari than in Gambella. Comparisons from the ESPA+ 2014 report show that more than 90% of facilities in SNNP and Benishangul Gumuz offer ANC services compared with only 50% in Gambella. Similarly, 80% of facilities in Tigray and Dire Dawa provide TT vaccine compared with <50% in Afar and Addis Ababa. Provision of ANC and TT services is lower in rural areas (42%) than urban areas (52%) settings.

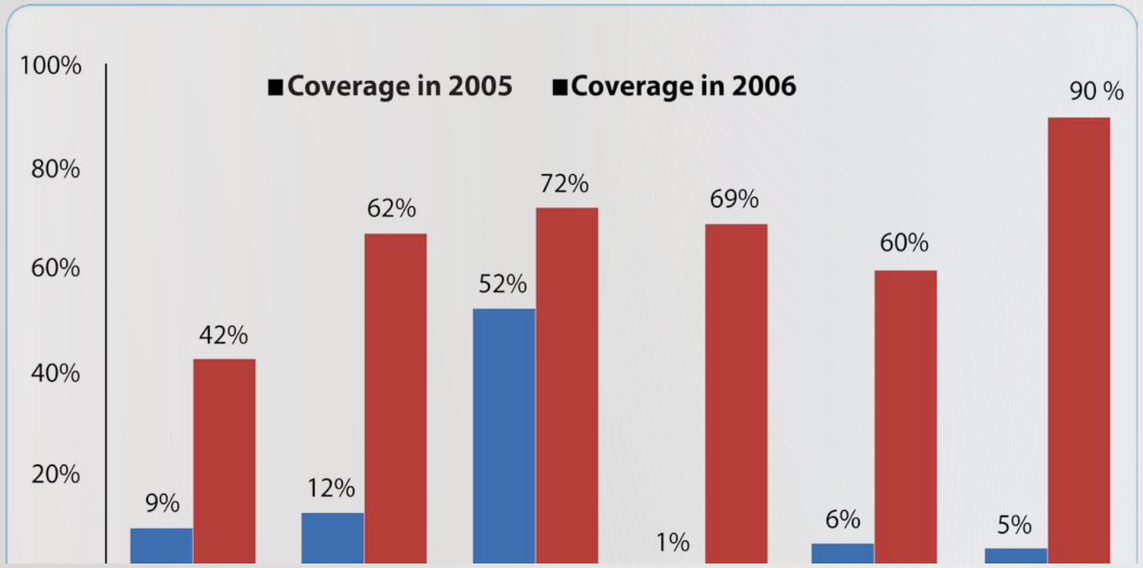


Figure 6: Coverage of maternal, newborn and reproductive health interventions along the continuum of care, 2005 and 2015, Ethiopia. Source: MOH, 2015

3.2.3. Prevention of Mother To Child Transmission (PMTCT) of HIV

Receiving HIV testing and counseling services during pregnancy as early as possible enables pregnant women living with HIV to benefit from HIV prophylactic and therapeutic services. The risk of mother-to-child transmission of HIV can be reduced by a range of interventions: providing antiretroviral therapy (Option B+) during pregnancy, safe labor and delivery, safe newborn care, administration of antiretroviral prophylaxis to the infant in the first week of life and safe infant feeding.

The national PMTCT guidelines was revised per the WHO Option B+ recommendations and launched in January 2012. Since then, implementation has been scaled up to 2,542 government and 153 private health facilities along with training of healthcare providers. A 97% target was met for physical expansion (MOH, 2014). Though 90% of pregnant women attending ANC have been counseled and tested for HIV, only 69% of HIV positive have received antiretroviral treatment (ART) and 59% of HIV-exposed newborns received ARV prophylaxis, reflecting a gap in HIV post diagnosis coverage (FHAPCO, 2014).

The PMTCT oh HIV program was further challenged with equity and quality gaps. The proportion of pregnant women tested for PMTCT of HIV in 2014/15 varies from as low as 7.5% in Somali and 33.4% in Afar to as high as 100% in Harari, Dire Dawa, Oromia and SNNP, showing the disadvantaged position of the developing regional states (MOH, 2015). Similarly, the proportion of HIV-positive deliveries who received a full course of ART (Option B+) in 2014/15 was as low as 3.8 in Somali, 15.5% in Afar, 18.5% in Gambella to as high as 81.7% in Harari and 100% in Addis Ababa (MOH, 2015). The coverage of antiretroviral prophylaxis for HIV-exposed infants (HEI) is only 59%; mainly due to the relatively weak integration of PMTCT services with MNCH. Quality of PMTCT services was further compromised by the poor availability of dry blood test (DBS) samples in the facilities (22%), poor health worker skills to perform DBS sample collection and the very long turn-around-time between facilities and regional laboratories. The mother-baby pair cohort initiative is showing a promising experience for elimination of mother to child transmission of HIV.

3.2.4. Adolescent and Youth Reproductive Health (AYRH)

Adolescent and youth, 10 to 29 years, in Ethiopia represent a large segment of the population. In order to improve the health status of this population group, the government has built impressive frameworks during the past fifteen years. These include the National Youth Policy (2004), Revised Family Law (1998), Youth Development Package (2010), Abortion Law (2005) and National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children in Ethiopia (2013). Following this, the Ministry of Health further strengthened and elaborated the law by developing strategies and guidelines. These include Making Pregnancy Safer (2000), Adolescent and Youth Reproductive Health Strategy (2007), Minimum Standards and Service Package for the Youth (2006), and the revised Technical and Procedural Guidelines for Safe Abortion Services (2014) and Tools for Planning, Monitoring and Implementing AYFRH Services (2010).

As a result of these efforts, there has been a continuous drop in fertility among youth (15-24 years) over the past fifteen years. It is attributed, but not limited, to increasing awareness levels, raising contraceptive prevalence rate, reducing the rate of early marriage and improving women's empowerment. However, there is still a great disparity of contraceptive utilization when taking residence into account. In EDHS 2011, 22.5% of women living in rural areas used modern contraceptive methods as compared to 49.5% of women living in the urban areas. Contraceptive prevalence rate (CPR) among all young women was 25% and unmet need for family planning was the highest for young married adolescents, 15-19 years old with 30% unmet need for spacing (CSA and ORC Macro, 2011, ICPS 2012).

Major physical, cognitive, emotional, sexual and social changes occur during adolescence and affect young people's sexual behavior which in turn compromises their health-seeking behavior. Among the top morbidities affecting this age group are consequences of the vulnerability associated with their age, specifically lack of information on sexual and reproductive health rights. As a result, the risk of sexually transmitted infection including HIV, unwanted pregnancy, unsafe abortion, teenage pregnancy and fistula significantly increases. The major supply side constraints for this age group are lack of wider community mobilization to inform and attract the youth to health service facilities and lack of tailored and affordable services that encourage utilization. On the demand side, cultural/societal norms and stigmatization of sexual and reproductive health services were also the major constraints (MOH, 2014).

Specific to adolescent and youth HIV infection prevalence, there is significant regional variation. In 2011, the lowest level recorded was in SNNPR with a prevalence rate of 0.6% and

highest in Gambella region with a rate of 4.7%. The regional comprehensive correct knowledge of HIV infection ranged from 3.9% in Somali to 35.1% in Addis Ababa (CSA and ORC Macro, 2014). Girls aged 15-19 years were seven times more likely to be HIV-positive than boys of the same age, and women 20-24 years old were four times more likely to be infected than men of the same age.

As a way to bring health care closer to adolescents, school health services have advantages in terms of access, equity and responsiveness to adolescents' needs. However, in Ethiopia, school health services have been compromised due to the challenge to cope with the rapid expansion of primary education and the ever-increasing number of students in rural areas. Persistent gaps hinder adolescents' preference to obtain health services at school, such as poor alignment of services with health priorities, inadequate skills and shortage of school health personnel, insufficient involvement of families and teachers in school-based health promotion programs, and inadequate funding of school health services. Moreover, the high dropout rate of girls from school compounds this challenge. A revamp of school health services coupled with strengthening girls' education can respond to these challenges.

There is a great diversity in how school health services are organized. Different models have been developed that provide some or all of the following services: individual clinical care, group-based health promotion, prevention, infectious disease control, screening, case management for chronic conditions and referrals for further health services. Despite the relative existence of health services in the better managed urban and private schools in Ethiopia, the approaches are not well standardized and little evidence is available on their effectiveness.

There is broad scientific agreement that sexuality education does not foster earlier sexual debut or unsafe sexual activity. Emerging evidence suggests that Comprehensive Sexuality Education (CSE) programs that include content on gender equality, power relations, and human rights and use participatory methods show positive SRH outcomes among adolescents. The use of interactive methods in CSE also shows promise in terms of improving overall academic outcomes. However, large-scale implementation of SCE programs has not occurred in Ethiopia and there is very limited progress in reaching the most vulnerable young people, including younger (aged 10-14 years) adolescents, both in-school and out-of-school. Though not studied, it is feasible to infer that the lack of continuous review and updating of the content of educational/training curricula impedes continuous quality improvement of interventions being delivered. Furthermore, weak institutional framework exists at all levels for monitoring, coordination and harmonization of programs among stakeholders that implement out-of-school CSE programs.

Therefore, in order to improve adolescent and youth health, strengthening sexual reproductive health education for adolescents at all levels, expanding youth friendly RH services and increasing access and quality, designing and implementing appropriate and quality knowledge management systems, strengthening multi-sectoral approaches for programming and monitoring adolescent health interventions are very crucial. Besides, building the capacity of adolescents and youth organizations in program planning, implementation and monitoring as well as improving the generation and use of strategic information to inform program design need not be spared. The cost-effectiveness of different organizational models also needs further study; quality standards for school health services have to be defined.

3.3. Input and process analysis (Health system)

3.3.1.Leadership, governance and management of RH

The Government of Ethiopia was committed to a series of governance reforms that have improved efficiency, collaboration and coordination of the RH program. It includes governance reforms to manage retention and utilization of revenue for improving logistics, drugs and supplies, administration of the fee waiver system, establishment of a functioning facility governance body, outsourcing of non-clinical services, establishing of private wings in health facilities and the exemption of certain services. The effect of the reforms in ensuring access and utilization of quality RH services would largely improve the health of women, children, adolescents and youth.

Recently, the MOH reformed its structure to improve its 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. Accordingly, five main programs were organized under the Maternal and Child Health Directorate (Maternal Health Program, Child Health Program, Immunization Program, Nutrition Program and PMTCT program) and similar structures are also being established at regional level. Responsible MOH experts were assigned to lead and coordinate the MNCH activities with development partners and donors. A health system special support directorate has also been established to support the developing regional states. The hospital reform initiative was launched in May 2010 with the Ethiopian Hospital Reform Implementation Guidelines (EHRIG) as a tool for the reform.

The government of Ethiopia has also won an international recognition for a successful leadership and supportive governance in designing and implementing a successful primary healthcare reform that introduced an innovative community-based Health Extension Program (HEP). 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. This new cadre of health workers has been instrumental in increasing access to basic obstetric and neonatal care, improving the nutritional status of women and children, and improving knowledge and behaviors around clean water and sanitation.

Since its initiation in 2004, the HEP has had a positive impact on increasing the number of human resources for health, access to health services, and improved sanitation in rural areas. Coverage of primary health services has increased in rural communities, resulting in increased coverage levels of maternal and child health care. With the aim of expanding the achievements of the HEP deeper into communities, improving community ownership and scaling up best practices, a Health Development Army (HDA) was established in 2010. The HDA has a variety of roles including discussing 'birth preparedness' and working with HEWs to disseminate pregnancy-related information.

3.3.2. Human resource for RH

The 2009-2014 human resource for health (HRH) strategic plan emphasized on the development of human resources for health critical for reproductive, maternal and child health. Health science training institutions have been expanded significantly and five priority initiatives (medical education, midwifery, emergency surgical officers, anesthesia and HEWs) were introduced. The number of medical schools has increased from 7 in 2008 to 33 in 2014 with a twenty-fold (200 to 4000) increase in the annual enrollment during the same period. In 2014, the number of physicians in the public sector (3,500) was more than double the number in 2009 (1,540). During the period 2009 to 2014, midwifery teaching institutions were increased from 23 to 43 with the resultant increase in the number of midwives by more than six-fold (from 1,270 to 7,944).

By March 2014, a total of 153 integrated emergency surgical officers (IESOs) graduated and have been deployed to 97 health facilities while 513 were on training. However, 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 distributed inequitably with severe shortages in hard-to-reach and remote areas, particularly in the developing regional states. In 2010, 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. Low health workers' clinical competence and lack of respectful care, particularly for women with conditions (such as abortion and HIV infection) that carry stigma, are implicated as factors affecting the quality and utilization of healthcare services. Barriers that hinder women from accessing care, even when it is available, include the lack of female service providers or someone who speaks the local language and appreciates local cultural norms.

In order to achieve an adequate number of fully-qualified midwives and others with midwifery competencies who can effectively manage the estimated number of pregnancies, the subsequent number of births, and the 15% of births resulting in obstetric complications between now and 2020, the RH human workforce development needs to give due attention.

MOH and regional health bureaus has been working 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, CAC, and PMTCT of HIV). In other words, the in-service trainings have helped health professionals to consolidate their pre-service education with their on-job experience, and contributed a lot to the improved quality health services. The main challenges for in-service trainings were attrition and turnover (changing profession, within and outside the country migration).

3.3.3. Logistics and supply chain management/essential medicines

The MOH's major comprehensive supply chain strategy, the integrated pharmaceutical 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 improvements in the logistics and supply chain management of lifesaving maternal/RH drugs, supplies and equipment and family planning products. In 2014, most healthcare facilities at all levels offered modern contraceptives except permanent methods that were offered in few facilities due to lack of trained staff, low or no client demand and delay in re-supply of contraceptives. All the seven lifesaving maternal/RH medicines were fully available in 88% of secondary level and 100% of tertiary level care facilities. However, a very 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. Direct delivery by PFSA is reaching 71% of facilities, but needs to reach more.

A recent survey report of the Pharmaceutical Fund and Supply Agency (PFSA) indicated that the availability of formats, quality of recordkeeping and storage conditions in health facilities need 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. The findings also stated that health posts

and the HEWs are not receiving the required technical support to perform the appropriate logistics functions. Further challenges include relatively weak coordination to efficiently manage quantification, procurement and supply planning that ensures seamless supply chain and absolute demand-driven supply system as well as poor capacity to manage donated products and the resultant overwhelming of MOH warehouse spaces.

3.3.4.RH financing

In Ethiopia, absolute government expenditure on health has risen markedly in the last decade, from US$ 5.6 per capita in 2000 to US$22.77 per capita in 2010. The total expenditure on reproductive health was Birr 3.6 billion (US$224 million) and accounted for 13% of the Total Health Expenditure (THE) during the same period. This converts to per capita spending per woman of reproductive age (15-49 years) of Birr 195 or US$12. One-fourth (24.8%) of the spending was from government treasury while development partners contributed the highest proportion (47%) and households out-of-pocket payment (28%). Government-owned health facilities received the majority (37%) of the total RH spending (37% hospitals and PHCUs), private (for-profit and nonprofit) health facilities received only 11%, and the rest (31%) was consumed by public health programs and administration. One of the least spending (3%) was on research and training. According to the fifth national health accounts, outpatient maternal care takes the major proportion of reproductive health financing (42%) followed by family planning and counseling programs (16%), capital investment (15%), and maternal health inpatient care (11%).

With this budget, Ethiopia has been able to demonstrate significant improvements in maternal and child health focusing on low-cost, high-impact interventions particularly those implemented at the community level.

Legislation enabling free maternal and newborn services in public health facilities has improved access to care. The community-based and social health insurance schemes are being scaled-up with the aim of augmenting financial risk protection. Expanding the coverage of essential MNH services package along with financial protection will emphasize equity in reaching the more disadvantaged people and reducing disparities within Ethiopia's population pointing to the need for a robust reproductive health financing strategy.

3.3.5.Evidence-based monitoring, accountability and partnership

As part of the continuing effort on strengthening the health information system, the reformed HMIS is being rolled out throughout the country. The new HMIS includes Main RH indicators for monitoring performance and tracking program progress. Recently, the government has established a new public entity to institutionalize the civil registration system which has been done by HEWs that captured only 7% of births. Thus, the country has relied on the series of DHSs conducted in 2000, 2006, 2011, and the mini-DHS in 2014 which have been instrumental in highlighting RH as a political priority. Maternal death reviews are also introduced as a main element of the accountability and response cycle. As part of a new and expanding system of maternal death surveillance and response for the country, Ethiopia prioritizes institutionalizing and legalizing maternal and perinatal death notification to further improve service quality.

Facility assessments such as EmONC survey-2008 and ESPA+-2014 and MNCH scorecards are used to inform MNCH policy and increase accountability. The latest national health account survey provides detailed sub-account analyses for tracking resources dedicated to RH and child health services among others (HIV, Malaria and TB). Ethiopia has increased the proportion of the national budget allocated to health to 8.5% in 2013-fulfilling the pledge for the

Abuja Declaration by more than 50%. The launch of advocacy campaigns on no tolerance for maternal death and the home delivery free kebele initiative along with the mobilization for engagement of main community actors-the health development army (HDA) groups and community leaders led and supported by the health extension workers, have created a mechanism for social accountability bringing together all stakeholders from local to national level, allowing greater publicity and dialogue in both formal and informal settings, in order to focus attention and promote action on RH. Main stakeholder groups for tracking government commitments such as the Countdown Country taskforce and the Partnership for Monitoring and Accountability-FP2020 produce evidence on the progress in universal access to RH care that is fed directly into the national policies for achieving MDGs 4 and 5, as well as the One Plan and the Health Sector Strategic Plan, thereby stimulating action on priorities and commitments.
Furthermore, the MNCH scorecard is used to monitor progress of regions on RH issues. The score card is shared with regional presidents and health bureau heads to encourage accountability.

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 primary healthcare infrastructure through the accelerated expansion initiative that built more than 16,000 health posts (1 per kebele) and over 3,500 health centers. However, the proportion of BEmONC and CEmONC facilities is still short to manage the 1,397 obstetric and newborn complications expected to occur each day, the majority (82% or 1,146) being in rural areas. BEmONC and CEmONC signal functions were not fully implemented in 2014; only 20% of BEmONC facilities were providing anticonvulsants, and 92% were performing assisted vaginal delivery. During the same period, the proportions of CEmONC facilities providing blood transfusion and conducting cesarean deliveries were 4% and 5%, respectively. Part of these challenges can be solved by commissioning and making functional the required number of primary hospitals per the national health tier system. The incidence of cesarean section in the community has stalled at 1.6%, signaling a lack of access to CEmONC services.

Cognizant of this, the MOH has implemented maternal health quality improvement initiative with special emphasis to labor and delivery. Currently, all functioning public hospitals are participating in the quality improvement initiative pursuant to the launch of the hospital reform initiative. High impact newborn care such as Kangaroo Mother Care (KMC) and corticosteroid therapy for preterm labor are recently given more emphasis and need to be widely scaled-up during the implementation of this strategy. The administration of misopristol for postpartum hemorrhage at the community level by HEWs for families lacking access to health facilities has to be considered taking the experience of Tigray region and Gedeo zone in Southern region.

The maternal death surveillance and review process is also the main part of Ethiopia's strategy to address quality. Maternal death reviews are often implemented to understand causes of deaths and to inform health sector planning and policy decisions. A new maternal death surveillance and response (MDSR) system is being scaled up nationwide by the MOH with the aim of identifying reviewing and responding to every maternal death. Supported by the National Guidelines (launched in May 2013), training was provided and data started to flow as of the end of 2013. Further scale up of the MDSR with the inclusion of perinatal death notification (MPDSR) is a priority to immediately identify and address causes and prevent future deaths.

3.4.Social determinants of RH

Social determinants of health are acknowledged as a critical component of the post-2015 sustainable development global agendas and of the push towards progressive achievement of universal health coverage (UHC). Reproductive health is directly affected by the social and institutional context of the environment in which women and men live. These social determinants of RH include 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.

Many Ethiopian women lack the reproductive and social self-determination needed to exercise their reproductive rights. Studies have consistently shown that educational attainment has a strong effect on reproductive behaviour, fertility, infant and child mortality and morbidity, and attitudes and awareness related to family health, use of family planning, and sanitation. In Ethiopia though, the proportion of women in the reproductive age (15-49 years) with no education has declined by 35% from 75% in 2000 to 49% in 2014 and disparities exist at all levels of education between regions; between urban and rural women and between the poor and wealthiest women (CSA, 2014). Low status of women in the society also leads to economic dependence and enforce 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).

Ethiopia has undertaken significant gender-sensitive legislative reforms in the last two decades, including the 1995 FDRE constitution, the 1998 Revised Family Law and the 2005 Revised Criminal Code. These legislations have addressed the issues of gender-based violence (GBV) and have criminalized most forms of violence against women and girls, including rape, women trafficking, and prostitution of another for gain, physical violence within marriage or in an irregular union, abduction, female genital cutting, and early marriage. Despite all these legal provisions, gender based violence has been practiced in one form or another in Ethiopia for several years. Attitude toward intimate partner violence, a common indicator of women's autonomy and empowerment, is still a problem. According to the EDHS 2011, 68% of women reported that they believed wife beating was justifiable for certain reasons; though significantly declined from the 81% in the EDHS 2005 (CSA, 2005, 2011).

Ethiopia is also characterized by a diversified society with various harmful traditional practices. Female genital cutting has the estimated prevalence of 56% in EDHS 2011, though reduced from 74% in EDHS 2005. Early marriage is one of the most harmful practices as it usually denies girls educational opportunities, leads to poverty and economic insecurity and has a serious negative impact on their reproductive health and decision-making capacities. In the EDHS 2011 report, the median age at first marriage among women age 25-49 was 16.5 years as compared to 23.1 years among men of 25-59 years old. Polygamy/polygyny is also another challenge that undermines the rights of women and estimated as 11% of married women were in the polygamous union (CSA, 2011).

In general, in order to improve the status of women and improve gender equality and reproductive health, it is crucial to focus on enhancing partnership and gender mainstreaming in all political, economic and societal spheres so that women and men participate and benefit equally from development. Re-enforcing the appropriate implementation of the existing legal frameworks to minimize HTPs and violence against women to protect the reproductive rights of everyone is very crucial.

3.5.Main successes and contributing factors

As indicated in the previous sections, Ethiopia registered as 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: national prioritization of and commitment to women's and children's health, the national focus on sectoral alignment and coordination of all partners, monitoring MCH outcomes using evidence, political prioritization of essential health interventions, focus on addressing health workforce shortages, legal and financial entitlements especially for the underserved population.

These commitments have been demonstrated by massively expanding access to and utilization of main health care services through HEP, 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 the trained health workforce. The health care finance (total health expenditure per capita) showed a paramount improvement in the last decade with introduction of new schemes, including retention and utilization of revenues in the health facilities; opening of private wings in hospitals; community-based and social health insurances. As a result, improvements in coverage of effective interventions to prevent or treat the most important causes of maternal and newborn mortality were achieved. Despite the success, efforts are still needed to improve and maintain functional performance monitoring system, accountability, and scaling up of best practices to attain optimal coverage, quality, and utilization of RH services.

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

Generally, the progress for scale up of high-impact RH interventions informs that measurable progress has been made in absolute terms, but coverage remains low, and a large gap remains between current coverage and universal health coverage target. To save the most lives, increasing coverage of care alone is not enough. Quality must improve and remain high in order to provide effective care and to maintain demand for health services. Ethiopia has, at least theoretically, an adequate number of CEmONC facilities, but they are not distributed within easy reach of all the women and newborns who need them. This highlights the challenges of concentrating staff, equipment, drugs and supplies in a health facility that has to be open 24 hours a day, 7 days a week, while also addressing the need to provide emergency obstetric care close to where women live.

3.7.Future directions

In order to combat the triple gap of coverage, competencies and access, Ethiopia needs to triple the number of midwives and others with midwifery competencies, increase coverage of emergency obstetric and newborn care facilities and fully address access issues from women's perspectives. Therefore, a large part of the unfinished business in RH is addressing pervasive inequality and ensuring that all women and children receive the services they need, regardless of socioeconomic and geographic differences. Increased investment to improve equitable access to care and targeting the poor, marginalized and hardest-to-reach areas will be systematically improved to reach all families, particularly during childbirth and the critical early postnatal period. Demand and supply side barriers still exist, including those associated with disrespect and abuse of women who seek maternity care in facilities or from skilled providers; often in women with conditions that carry a stigma.

Ethiopia needs also to implement a robust reproductive health financing strategy that is sustainable with increased domestic financing, sustained and strengthened reduction of the burden on households, speedy scale-up of health insurance, and prioritization of reproductive health care services in health insurance benefit packages except those covered by treasury such as maternal health services.

3.8. SWOT analysis

Strengths (S)	Weaknesses (W)
Impact level	
• Marked decline of child mortality and achievement of MDG 4. • Progressive decline in maternal mortality. • Significant reduction of the share of abortion from the causes of maternal death.	• In spite of the decline, the number of maternal and neonatal deaths remains high. • The share of neonatal mortality from child mortality has increased. • Persistent challenges in newborn health care quality, access and utilization. • Preventable causes of maternal and neonatal deaths are still not fully avoided. • Geographic and economic disparities in the maternal mortality ratios and neonatal mortality rates. • Obstructed labor/uterine rupture for the maternal deaths, and asphyxia and prematurity for perinatal deaths are still at the top. • Breast and cervical cancers are still the major killers among all cancers in women.
Outcome/service coverage	
• Steady increase in some of the Main intervention coverages such as • Antenatal care (ANC) at least one visit increased significantly. • HIV testing among ANC-attending pregnant women for PMTCT markedly increased. • Skilled delivery and postnatal care (PNC) increased. • Improvement in safe abortion services and post-abortion care. • Significantly increased family planning service. • The total fertility rate is reduced.	• Low coverage of ANC 4+ and early initiation ANC and PNC. • Inadequate availability and quality of BEmONC and CEmONC signal functions, particularly cesarean delivery and use of MgSo4. • Low coverage of the proportion of HIV-positive deliveries who received a full course of antiretroviral prophylaxis. • Low nutritional status during pregnancy (essential nutrition, dietary practice). • Regional and socio-economic disparities in the main service coverages. • Disparities in access and coverage of BEmONC & CEmONC facilities, particularly pastoralist areas. • LARC and permanent contraceptive methods acceptance, access and utilization is low. • Integration of sexually transmitted infections

	(STI/HIV) prevention, detection and treatment in the reproductive health service platforms is low. • Referral linkage is weak • Lack of sustained clinical supervision and mentoring • High rate of adolescent pregnancy • Reproductive organ cancers prevention, detection and treatment services are low.
Input and process of service delivery	
Policy environment	
• The 1995 FDRE constitution, the 2003 Revised Family Law, the 2005 Revised Criminal Code and abortion law, The Youth Policy, National Strategy and Action Plan on Harmful Traditional Practices against Women and Children, The planned Health Sector Transformation Plan (HSTP) under the umbrella of the Growth Transformation Plan (GTP plan II). • Availability of strategic documents such as HSDP. • Fee waiver for maternal health and family planning services • Availability of guidelines (protocols on obstetric topics, family planning, referral system, health facility standards, technical and procedural guidelines) • MNH service integration. • Health center reform guidelines developed • New initiatives such as maternal death surveillance and response (MDSR), perinatal death review (PDR) and Ethiopian Hospital Alliance for Quality (EHAQ). • New program initiatives such as integrated community case management (ICCM) and community-based newborn care (CBNC). • Scale-up of eMTCT (elimination of mother to child transmission) • Implementation of the health financing reform	• Inadequate availability and implementation of clinical service protocols at service delivery points. • Little integration of nutrition in RH services. • Low utilization of latest technologies and innovations such as mobile Health. • Non-uniformity of free maternal health service implementation
Infrastructure, logistics and supplies	
• Health facility expansion, particularly primary health care facilities. • Increased availability of ambulance services. • Increased access to blood bank services. • Availability of pharmaceutical logistics system. • RH commodity forecasting.	• The level of availability of some of the important signal functions at BEmONC and CEmONC facilities are not available to the expected standards • Stock-out of dried blood spot (DBS) test products and lifesaving drugs for newborns and mothers).

	• Inadequacy and misuse of the available ambulances (using for other purposes) and weak referral system. • Lack of well-equipped and organized newborn corners, neonatal intensive care units (NICUs) and general ICU. • Absence of water, electric city and facility organization • Poor capacity for equipment procurement (developing specifications) • Poor quality of equipment and maintenance capacity • Lack of medical equipment for emergency obstetric and neonatal care (EmONC). • Weak supply chain management. • Lack of set-up for universal screening of precancerous cervical and breast lesions. • Lack of radiotherapy and chemotherapy facility for the majority of ROCs outside Addis. • Lack of vaccination for HPV
Human resource for RH	
• Increasing number of skilled health professionals. • Focus on midwifery and integrated emergency surgical officers (IESOs) training. • Focus on quality education, capacity building through trainings. • Initiatives for competency-based modular curricula. • Inter-country support team (IST) directives in place. • New initiatives such as continuous professional development (CPD), leadership programs for hospitals. • Well planned carrier structure, motivation and retention. • Hospital-based residency training initiatives. • National licensing exam for medical doctors immediately after completing the internship.	• Required skilled health professionals and skill mix are not adequate as per the standard (particularly, Ob/Gyns, IESOs, midwives, anesthetists) • Disparity in skilled professionals distribution (pastoralists are not well addressed). • Necessary trainings on some of the RH service delivery, newborn care are not given to all. • Negative attitude and low commitment (motivation) of health care workers. • Gap in the skill of health care workers. • Increasing number of pre-service trainees per class and high student to teacher ratio in practical areas. • Inadequate clinical/practical attachment sites and limitations in skill/competency-based trainings • Weak and untargeted in-service trainings/ CPD
• Large number of production of health extension workers (HEWs). • Upgrading HEWs to level-IV to attend deliveries. • Introduction and scale-up of the health development army (HDA).	• Lack of female HEWs in some pastoralist areas. • High attrition of HEWs due to changing profession, internal and external migration • Shouldering multiple tasks and responsibilities. • Lack of transport and motivation to carry out home visits.

• Well integrated health extension program (HEP) and HDA in agrarian regions. • Contribute to the increasing family planning, antenatal, delivery and postnatal care services.	
RH financing	
• Initiatives of free maternal and newborn health services at all public health facilities. • Health care financing reform. • Revolving drug fund (RDF) capital. • Initiation of community-based health insurance (CBHI). • Provision of family planning services for free.	• The RH services partly being donor dependent. • Low percentage of government health expenditure. • High out-of-pocket expenditure. • Low saving for health at the community level. • Community-based health insurance (CBHI) not well implemented. • Low knowledge of the community about health care insurance
Coordination, leadership and governance	
• Policy commitment to RH as priority. • Governance of facilities (health center governing body and hospital board). • Regular and participatory review mechanism such as the Annual Review Meetings. • Strong coordination (JSC, JCF, JCCC, CCM, ICC, TWGs, partners' forum at sub-national level).	• Lack of leadership skills, resource utilization and institutional management skills in some remote regions and peripheral facilities • Slow implementation of regulatory mechanism in some areas. • Suboptimal program delivery capacity at ministry, regional and PHCU level. • Suboptimal program implementation level coordination of partners.
HMIS and M&E	
• The use of Ethiopian demographic and health survey (EDHS) to measure impact at regular intervals. • Use of Health and Health-related indicators. • Existence of health management information system (HMIS) and reformed HMIS. • Initiatives such as e-HMIS. • Existence of demographic and diseases surveillance system/public health emergency management and documentation of best practices. • Supportive supervision, monitoring progress by quarterly reports. • Community-based health information system.	• Weak data generation, updating and handling (HRH, infrastructure and logistics). • Low accuracy, timeliness, completeness of data. • Low data utilization for improving service and client care. • Community health information system (CHIS) is not well developed. • Big discrepancy between population-based and facility based indicators of service use coverage (poor estimation of catchment target population). • The EDHS and HMIS data do not capture some important data like causes of maternal and child deaths • Weak generation, analysis and utilization of evidence for decision making.
Community level	
• Closely working with the HEWs and WHDA. • Supporting each other in case of emergencies (e.g. carrying the laboring mother: traditional ambulances).	• Low awareness about risks of pregnancy and importance of service use. • Lack of recognition of maternal and newborn danger signs. • Delay in disclosure of pregnancy.

• Financial, crop and material contributions during emergencies. • Community-facility referral linkages establishment taking WHDA as the smallest unit. • 1500 youth centers built throughout the country and some have integrated adolescent and youth health services into their programs. • High unmet need for family planning, particularly among adolescents and youth. • Limited engagement of the private sector in family planning and adolescent and youth health services.	• Low levels of care-seeking at labor and for neonates. • Cultural beliefs that discourage recognition or mourning of newborn deaths. • Low care-seeking and delayed response for emergency. • Poor savings and poor husbands' involvement in RH services. • Still high proportions of harmful traditional practices (high FGC, abduction, child marriage, teenage pregnancy, and fertility). • High prevalence of physical and sexual violence. • Women's literacy and decision-making authority at home is low. • Women's unemployment is high • High youth unemployment and low education attainment. • High transactional sexual relationship or commercial sex. • Health care seeking for adolescent youth-friendly health service is very low.
Opportunities (O)	**Threats (T)**
• Determination and political commitment by the government • Existence of strong Government structure up to the community level • Strengthening the flagship HEP supported by HDA • Civil service HDA (platform for improved knowledge sharing and service delivery) • Sustained national economic development. • Industrialization, improving road infrastructure, telecom and electricity. • Establishment of Vital Events Registration Agency (VERA) • Partnership and donor source for health expenditure • Development of partners support • Increased female enrollment at primary, secondary and tertiary education • Improved technology and means of communication • Change in (lower) fertility desire among the general population • Current and anticipated economic growth • Increased number of health workforce and facilities	• Potential for community fatigue for HDA activities • Mismatch between infrastructure, service development and population migration to urban areas • Rapid population growth. • Low predictability of foreign funding. • Poverty and the low status of women's education. • Increasing substance use (Khat, cigarette, alcohol, hashish, shisha) among adolescents and youth • Expansion of industrialization in urban areas • Inward and external migration, women and child trafficking, street children • Religious/cultural influence that restricts abortion, use of contraception and the majority of the RH services.

4. GUIDING PRINCIPLES

The implementation of this strategy is guided by the principles and the common values of the national health policy and the HSTP as well as the roadmap on Ending Preventable Maternal Mortality and the Every Newborn Action Plan. 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 programmes 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.

• **Equity and accessibility:** Equitable and universal coverage of high-impact interventions and a focus on reaching remote, vulnerable and poorest population groups are central to realize the rights of every woman, newborn, adolescent and youth to health and development. The strategy also emphasizes on the provision of quality RH services across income, gender, ethnicity, and lifestyles.

• **Excellence in quality improvement and assurance:** Per the HSTP, 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 MCH 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.

•Compassionate, respectful and competent human resource: 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 of/scaling up of globally accepted and cost-effective innovations and technologies such as m-health and e-health for RH services in selected areas.

•Partnership and multi-sectoral collaboration: The vision of the health policy is inclusive and multisectoral. It entails improving the health of women, newborns, adolescents and youth through access and quality reproductive health services; integrated with the prevention and treatment of sexually transmitted infections (STIs) including HIV, reproductive organ cancers (ROCs), pelvic organ prolapse (POP), and also measures that build social and economic participation. The strategy recognizes that this vision can be better carried out in partnership with the different program units of the MOH and across a diversity of ministries, reflecting national and regional priorities and contexts, as well as tapping into the resources and expertise of national and international non-governmental organizations (NGOs) and charity based organizations (CBOs).

•Integration: Providing every woman, newborn, adolescent and youth with good-quality care requires integrated service delivery. Effective service delivery integrates the delivery of key interventions across the RMNCH+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 programmes, stakeholders and initiatives across the continuum of RMNCAH/N is included in the guiding principles.

•Improve metrics, measurement systems and data quality for evidence-based decision making: A crosscutting priority for the post-2015 strategy is improved metrics and measurement systems, including for the purpose of accountability, to track equity, and to ensure programme effectiveness. Hence, the strategy will promote conducting and disseminating representative operational researches to enhance the understanding of decision makers at all levels with scientific evidence and knowledge. Indicators of equity need to be developed that do not overburden data collection systems, specifically at the facility level. New technologies for data collection (e.g., mapping, mobile phones) with shown effectiveness could also speed up data collection to allow effective, real-time use. Moving toward counting every maternal and perinatal death through the establishment of effective national registration and vital statistics systems is also a post-2015 priority.

5. GOAL AND PRIMARY TARGETS

5.1. Goal

The goal of this strategy is to improve the reproductive health of Ethiopian women, men newborns, adolescents and youth.

5.2. Primary targets

5.2.1. Primary impact targets by 2020

- Reduce the maternal mortality ratio (MMR) from 353 to 199 per 100,000 live births
- Reduce the neonatal mortality rate (NMR) from 28 to 10 per 1,000 live births
- Reduce stillbirth rate from 18 to 10 per 1000 births
- Reduce HIV infection rate among infants born to HIV-positive mothers from 11% to <2%
- Reduce the total fertility rate (TFR) from 4.1 to 3 children per woman.

5.2.2. Primary outcome targets by 2020

- Reduce unmet need for modern contraceptive methods from 24% to 10%.
- Increase contraceptive prevalence rate (CPR) from 42% to 55%.
- Increase the long-acting reversible and permanent contraceptive methods use to 50%.
- Reduce adolescent pregnancy rate from 12% to 3%.
- Increase antenatal care four visits (ANC4+) from 68% to 95%.
- Increase skilled care at birth from 60.7% to 90%.
- Increase early postnatal care coverage (within 24) from 90% to 95%
- Increase the proportion of HIV-positive women, who received antiretroviral treatment (ART) (Option B+) during pregnancy, labor and delivery and post-partum period from 59% to 95%
- Decrease the number of women with obstetric fistula to (from about 9000) to <1600
- Reduce prevalence of iron deficiency anemia among pregnant women from 17% to <5%.
- 20% of women age 30-49 will have precancerous screening for cervical cancer.

6. STRATEGIC OBJECTIVES

The national RH strategy is structured based on the HSTP strategic map and contains 22 strategies under 12 strategic objectives as indicated below.

Perspectives	Strategic Objectives (SO)	
Internal process (P)	SO1	P1: Improve Equitable Access to Quality RH Services
	SO 2	P3: Enhance Good Governance
	SO 3	P4: Improve Regulatory System
	SO 4	P5: Improve Logistics and Supply Chain Management
	SO5	P6: Improve Community Participation and Engagement
	SO 6	P7: Improve Resource Mobilization
	SO 7	P8: Improve Research and Evidence for Decision Making
	SO 8	CB1: Enhance use of Technology and Innovation
Social determinants	SO 12	Address social determinants of RH

7. STRATEGIES, KEY PERFORMANCE TARGETS AND STRATEGIC INTERVENTIONS

SO 1: Improve Equitable Access to Quality RH Services

Family Planning/Fertility:

Strategy 1: Increasing access, creating demand and improving utilization of quality family planning (FP) services.

Performance targets by 2020:

- Reduce total fertility rate (TFR) from 4.1 to 3 children per woman.
- Reduce unmet need for contraception from 25% to 10%.
- Increase contraceptive prevalence rate (CPR) from 42% to 55%.
- All regions will have at least annual CPR increment rate of 2% on the average
- Reduce adolescent fertility rate from 12% to 3% .
- Increase the proportion of long-acting reversible and permanent contraceptive methods as a method mix to 50% (Implants 33%, IUCD 15%, female sterilization 1.5% and male sterilization 0.5%) from the total method mix.
- Meet need for immediate postpartum and post-abortion contraception is 100%.
- Scale up postpartum family planning service to all woredas.
- All service delivery points to offer at least five modern contraceptive methods (condom, pills, injectables, implants and IUCDs)

Strategic interventions:

- Avail all the required contraceptive commodities at all service delivery points (SDPs), including private health facilities as per the recommended standard.
- Build the competency of health workers to provide long-acting and permanent methods of contraception.
- Provide immediate post-abortion and postpartum family planning information and services for all women giving birth at health facilities, including adolescents (need, right and choice).
- Develop and distribute counseling tools and tailored FP communication materials, and monitor their utilization at all levels.
- Develop and implement family planning Mass media interventions. • Develop tailored communication mechanism to bring behavioral change among the pastoralist community to increase demand for FP
- Identify women who have unmet need for FP by women development armies and link with the health facilities for information, education, counseling and services
- Integrate FP with other service outlets, such as antenatal care, delivery, postnatal, abortion, antiretroviral treatment clinics, EPI and other child health services by developing national implementation manual, job aids, and protocols addressing different SDPs.
- Use the women development armies, male development armies and health extension workers to educate the community about the social, economic and medical impacts of high fertility, and the benefits of FP use with due emphasis on long-acting reversible contraception (LARC).
- Involve men to support their partners in decision-making and to use FP and also as users themselves

- Roll out mobile clinics for hard-to-reach rural areas/pastoralist communities to provide FP services, including LARC. (the description is annexed)
- Expand outreach FP provision services to increase accesses, particularly LARC.
- Engage clan leaders, religious leaders and other influential community opinion leaders to address cultural and community norms related to FP, especially in developing regional states.
- Implement FP quality improvement initiatives and put in place regular supervision to offer compassionate client-friendly service, respecting choice, safety and quality
- Train all service providers (doctors, nurses, midwives and HEWs) on post-partum contraception as part of protocols on RMNCH service integration
- Increase access to FP service for adolescents and youth by integrating youth-friendly services into the existing facilities
-

Strategy 2: Improving the prevention, investigation and management of infertility.

Performance Targets by 2020:

- A guideline on the management of couples with infertility will be developed.
- At least three medical schools will start training in reproductive endocrinology and infertility.
- At least 6 specialized hospitals will provide basic service for couples with infertility:(basic diagnostic such as laparoscopic investigation and basic therapeutic, including hormonal therapy, laparoscopic surgery and tubo-plastic surgery)
- Initiate Assisted Reproductive Technology (ART) in at least 3 specialized hospitals as per the national guideline.

Strategic interventions:

- Develop national guideline/protocol for the prevention, investigation and management of infertility, including services standards for different levels of health facilities.
- Develop IEC/BCC materials that provide clear information on infertility for the community.
- Conduct national studies that document the prevalence of infertility and felt need, preferably by including it in the EDHS questionnaire
- Improving Diagnostic facilities for investigating infertility
- Work with relevant stakeholders, including universities, to define drugs, instruments, technologies and other supplies needed for infertility management; work with FMHACA and PFSA to register and facilitate import; and ensure their availability at respective facilities.
- Encourage investment and public-private partnership in area of creating a specialty unit that deals with infertility prevention, investigation and management.
- Support universities with postgraduate school to initiate a training program in reproductive endocrinology and infertility.
- Strengthen the prevention, diagnosis and management of STIs so as to prevent the incidence of infertility.
- Equip the health facilities (health center and hospitals) by availing necessary equipment and supplies to make them ready for the prevention, diagnosis and management of infertility as per the facilities' standards.

Maternal and Newborn Health:

Strategy 3: Improving access to and utilization of essential maternal and neonatal health (MNH) services at all levels of the health care delivery system.

Performance targets by 2020:

- 95% of pregnant women will start the first antenatal care visit before 16 weeks' gestation and will have at least 4 antenatal care visits.
- Pregnant women attending ANC who are screened for syphilis increased from 54% to 100%
- 100% pregnant women attending ANC will be supplemented with iron and folic acid (90+tab)
- Reduce the percentage of reproductive age women with BMI <18.5 kg/m2 from 27% to <16%.
- 90% of the deliveries will be attended by skilled person.
- 90% of asphyxiated newborns will be provided with appropriate newborn care
- 100% mothers who delivered in a health facility will be observed at least for 24 hours in the same facility.
- 95% of mothers will have postnatal care visit between 24 hours and 7 days and will be provided with family planning counseling.
- Mother-to-child transmission (MTCT) of HIV will be reduced from 11% to less than 2%.
- 100% health facilities institute protocol on respectful maternity care.
- 75% of kebeles will be declared as 'home-delivery-free'.

Strategic interventions:

- Increase community's awareness on the importance of birth preparedness, complication readiness, and facility delivery by strengthening the activities of Women Health Development Armies (WHDAs) and health extension workers (HEW) and advocating "no mother should give birth without skilled attendant".
- Ensure the provision of optimal clinical care in all health facilities during pregnancy, delivery and postnatal period, including early detection and management of complications, micronutrient supplementation, prophylaxis administration, and counseling on maternal nutrition, infant feeding and family planning.
- Strengthen the primary level health care linkage and referral (front and back) system across household, community and health service level.
- Strengthening/creation of mother-baby-friendly facilities such as allowing birth companion, preferential laboring and birthing positions, and allowing for cultural ceremonies in facilities.
- Expand the prevention of mother-to-child transmission (PMTCT) of HIV services to Health center and hospitals so that all eligible mothers attending antenatal, labor and postnatal care receive the minimum PMTCT services package (HIV testing and counseling, ART, safe delivery, antiretroviral prophylaxis for the newborn, DBS testing for HIV and safe infant feeding)
- Strengthen the linkage of PMTCT to ART so that all mothers can continue the ART care
- Facilitate implementation of continuous quality improvement (CQI) and mother baby pair (MBP) cohort follow up.
- Ensure implementation of safe child birth checklist, partograph, obstetrics management protocols and guidelines in all health center and hospitals.
- Micro-nutrient supplementation, nutritional assessment and counseling, intervention (during the first 1000 days.
- Putting in place Life-cycle interventions

- Implement community-based joint interventions by HEWs, Agricultural Development Agents (DAs) and HDAs, including education on food diversification and dietary practices. Strengthen Public-Private Partnership (PPP) in providing quality MNH services.

- **Strategy 4: Improving the quality of basic and comprehensive emergency obstetric and newborn care (EmONC) services at health centers and hospitals.**

Performance targets by 2020:

- 100% health centers and hospitals will provide the 7 BEmONC and the 9 CEmONC signal functions, respectively.
- 8% of the total deliveries will be by cesarean section.
- 100% met need for EMONC services.
- Institutional case fatality rate of direct causes of maternal mortality will be <1%, and institutional perinatal mortality rate will be reduced from about 15 to 5 per 1000 births.
- Total number of women with obstetric fistula will be <1600.
- 100% health centers and hospitals provide comprehensive abortion care services as per the law and per the guidelines.
- 100% hospitals will have access to quality blood and blood products for RH services.

Strategic interventions:

- Scale up provision of high-impact interventions (BEmONC services at all health centers and CEmONC services at all hospitals) to address the major causes of maternal and neonatal mortality.
- Ensure the sustained availability of trained health care providers and essential medical equipment for BEmONC services at all health centers and CEmONC services at all hospitals including adequate blood supply.
- Ensure the sustained availability of all essential drugs and supplies for MNH at all health facilities, with due emphasis to oxytocin, misoprostol and magnesium sulphate.
- Advocate for community participation in preventing the occurrence of obstetric fistula, identification of women living with fistula and linking them with treating health facilities.
- Strengthen the health facilities' capacity to diagnose and treat obstetric fistula, and reconstitute the psychology, fertility and productivity of victims.
- Build the capacity of the health staff (in terms of skill, willingness, and friendliness) to provide safe abortion and post-abortal care to all who need the service as per the law and per the guidelines.
- Promote and implement the integration of other reproductive health services (family planning, screening for selected STI, HIV, cervical and breast cancers) within abortion care package.
- Establish stronger relationships between catchment facilities for effective referral, clinical supportive supervision, clinical mentoring and capacity-building.
- •Strengthening the health posts so that the HEWs will examine, counsel, check vital signs, give anti-pain and refer the client to health center as per the guideline.
- Strengthening access to safe blood and blood products
- Increase public awareness about the safety of blood donation and blood transfusion.
- • Community involvement and initiatives on improving access to facilities during emergencies.

Strategy 5: Strengthen maternal death surveillance and response (MDSR) and perinatal death review (PDR) system to address quality of care for maternal and perinatal health.

Performance targets by 2020:

- 100% 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.
- 50% of hospitals performed near-miss review.

Strategic interventions:

- Establish MDSR/PDSR committees in all health facilities; train PHEM officers; conduct supervisions; analyze deaths, and prepare yearly MDSR reports.
- Establish a system of governance so that the MDSR/PDSR data shall not be used for blaming the individuals but rather for solution.
- Ensure that for every maternal and perinatal death, appropriate response is given to avoid the occurrence of similar casualties in the future.
- Create awareness within the community regarding the importance of maternal and perinatal deaths, notification and reviews.
- Ensure that every maternal and perinatal death in a facility or in a community is notified to surveillance focal person within 24 hours.
- Strengthen the maternal and perinatal death investigations and verifications at the community level in the form of verbal autopsies and at the facility level in the form of maternal and perinatal deaths summaries or reviews.
- Capacitate providers, managers and other stakeholders to conduct MDSR and PDR, and use the lessons to improve the health system.

Adolescent and Youth RH:

- **Strategy 6: Increase access to sexual and reproductive health (SRH) information, education and health services**

Performance targets by 2020:

- 50% of adolescents and youth have access to socially appropriate, culturally acceptable, sexuality education/SRH information.
- 100% health centers and hospitals provide quality adolescent and youth-friendly SRH services as per the standard.
- 90% of needy adolescents and youth age 10-24 access quality SRH and/or maternity care.

Strategic interventions:

- Train health workers on adolescent-friendly health care to improve skills on providing quality adolescent and youth-friendly SRH information and services.
- Train the HEWs on providing appropriate SRH information and services as per the standard.
- Develop and distribute job-aids for health workers including HEWs in all health facilities
- Engage, communicate and disseminate information to adolescents and youth through knowledge-sharing (online libraries, social media, and mobile health) and IEC/BCC education of individuals, families and communities by HEWs.
- Support MOE to integrate comprehensive life skills, family life and sexuality education into school curricula emphasizing gender norms and rights; train and improve teacher skills on diversified interactive methods and practice with new skills (assertive communication).
- Conduct mass media and other large-scale communication programs (edutainment) to raise awareness and motivate discussions about ASRH issues.

- Work in collaboration with The Ministry of Sports and Youth and other respective partners to strengthen youth centers and enhance their friendliness and functionality (7 days a week including after working hours).

Strategy 7: Promote a safe and supportive environment, multi-sectoral collaboration and participation in policy and program development

Performance targets by 2020:

- A multi-sectoral institutional arrangement that coordinates adolescent and youth health issues becomes operational.
- Adolescent and youth health coordination entity established within the ministry of health.
- Adolescent and youth organizations (representatives of youth forums, youth associations, youth leagues) have active participation in AYRH programming.
- A mechanism is in place for generation and use of strategic information to inform AYH programming.

Strategic interventions:

- Establish steering and technical committees on adolescent and youth health represented by all relevant sectors: parliament, ministries, commissions, agencies, youth and women's associations, public health and medical associations, universities, non-governmental organizations.
- Orient and sensitize law enforcement bodies and local communities for garnering support to monitor and enforce existing laws that protect adolescents and youth.
- Provide collaborative capacity-building/training programs on planning, leadership and decision-making skills.
- Engage youth in health sector planning and strategy development as well as documenting and evaluating large-scale implementation.
- Establish a case team of adolescent and youth health within the ministry of health.
- Build the capacity of adolescent and youth organizations to enable them to engage in AYRH.
- Conduct studies/research to produce more evidence and inform AYRH program design.

Sexually transmitted infections (STI) including HIV:

Strategy 8: Strengthen the integration of STI/HIV prevention, detection and treatment in the RMNAYH services.

Performance targets by 2020:

- 100% HCs and hospitals perform counseling, diagnosis and treatment of STIs
- 100% health centers and hospitals perform routine screening and treatment for STIs (syphilis and HIV) during antenatal care, family planning, abortion care, HIV treatment and care and during visit for any other gynecologic problems.
- 100% of health centers and hospitals screen for Hepatitis B
- 100% health care providers working in different reproductive health clinics are capable of
- o Diagnosing and treating STIs;
- o HIV testing, counseling and linking HIV positives to ART clinic;
- o Counseling on family planning and providing contraceptive methods;
- HIV testing coverage among the reproductive health service users reached 95%.

- 100% HIV positive patients of any age category will be linked to antiretroviral treatment (ART) clinic.

Strategic interventions:

- Increase public awareness of the advantages of early diagnosis and early initiation of treatment for STIs including HIV.
- Ensure integration of STI/HIV prevention and detection services at all levels of reproductive health care platforms.
  - Provide STIs diagnosis, treatment and counseling services to couples/partners as part of a comprehensive reproductive health package in the clinics of antenatal care, general gynecologic, ART, family planning and adolescent and youth health.
  - Provide HIV testing, counselling and linking to the ART clinic to couple/partners as part of a comprehensive reproductive health package.
- Ensure adequate capacity at all levels for the provision of integrated STI/HIV- related services in all reproductive health care platforms.
  - Advocate the provision of integrated STI/HIV services in all reproductive health clinics.
  - Build the health care providers' capacity to counsel, diagnose and treat STIs including HIV.
  - Enhance positive attitude towards HIV-positive patients and denounce HIV-related stigma and discrimination among the health professionals, and within the community.
  - Provide the essential physical facilities, drugs and supplies to strengthen and sustain the integrated STI/HIV services.

Reproductive Organ Cancers and pelvic organ prolapse

Strategy 9: Reduce the incidence and associated morbidity and mortality of reproductive organ cancers (ROCs) in both women and men

Performance targets by 2020:

- 1 health center per Woreda (about 20% of HCs) and 118 (about 50%) hospitals provide VIA screening and cryotherapy for precancerous cervical lesion.
- 50% oncology centers start providing chemotherapy, radiotherapy and rehabilitation for ROCs, among others.
- All specialized hospitals have full capacity to identify and treat all types of ROCs.
- 80% of girls aged 9 -13 years are vaccinated for human papilloma virus (HPV).
-

Strategic interventions:

- Improve the public's awareness of ROC's risk factors, prevention modalities and availability of treatment options by /SBCC interventions
- Promote screening for, early detection and treatment of ROCs primarily cervical cancer, breast cancer and ovarian cancer in women, and penile and testicular cancer in men.
- Enhance service preparedness of health facilities to screen, diagnose, treat, palliative care and rehabilitate ROCs.
- Scale up HPV vaccination for girls aged 9-13 years.
- Advocacy and involvement of influential officials (eg. First lady) in promoting services and resource mobilization
- Human resources capacity building by training professionals in oncology
- Strategy 10: Improve the pelvic organ prolapse (POP) detection, management and prevention capacity at different levels.

Performance targets by 2020:

- 100% women with POP get access to and treatment in the hospitals.
- Public awareness about risk factors for POP is raised.

Strategic intervention:

- Improve the early detection of women living with POP in the community and link them with hospitals where they can get treatment.
- Strengthen the health facilities' capacities to diagnose and refer or treat women with POP.
- Education and counseling on risk/predisposing factors (e.g. multi-parity,

Reproductive Health in emergencies

Strategy 11: Ensure provision of sexual and reproductive health services in emergency affected areas

Performance targets by 2020:

- MISP (Minimum Initial Service Package) for RH is provided to 100% of emergency-affected populations

Strategic interventions:

- Adopt/adapt minimium services standards (package) and service delivery modality
- Prevent and manage the consequences of sexual violence through coordination with other sectors (camps management) and provision of treatment for sexual violence survivors
- Reduce HIV transmission through enforcement of standard precautions, distribution of free condoms and safe blood tranfusion
- Prevent excess newborn & maternal morbidity and mortality through Provision of Basic EmONC in primary health care facilities, Comprehensive EmONC in referral hospitals and Ensuring a functional referral pathway
- Orient and train health care workers on MISP for RH
- Formulate an Inter-Agency Working Group (IAWG) for RH that should be activated immediately during an emergency
- Ensure provision of RH kits

SO 2: Enhance Good Governance

Strategy 12: Enhance coordination and effective monitoring of RH programs

Performance targets by 2020:

- Planning, implementation, monitoring and evaluation of RH programs maximally coordinated for effectiveness and efficiency across the continuum of care and geographic locations, backed by technology and innovation.
- Program supervisions and coordination meetings are regularly conducted by all RMNCAH programs at all levels and effectively serve their purpose.
- Stakeholders fully discharge roles and responsibilities pertaining to their memberships to the different coordination units or teams.

- Accountability and transparency of MCH leadership enhanced through public and civil society engagement in RH/MCH decision-making.
- Improved responsiveness of service-delivery outlets and customer satisfaction.

Strategic interventions:

- Equitably align, harmonize and distribute programs and resources of development partners along the continuum of care and according to geographic distribution.
- Conduct regular coordination meetings and program supervisions from national to PHCUs level with effective feedback and follow up on actions and recommendations.
- Strengthen the institutional framework of the RMNCAHN research and advisory council to build an effective governance podium towards a strong local accountability framework.
- Create opportunities for capacity-building on RH leadership and management skills for regional and district RH program coordinators, heads and deputies of RHBs and health offices as well as support staff.
- Oversee and ensure the functionality and effectiveness of the different coordination committees, TWGs and taskforces of the RMNCAYH program at national and sub-national levels, including implementing mechanisms that ensure equal and uniform commitment and contribution of stakeholders both within and outside MOH/MCH.
- Conduct regular town hall meetings/public wing meetings.
- Service delivery points plan and implement citizens' charters to improve good governance in RH service delivery.

SO 3: Improve Regulatory System

Strategy 13: Improve the standards of premises, products, practice and professionals for appropriate provision of RH/EmONC services

Performance targets by 2020:

- Revised facility standard of EmONC services is applied to 100% facilities (old and new).
- Roadmap for quality improvement of pre-service education on RH care is developed and implemented.
- Competency-based pre-and in-service training curriculum and manual are implemented.
- 100% health facilities implemented the RH clinical practice protocols.
- RH products quality will be assured through the national quality control system.

Strategic interventions:

- Revise facility standards for RH/EmONC service delivery and to ensure that health facilities are renovated and newly constructed per the revised facility standard.
- Conduct task analysis and identify competencies to be incorporated into pre-service education curricula.
- Harmonize and standardize IEC/BCC materials
- Incorporate missing competencies and revise curricula to make them competency-based type.
  - Integrate in-service EmONC (BEmONC and CEmONC) trainings into pre-service education.
  - Incorporate long-acting and permanent contraceptive methods and competency based training in the curricula of pre-service education of all clinical service providers' graduate profile.
  - Include long-acting contraceptive methods service provision (Implant insertion and removal) in the training and job-description of HEWs.
  - Ensure that all midwives and medical doctor graduates have acquired BEmONC and CEmONC skills, respectively during pre-service training.
  - Establish and operationalize RMNCHN skill labs in college of health sciences.
- Maintain and improve competence of RH care providers through continuing professional development including licensing exams and in-service trainings.
- Conduct pre-service educational resource gap assessment and strengthen educational resource centers in 20 universities.
- Develop and enforce RH standards and practice protocols, monitor the implementation of these practice standards.
- Institute and implement RH product quality assurance system (procurement specification, inspection, quality testing, storage and distribution, pharmaco-vigilance).

SO 4: Improve Logistics and Supply Chain Management

Strategy 14: Improve capacity and coordination of logistics and supply chain management for increased availability of RH commodities

Performance targets by 2020:

- 100% healthcare facilities will have adequate stock of all RMNCAH lifesaving commodities all year long (13 UN live saving commodities).
- Strategic interventions:
- Strengthen the linkage between technical working group of MOH and PFSA
- Support Pharmaceutical Fund and Supply Agency (PFSA) and jointly conduct annual forecasting, quantification and procurement planning of RH commodities, including supplies and consumables; and training of RH program and service staff on Integrated Pharmaceutical Logistics System (IPLS).
- Design and implement programmatic logistics coordination protocol including innovative strategies for managing donations.
- Establish a public-private partnership (PPP) forum to continually support and monitor the local production and distribution of essential RH commodities.
- Full implementation of health commodities management information system at national and sub-national levels.
- Enhance the distribution, availability and feedback system for effective and efficient supply of RH products.

SO 5: Improve Community Participation and Engagement

Strategy 15: Improve community engagement in RH program with particular focus on men and young boys.

Performance targets by 2020;

- 100% women in the rural areas will have access to recommended RH care through HEP.
- 95% of kebeles will conduct pregnant mothers' conference regularly.
- 99% of households will be informed about content of the family health card and will own.
- Train and certify 3 million households as model families/kebeles for level 1 certificate of competence (COC) on RH issues and enable woredas to fully implement the RH component of the HEP.
- 100% husbands and young boys will be aware of the importance of male involvement in RH and have favorable attitude.
- Mobilize for scaling up the existing social and community health insurance schemes including fee waiver system for selected RH services

SO 7: Improve Research and Evidence for Decision-Making

Strategy 17: Improving use of research and evidence for decision-making for better RH care

Performance targets by 2020:

- RMNCHN Research Advisory Council (RAC) will be functional.
- 50% of hospitals and 10% of HCs will have a knowledge resource center for RH
- 90% of facilities will use local data for improved services.
- Research outputs on RH issues will be obtained from all research institutions, including universities and utilized for decision making.
- National RH data integrated and digitalized.
- 100% hospitals and Health centers will have clinical audit and quality improvement standards
- Strong clinical and QI skills are developed through pre-service and continuing medical education for all health care providers

Strategic interventions:

- Establish and strengthen knowledge resource centers at selected health facilities.
- Provide orientation and training on data quality for service providers and data managers, and on operations research technique for M&E units at different levels.
- Train HEWs and orient Woreda council and Kebele management on Community Health Information System (CHIS) and implement it in all health posts.
- Advocate for adequate allocation of research funds at national and regional levels and undertake operational researches on the quality of RH care and population surveys to look at the status of utilization of RH services; identify determinants and gaps.
- Promote the use of data for decision making at the national and local levels.
- Work on RH data integration and digitization.
- Establish/strengthen coordination of research undertakings eg. RMNCHN Research Advisory Council (RAC)
- Building capacity of research institutions to conduct problem solving/felt need-based researches.
- Fully institutionalize the RMNCAHN policy and research advisory council.
- Control the quality of facilities by clinical audits and inspections of health facilities, licensing for private hospitals and develop reporting standards and requirements

SO 8: Enhance use of Technology and Innovation

Strategy 18: Improving use of technologies and innovation for better RH outcomes

Performance targets by 2020:

- Strengthen the unit under the HIT directorate to implement and monitor the innovations, including m-health.
- Mobilize for scaling up the existing social and community health insurance schemes including fee waiver system for selected RH services

SO 7: Improve Research and Evidence for Decision-Making

Strategy 17: Improving use of research and evidence for decision-making for better RH care

Performance targets by 2020:

- RMNCHN Research Advisory Council (RAC) will be functional.
- 50% of hospitals and 10% of HCs will have a knowledge resource center for RH
- 90% of facilities will use local data for improved services.
- Research outputs on RH issues will be obtained from all research institutions, including universities and utilized for decision making.
- National RH data integrated and digitalized.
- 100% hospitals and Health centers will have clinical audit and quality improvement standards
- Strong clinical and QI skills are developed through pre-service and continuing medical education for all health care providers

Strategic interventions:

- Establish and strengthen knowledge resource centers at selected health facilities.
- Provide orientation and training on data quality for service providers and data managers, and on operations research technique for M&E units at different levels.
- Train HEWs and orient Woreda council and Kebele management on Community Health Information System (CHIS) and implement it in all health posts.
- Advocate for adequate allocation of research funds at national and regional levels and undertake operational researches on the quality of RH care and population surveys to look at the status of utilization of RH services; identify determinants and gaps.
- Promote the use of data for decision making at the national and local levels.
- Work on RH data integration and digitization.
- Establish/strengthen coordination of research undertakings eg. RMNCHN Research Advisory Council (RAC)
- Building capacity of research institutions to conduct problem solving/felt need-based researches.
- Fully institutionalize the RMNCAHN policy and research advisory council.
- Control the quality of facilities by clinical audits and inspections of health facilities, licensing for private hospitals and develop reporting standards and requirements

SO 8: Enhance use of Technology and Innovation

Strategy 18: Improving use of technologies and innovation for better RH outcomes

Performance targets by 2020:

- Strengthen the unit under the HIT directorate to implement and monitor the innovations, including m-health.

- Toll free line for ambulance/referral/emergency service and awareness creation communications will be initiated in all kebeles (nationwide coverage).
- m-Health services for behavior change communication and consultation by users will be initiated in all kebeles (nationwide coverage).
- All health Extension Workers (HEWs) will use m-Health services for RH information, consultations and referral.
- All hospitals will have access to and utilize telemedicine and tele-education technologies for RH services.
- 80% of health facilities will have the appropriate medical diagnostics and equipment required for RH services.

Strategic interventions:

- Work closely with the HIT Directorate to strengthen the unit under it that synthesizes findings around the world on new products, processes, services, technologies or ideas to transform reproductive health.
- Initiate toll free line for ambulance/referral/emergency service/awareness creation in all kebels; initiate the application of m-health services (referral services and for consultation) by the users and HEWs in all kebels with particular emphasis to the remote and hard-to-reach areas.
- Evaluate and document the m-health practices (successes and challenges) for scale up.
- Avail telemedicine and tele-education in all hospitals and sensitize professionals to utilize them.
- Equip the health facilities with the appropriate medical diagnostics and equipment required for RH services

SO 9: Development and Management of Human Resource for Health

Strategy 19: Improve availability, motivation and retention of compassionate, respectful and competent RH care providers across all regions and all levels of health facilities.
Performance targets by 2020:

- Increase the national health professionals' density per 1000 population from 1.5 to 1.6.
- Increase the proportion of physicians, nurses and midwives from the total health professionals from 44.7 % to 50%
- Reduce staff attrition rate from 6.6% to 4%.
- All health centers will be staffed with at least 3 midwives.
- All primary hospitals will be staffed with 1 integrated emergency surgical officers (IESOs), 3 anesthesia professionals and 4 midwives.
- All general hospitals will be staffed with at least 2 obstetrician-gynecologists, 13 anesthesia professionals and 13 midwives.
-

Strategic interventions:

- Ensure that all the health facilities are staffed as per the standard; the hospitals and health centers function 24 hours a day and 7 days a week.
- Maintain and improve competence of RH care providers through continuing professional development by in-service trainings.
- Standardize, institutionalize and ensure need-based implementation of all RH in-service trainings.

- Provide need-based in-service trainings on BEmONC, CAC, FP and youth-friendly service as an interim solution to improve quality of RH services.
- Ensure that in-service CEmONC trainings are applied to build effective capacity and bridge gap in CEmONC service delivery pending deployment of qualified staff (IESOs and Obstetricians).
- Support the new specialty training in obstetrics and gynecology.
- Implement special remuneration and incentive package in hard-to-reach areas with special emphasis to regions that need special support during pre-service training enrollment (medical doctors and midwives). So that, indigenous graduates from the remote regions will increase.
- Strengthen the existing incentives for RH service providers and introduce performance-based-financing (PBF) schemes for health facilities and health workers.
- Avail platforms to improve the availability of compassionate, respectful and competent HR for RH.
-

SO 10: Improve Health Infrastructure

Strategy 20: Improve health infrastructure as per norms for proper RH service delivery

Performance targets by 2020:

- 100% HCs and hospitals will have constant running water, telephone communication and an electric power supply with backup generator/solar in case of power failure.
- 50% of health facilities will have ample 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 will have a neonatal intensive care unit (NICU) and radiant warmer, respectively.
- All Woredas will have at least 2 ambulances

Strategic interventions:

- Use inter-sectoral forums to address telephone, water and electricity supply problems in health facilities.
- 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.
- Strengthen community contribution for procurement of ambulances

SO 11: Enhance Policy and Procedures

Strategy 21: Ensure availability and implementation of enabling policy environment for the RH services.

Performance targets by 2020:

- RH issues got full attention in developing sectoral/inter-sectoral policies and plans, and a task force is established for inter-sectoral collaboration at F.
- 100% health centers and hospitals give fee-exempted services for lifesaving EmONC functions, FP, VIA screening for precancerous cervical lesion and vaccination for HPV.

- 100% private sector, non-governmental organizations (NGOs) and charity-based organizations (CBOs) participate in continuing professional development (CPD), and development of RH policies, strategies, protocols and guidelines.
- Existing and new protocols, guidelines and standard checklists are properly applied for quality RH service provision
- Strategic interventions:
- Initiate multi-sectoral participation and dialogue in policy making and implementation, particularly with The Ministry of Women and Children, Ministry of Youth and sports and Ministry of Social Affairs, and Ministry of Education.
- Adopt the health care financing policy and enforcement mechanism to allow exempted services for selected RH services.
- Strengthen the engagement of the private sector, NGOs and CBOs in the RH services delivery.
- • Monitor proper implementation of protocols and guidelines and develop standard checklists to enhance healthcare workers' capacity to deliver high-quality reproductive, maternal and perinatal care.

SO 12: Address the Social Determinants of RH

Strategy 22: Improving advocacy and partnership to improve women's decision making power on RH matters.

Performance targets by 2020:

- Increase women's decision-making on RH matters to 100%
- Conduct at least one national advocacy workshop every year on gender and RH.
- Build partnership with all relevant ministries and relevant sectors.

Strategic interventions:

- Organize and conduct advocacy workshops at national and regional levels to strengthen intersectoral collaborations with other sectors; such as: Ministry of Education (MOE), Ministry of Women and Children Affairs and Ministry of youth and sports , NGOs and private sectors in improving the status of women in the society and their decision-making power concerning RH matters.
- Improve women's participation in decision-making related to reproductive health matters, starting from planning through implementation and monitoring and evaluation.
- Maximize the utilization of Medias, including Mass-Media, to promote the importance of women empowerment and seek attention from all actors.
- Strengthen families', teachers', girls' and other communities' forums working on gender and sexual and reproductive health by arranging awareness-raising forums and community conversations to ensure their full participation.
- Strengthen the capacity of women leaders by providing leadership trainings for women leaders in collaboration with the Ministry of Women, Children and youth Affairs and other donors.
-

Strategy 23: Advocating for the enforcement of the implementations of the legal frameworks that protect and advance women's RH rights, including harmful traditional practices elimination.

Performance targets by 2020:

- Median age at marriage will be >18 years.
- Incidence of female genital cutting (FGC) will be <1%.

- At least one national advocacy and sensitization workshop conducted each year with law enforcing bodies (lawyers, judges, police and other relevant).
- Awareness about the negative effects of harmful traditional practices among women will be increased to 100%.

Strategic interventions:

- Advocate for the implementation of existing laws that protect reproductive rights such as family health law, abortion law, and laws related to harmful traditional practices.
- Organizing sensitization and advocacy workshops for law reinforcing 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.
- 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.
- 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 by using the health workers, HDAs, HEWs and other community opinion leaders as a vehicle.
- Promote operational and population-based researches on gender-based violence, health system and other social determinants of RH including their magnitudes and root causes for the evidence-based and effective implementation of the designed interventions.

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. The continuum of care approach as a service delivery model is comprehensive on many fronts. The central premise of the model is the delivery of essential services for mothers, newborns and children in an integrated package at critical points in the life cycle, in a dynamic health system. The continuum of care has two dimensions: time of care giving, and place and approach of care giving.

In time - an effective continuum of care connects essential reproductive health packages throughout adolescence, pregnancy, childbirth, postnatal and newborn periods and into childhood, building upon their natural interactions throughout life.

In place - an effective continuum of care strengthens the links between the home and the first level facility and hospital, assuring the appropriate care is available in each place. Strategies involve improving the skills of health workers, strengthening health system supports, and improving household, community practices and community actions for health. This approach brings care closer to the home through outreach services and promotes referral by strengthening access to and

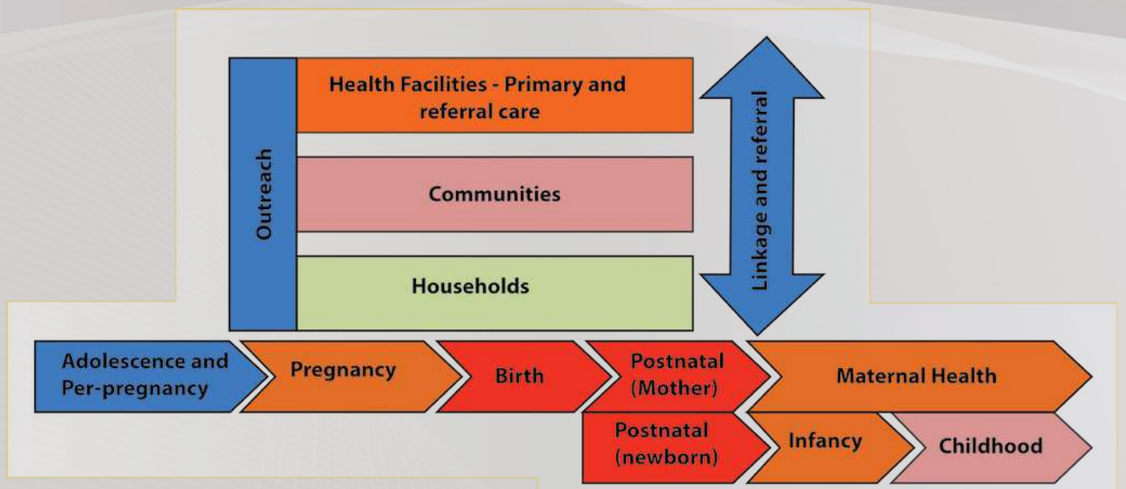


Fig.7: The Continuum of Care Model

The continuum of care service delivery strategy is adopted in line with the three key implementation modalities (described below) for delivering high-impact interventions at each service delivery level starting from the household/community up to the referral or specialized care facilities.

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 government flagship health extension program, 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.

8.2. Population-oriented outreach services

In a country like Ethiopia where geographical access presents major barriers, 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, child health days and 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. The focus will be on areas or populations that are underserved. Outreach will be planned with the community members to support services such as tracking defaulters. Evidences show that increased coverage of outreach and facility-based preventive interventions will reduce neonatal mortality by 3.5 percent.

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 child health care, and are 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.

Once key bottlenecks are addressed, the individual-oriented clinical services can lead to 25.8% decrease in neonatal mortality rate. Infrastructure development will be required to strengthen this strategy. Accelerated expansion and staffing of primary health care facilities, and training of health workers are needed to achieve universal coverage. Accelerated in-service training of medical and paramedical staff on key RH interventions is essential to fill the skill gaps. However, follow-up after training and supportive supervision remain the key actions to reinforce skills and facilitate implementation. 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.

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 F, 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. The RH scorecard will be updated to reflect the new high- impact interventions to track performance and progress in regional states and districts with emphasis on equity in access to and utilization of high-impact RH services and interventions.
In this strategy, the monitoring and evaluation of activities is broadly divided into two: regular performance tracking system and operations research, studies and evaluation.

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.

10.COSTING

The OneHealth tool was used to determine the cost of implementation of this strategic plan. High-impact interventions were selected from each of the component strategic plans and costed as a whole. Program activities were also identified from each component strategic plan and costed accordingly. The best accessed information on diseases profile and official figures

for base-year population demographics were used for the costing. Service coverage targets are set in line with the visioning exercise of achieving impacts that are comparable to middle income countries by 2025/35, in line with the national growth plan.

10.1. Costing summary

The total cost of the strategic plan is US$2.35 Billion (ETB 50.5 Billion). Overall, 34% (US$ 818 Million) of the overall costs are intervention costs and the rest (US$ 1.53 Billion) are program activity costs including procurement. The total cost reflects the overall financial requirement for both service delivery and the capital cost/health systems for RMNCAYH. In the HSTP, the capital/health systems cost for RMNCAYH is included in the overall health systems cost for the health sector. The cost indicated under RMNCAYH in the HSTP is only for services and is less in amount compared to the total cost of the RH strategy. The total number of services is also calculated under each service package and presented in Figure 8 and 9. Costs and number of services are spread over the duration of the strategic plan (see Annexes).

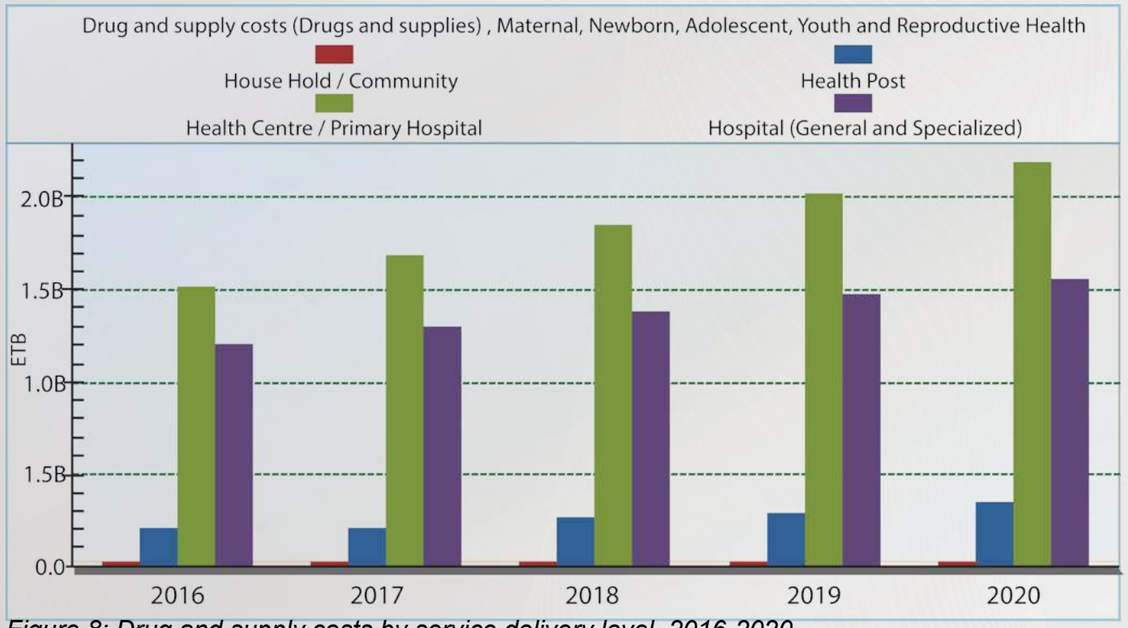


Figure 8: Drug and supply costs by service delivery level, 2016-2020.

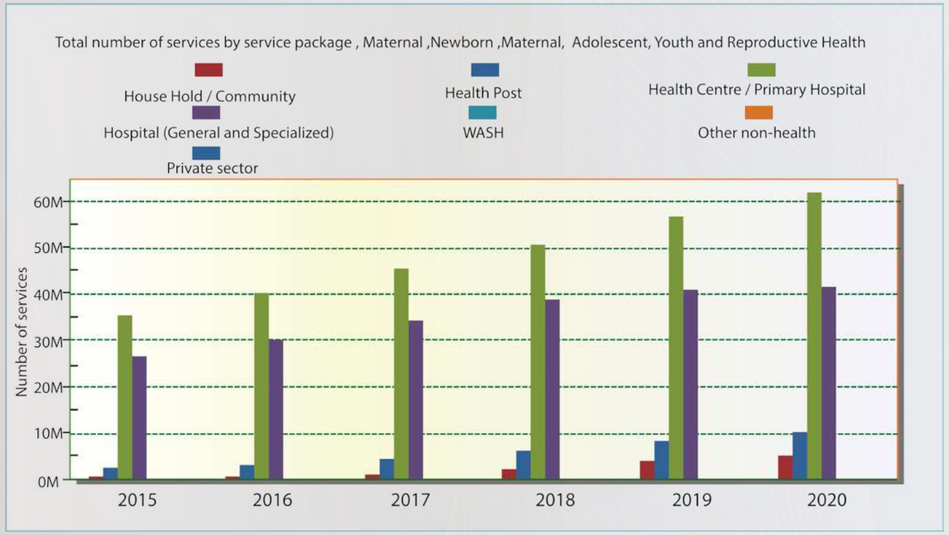


Figure 8: Total number of services by service package, 2015-2020.

11. ANNEXES

11.1. ANNEX 1: INDICATIVE WORKPLAN

11.1.1. FAMILY PLANNING/FERTILITY

Strategic priorities	Activity	2016	2017	2017	2019	2020
Increasing access, creating demand and improving utilization of quality family planning (FP) services	Avail all the required contraceptive methods at all service delivery points					
	Build the competency of health workers to provide LAR and permanent contraceptive					
	Develop and distribute counseling tools and tailored FP communication materials					
	Advocate and Integrate FP with other service outlets					
	Engage WDAs, MDAs, HEWs and community opinion leaders demand creation					
	Roll out mobile clinics for hard-to-reach rural areas, including LARC and permanent contraception					
	Put in place regular supervision to offer compassionate and client-friendly service					
	Develop and implement FP mass media campaign					
	Utilize mobile platforms for FP outreach and information distribution					
	Create communication materials and outreach opportunities targeting youth					
	Select and train male role models on FP					

Strategic priorities	Activity	2016	2017	2017	2019	2020
Improving the prevention, investigation and management of infertility.	Develop national guideline for the prevention, investigation and management of infertility.					
	Develop IEC/BCC materials that provide clear information on infertility for the community					
	Conduct national studies that document the prevalence of infertility and felt need					
	Work with relevant stakeholders, including universities, to define drugs, instruments, technologies and other supplies needed for infertility management					
	Work with FMHACA and PFSA to register and facilitate import; and ensure their availability at respective facilities.					
	Encourage investment and public-private partnership in the area of creating a specialty unit that deals with infertility prevention, investigation and management					
	Support universities to initiate the training program in reproductive endocrinology and infertility					
	Strengthen the diagnosis and management of STIs to prevent the incidence of infertility					
	Equip the referral/specialty hospitals by availing necessary equipment and supplies (make the facilities ready to deal with infertility investigation and management)					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Work with Ministry of Education and higher teaching institution including the private sector to incorporate competency-based FP training in the curricula for health science students					
	Train all service providers to meet the special needs of young people and adolescents, especially those who are married and those in rural areas.					
	Ensure health facilities have trained staff, supplies and equipment necessary for delivery of full spectrum of FP services					
	Ensure youth center staff members are trained in the full spectrum of FP services					
	Exploit further possibilities for task shifting at public and private health facilities					
	Quantify, forecast, and procure FP commodities annually					
	Support PFSA and FMHACA to ensure availability and quality of contraceptives					
	Build regional and district-level staff's capacity to quantify and distribute contraceptives					
	Expand regional hubs with capacity to delivery supplies					
	Provide logistics trainings for Health Extension Workers as part of integrated refresher training (IRT)					
	Seek out and diversify sources of funding for commodity procurement through sustained advocacy and targeting partners including the private sector and donors to raise level of FP support					
	Avail contraceptive method mix as per the standard for the level of service delivery point					
	Harmonize the FMHACA guidelines with the FP service guideline					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Enhance coordination and effective monitoring of FP programs	Coordinate FP activities with other ministries for a multi-sectoral approach to FP programming					
	Foster collaboration among MOH, MOE and other sector ministries on capacity-building of parents					
	Coordinate with implementing partners to integrate FP information into other women's empowerment areas					
	Institutionalize FP TWGs/forums/networks in all regions					
	Foster enabling environment for the private sector in FP service provision including clarifying the service provision protocol for the private sector by level and health workers					
Ensure integration of FP services at all service delivery points	Set up a workgroup and develop national implementation manual					
	Conduct orientation workshops with topics on integration for health mangers and health staff at different levels					
	Ensure implementation of integration manual during integrated supportive supervision					
	Support health facility mangers to define level of integration at different units and to initiate service					
	Support structured on-the-job training for service providers to enable them to provide service expected at respective levels.					
	Define measurable indicators and agree on M&E approach					
	Incorporate emergency contraception as backup method and avail the same at all levels					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Increase access to SRH information and education	Use healthcare facilities as key information source: Develop and disseminate tailored IEC/BCC materials/tools for HCWs in HFs					
	Leverage existing outreach models: equip HEWs, HDAs and peer educators at youth centers with IEC/BCC tools to educate communities on AYRH					
	Train teachers, parents, youth and adolescent organizations (Youth Associations, Women Associations, Anti-AIDS Clubs) to educate adolescents and youth in-school and out-of-school					
	Conduct orientation workshops for religious, community leaders and parents to raise awareness on SRH of adolescents and youth					
	Create social media accounts (FB, Twitter, Instagram) under MOH/AYH and use for information sharing					
	Establish center for documentation, bibliography and web-based knowledge sharing and learning					
	Implement mobile health for AYRH at national level					
	Develop and implement AYH mass media campaign (radio soap opera, edutainment)					
Increase access to quality adolescent friendly healthcare services	Train health workers including HEWs on adolescent-friendly health services					
	Establish youth-friendly corners in all hospitals and health centers					
	Develop and distribute job-aids and service protocols on youth-friendly service for health workers					
	Establish operational (24/7) youth-friendly centers and rebrand					
	Establish and integrate AYRH quality assurance mechanisms with the national health quality control system					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Improve the generation and use of strategic information to inform AYRH programming	Develop up-to-date AYRH M&E tools (registers) and guidelines which cater for appropriate disaggregation					
	Integrate data and indicators on AYRH into HMIS reporting tools					
	Review and update the RMNCH score card to include a core set of AYRH indicators					
	Conduct policy, operations and actions research on the dynamics of access to information and services, health care delivery systems and health care-seeking behaviour of adolescents and youth					
	Conduct assessment of sexuality education programs and rigorous evaluation of interventions aimed at affecting health, social and economic outcomes					
Strengthen partnership and multisectoral collaboration for AYH programming	Establish national AYH multi-sectoral coordination unit (technical and steering committees)					
	Conduct coordination meetings					
	Establish AYH case team within MOH					
Create supportive policy environment	Orient parliamentarians on the policy and legislative needs of adolescents and youth health and development					
	Orient decision makers, planners, and lawyers on implementation of policies and legislation in support of improved AY health and development					
Build capacity of adolescents and youth to plan, implement and monitor AYRH programs	Train members of youth associations, women associations, Anti-AIDS Clubs and RH Clubs on leadership and program management, participatory planning					
	Engage adolescent and youth organizations in program planning, M&E and research (planning workshops, program review meetings, joint supportive supervisions)					
	Create functional linkage between youth associations and professional associations (EPHA, EMA, ESOG)					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Improving access to and utilization of essential maternal and neonatal health (MNH) services at all levels of the health care delivery system.	Increase community's awareness on the importance of birth preparedness, complication readiness and facility delivery by strengthening the activities of Women Health Development Armies (WHDAs) and health extension workers (HEW).					
	Ensure the provision of optimal clinical care in all health facilities during pregnancy, delivery and postnatal period, including early detection and management of complications, micronutrient supplementation, prophylaxis administration, and counseling on maternal nutrition, infant feeding and family planning.					
	Strengthen the primary level health care linkage and referral (front and back) system across household, community and health service level.					
	Conduct regular catchment community forums by involving the Women Health Development Team and health extension workers					
	Avail MNH service delivery protocols and guidelines at all levels of health facilities, and promote their routine use in all clinical activities.					
	Micro-nutrient supplementation, nutritional assessment and counseling, intervention (during the first 1000 days.					
	Putting in place Life-cycle interventions					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Improve quality integrated PMTCT into the MNH care services at ANC, labor and delivery and PNC	Expand the prevention of mother-to-child transmission (PMTCT) of HIV services to all health facilities so that all eligible mothers attending antenatal, labor and postnatal care receive the minimum PMTCT services package (HIV testing and counseling, ART, safe delivery, antiretroviral prophylaxis for the newborn, DBS testing for HIV and safe infant feeding)					
	Facilitate implementation of Continuous Quality Improvement (CQI) and Mother Baby Pair (MBP) cohort follow up					
	Standardized PMTCT training package materials and PMTCT guidelines focusing on competency-based contents are available and used					
	Develop and distribute job aids and wall charts to follow MBP cohort follow up					
	Train MNH service providers and district health managers on Comprehensive Option B+, CQI and MBP cohort follow-up					
	Involve level 4 HEWs in supporting the community in the identification and utilization of services for PMTCT including timely referral and linkage					
	Strengthen the integration of family planning services in the MNH services to ensure that all needy HIV positive mothers will get the service					
Provide quality care for adolescent mothers by ensuring equity	Increase knowledge, positive attitude and life skills of adolescents to practice healthy behaviors					
	Expand and improve quality adolescent health services (FP, ANC, delivery, abortion care) in all public, private and NGO facilities and institutions that cater to a large number of adolescents; such as higher learning institutions, mega projects and other construction sites based on MOH standard					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Work together with MOE to integrate comprehensive life skills, family life and sexuality education into school curricula					
	Standardize training manuals and IEC materials for adolescents to be delivered at different levels					
	Engage adolescents, families, teachers and community in the program to promote services, address cultural norms and enhance service utilization					
Improving the quality of basic and comprehensive emergency obstetric and newborn care (EmONC) services at health centers and hospitals	Scale up provision of high-impact interventions (BEmONC services at all health centers and CEmONC services at all hospitals) to address the major causes of maternal and neonatal mortality. Ensure the sustained availability of all essential drugs and supplies for maternal and neonatal health at all health facilities, with due emphasis to oxytocin, misoprostol and magnesium sulphate					
	Ensure the sustained availability of trained health care providers and essential medical equipment for BEmONC services at all health centers and CEmONC services at all hospitals					
	Conduct regular on-site clinical mentoring, quality improvement process and reviews using standard tools; and assign a quality assurance officer/ committee at all health facilities					
	Ensure implementation of safe child birth checklist, management protocols and guidelines in all health facilities.					
	Promote the routine use of partograph; routine administration of antibiotics for pPROM; practice of AMTSL; and lifesaving interventions for critically ill pregnant or postpartum women					
	Create community awareness about the maternal and neonatal health services available and the services menu in the vicinity					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Advocate for community participation in preventing the occurrence of obstetric fistula, identification of women living with fistula and linking them with health facilities treating it					
	Strengthen the health facilities' capacity to diagnose and treat obstetric fistula, and reconstitute the psychology, fertility and productivity of victims.					
Provide comprehensive abortion care services in all facilities	Monitor the proper implementation of the abortion law and the use of the revised technical and procedural guidelines on safe abortion service provision					
	Build the capacity of the health staff (in terms of skill, willingness, and friendliness) to provide safe abortion and post abortal care to all who need the service as per the law and per the guidelines.					
	Promote and implement the integration of other reproductive health services (family planning, gender based violence, screening for selected STI, HIV, and cancer) with abortion care package					
	Provide counseling on risks of repeated induced abortions (infertility, ectopic pregnancy, endometrial synechiae, cervical insufficiency, chronic pelvic pain and chance of perforation) and provide the women's choice of postabortal contraceptive method					
	Provide the women's choice of postabortal contraceptive method and advocate for the use of contraceptive methods to reduce unwanted pregnancies among the vulnerable group.					
Strengthening the referral system across household, community and health service	Advocate for "no mother should give birth without skilled attendant" in the community					
	Build the community capacity for identifying the danger symptoms of pregnancy, early recognition of pregnancy- related complications; and ensure that a pregnant woman or her partner knows someone (ambulance driver, health professional) to communicate with in case of emergency					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Empower the Women Health Development Team for the early transfer of sick or laboring women and sick newborns to health facilities (level 1 action); improve the health facility's ability to accept and timely manage transferred cases (level 2 action)					
	Establish ahead communicated referral linkages across levels of care in order to ensure efficiency in use of resources and reduce delays in lifesaving interventions					
	Support the utilization of technologies to improve communication and transport facilities at all levels to facilitate early transfer and early interventions in case of emergency					
	Avail region-specific referral service guidelines in all health facilities					
	Designate all-time referral coordinator/liaison officer in all health facilities					
	Establish a national toll free ambulance service line					
	Establish dispatch centers as close to the community as possible					
	Assign 1-2 pre-facility emergency responders with the necessary supplies accompanying each ambulance					
Strengthening access to safe blood and blood products	Expand blood banks for hospitals to have access to quality blood products for MNH services, expand MINI BLOOD BANK at hospital level					
	Capacitate blood banks (including supplies, technologies and skilled personnel) to collect and also diversify blood products availability					
	Increase efficient utilization of blood and blood products by networking through ICT and safe transport					
	Avail blood donation and transfusion guidelines at all levels of health facilities and monitor the appropriate use these guidelines					
	Create public awareness about the safety of blood donation and blood transfusion; and mobilize community members to donate blood (community organizations/schools / colleges / universities)					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Strengthen primary level health care linkage for improved quality of maternal and neonatal health care	Establish and strengthen the activities of the Women Health Development Army in all kebeles					
	Strengthen and scale up the networking and support of hospitals to catchment health centers, and health centers to health posts and the Women Health Development Army					
	Conduct clinically oriented supportive supervisions by creating subject matter specialists who can do clinical supervision					
	Oversee the regularity and reliability of the reported maternal and neonatal health vital statistics					
	Strengthen the mechanism for midwives to be engaged along with HEWs in educating the community on pregnancy/birth related complications, birth preparedness and neonatal health by creating forums at Kebele level					
	Introduce clinical supervision through hospital to health centers network					
	Sensitize communities using other similar country experiences on community-based participatory intervention for significant reduction in maternal and neonatal mortality					
Strengthen maternal death surveillance and response (MDSR) and perinatal death review (PDR) system to address quality of care for maternal and perinatal health.	Establish MDSR/PDR committees in all health facilities; train PHEM officers; conduct supervisions; analyze deaths and prepare yearly MDSR reports.					
	Ensure that for every maternal and perinatal death, appropriate response is given to avoid the occurrence of similar casualties in the future					
	Support Women Health Development Army and health facilities at all levels to cooperate with maternal and perinatal death notificatio					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Create awareness within the community of the importance of maternal death notification and reviews					
	Ensure the availability of guidelines and tools to conduct MDSR and PDR at the facility level					
	Establish a system of governance to eliminate blaming and shaming from MDSR and PDR					
	Capacitate providers and managers to conduct MDSR and PDR and use the lessons to improve the health system					
	Establish monthly perinatal & maternal death review at the health facility level, with due emphasis to near-miss cases and deaths					
	Designed action plan and implemented for recommendations emanated from maternal & perinatal death review					
Strengthen respectful maternity care initiative in all facilities	Strengthening of mother-baby-friendly facilities such as allowing birth companion, preferential laboring and birthing position, and allowing for cultural ceremonies in facilities.					
	Provide training on the concept of “respectful maternity care” to maternity care providers					
	Introduce facility-specific citizens charter in all health facilities					
	Conduct quarterly maternal satisfaction survey in facilities					
Improve availability of running water, telephone and electric power supply at all health centers and hospitals	Advocate for prioritization of telephone communication, water and electric supply of health facilities					
	Use inter-sectoral forums to address telephone, water and electricity supply problems in health facilities					
	Analyze available data to identify facilities with lack/interrupted supply of water, telephone and electricity					
	Mobilize resources to procure and distribute backup power sources as per identified gaps					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Improve the standard of facilities for the appropriate provision of EmONC service, including friendly services for pregnant and disabled women	Revise facility standard for the appropriate provision of MNH/EmONC service (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					
Equip facilities per the norm for proper MNH/EmONC service delivery	Ensure the availability of adequate EmONC equipment in health facilities					
	Establish a functioning newborn corner in health centers, NICU and adult ICU in hospitals					
	Ensure availability of trained health professionals all the time for newborn resuscitation, one each in health center delivery room (newborn corner), hospital delivery room, cesarean section room, and the NICU					
	Establish a unit to develop medical equipment specification for MNH service delivery					
	Create a mechanism to regularly audit and ensure availability of equipment at facilities					
	Ensure alignment of facility construction with the timely available medical equipment					
	Ensure availability of biomedical technicians / engineers for equipment maintenance					
	Orient MNH service providers on installation and proper application of medical devices					
Improve the availability and skills mix of MNH care providers across all levels of health facilities	Ensure that all health facilities are staffed as per the standard					
	Ensure availability of qualified health professionals, specifically midwives 24 hours a day and 7 days a week in all health facilities (health centre and hospital)					
	Ensure that all midwifes working in health centers are trained on BEmONC					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Ensure that the MNH workforce needed for the next five years is well incorporated into the resource for health (HRH) comprehensive plans					
	Advocate to secure budget for salaries, evidence-based incentives and top ups of required MNH care providers at regional levels to motivate and retain them.					
	Strengthen the existing staff motivation and retention mechanism by ensuring equity					
	Scale up team-based training of maternal and child care providers (Midwife, Anesthetist and Neonatal nursing)					
	Ensure that in-service CEmONC trainings are applied to build effective capacity and bridge gaps in CEmONC service delivery pending deployment of qualified staffs (IESOs and Obstetricians)					
	Support the new specialty training in obstetrics and gynecology					
	Prioritize enrollment of interested candidates in pre-service MNH education					
	Involve (with HRHD Directorate) in the deployment process of MNH providers to ensure equitable distribution					
	Prioritize enrollment of female candidates in pre-service midwifery training					
Contribute to quality improvement in pre-service and in-service MNH care training	Ensure pre-service education institutions adopt and implement competency-based curricula on MNH (with MOE)					
	Ensure all universities have educational relevance and quality monitoring assurance mechanisms, organization and strategy (with MOE)					
	Strengthen quality assurance mechanisms for all health graduates, including COC (with MOE)					
	Improve the quantity and quality of health instructors by recruiting and training qualified professionals and regularly updating whenever new initiatives or programs are introduced (with MOE)					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Ensure competencies on attitude and professional ethics (Respectful Maternity Care) are incorporated and implemented in pre-service education (with MOE)					
	Create a mechanism for conducting strict and regular Joint (HR, MCH, MOE and RHBs) monitoring of training institutions for proper curriculum implementation					
	Contribute in infrastructural development of regional HSCs (proper design and construction of training rooms, skill labs)					
	Strengthen capacity of training institutions and skill of trainers (skill lab equipment, ICT equipment, faculty development through ETS training, in-service trainings for instructors on clinical teaching skills, BEmONC, CEmONC, CAC and PMTCT)					
	Ensure acquisition of BEmONC and CEmONC skills by midwifery and medical education graduates, respectively					
	Develop and implement roadmap for quality improvement of pre-service education on MNH					
	Revise Health Science College (HSC) legislation to better address attrition and maximum retention of tutors					
Maintain and improve competence of MNH care providers through continuing professional development including in-service training	Enforce the implementation of CPD guidelines and directives and their linkage to re-licensure					
	Ensure that in-service training tools are revised to address competency-based curricula, standardized and institutionalized					
	Strengthen need-based in-service trainings (BEmONC, CEmONC, CAC, etc.) for service providers to enable them to acquire appropriate competencies/skills, proper attitudes and ethics					
	Establish functional in-service training database at MOH, regional and Woreda levels					
	Develop midwifery professionals' mentorship guidelines					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Conduct competency gap assessment of midwives and provide mentorship					
	Ensure in-service trainings are need-based and linked to CPD					
	Ensure the availability of technologies such as internet network and ICT equipment within health facility premises					
	Standardize and institutionalize training materials and procedures					
	Build the capacity of training centers based on standards and establish knowledge resource centers within facilities					
	Advocate for adequate allocation of research funds at regional and zonal levels					
Reduce inequity (in geographic distribution and gender) of MNH health workforce	Identify factors that underlie the inequity of health workforce geographic distribution and skill mix in all regions					
	Build capacity of regional health bureaus and woredas to attract and deploy health professionals in hard-to-reach geographic areas					
	Conduct policy advocacy for special remuneration and incentive package in hard-to-reach areas (link with motivation and retention)					
	Sensitize health workforce to provide services for communities with the highest needs					
	Continue enforcing minimum public (the mandatory) service for selected priority health professionals					
	Revise task-shifting to address skills mix and staffing at hard-to-reach geographic areas and critical resources shortage					
	Prioritize enrollment of female candidates in pre-service midwifery training					
	Involve in the deployment process and decisions of MNH providers to ensure equitable distribution					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Enhance the retention, motivation and performance of MNH workforce	Focus on local capacity-building during resource planning, specially upgrading local midwifes					
	Introduce performance-based financing (PBF) schemes for health facilities and health workers on MNH					
	Undertake advocacy work for endorsement of evidence-based incentive packages for MNH providers					
	Strengthen the currently applied professional fee and duty allowance of MNH providers to a significant level					
Ensure the incorporation and implementation of MNH issues in relevant sectorial/ inter-sectorial policies and plans	Conduct regular supportive supervision, mentorship and feedback at all levels					
	Initiate social participation and dialogue in policy making and implementation					
	Ensure successful application of intersectoral policies and collaboration in implementation particularly with The Ministry of Women, Children and Youth Affairs (MOWCYA)					
	Establish a task force for leading and facilitating intersectoral collaboration					
	Fully institutionalize the RMNCAHN policy and research advisory council					
	Ensure preparation of implementation guidelines for intersectoral collaboration on MNH					
	Work in collaboration to avail newborn emergency-free ambulance service					
Strengthen and enforce reproductive health care financing (HCF) policy to allow exempted services for lifesaving EmONC functions across all levels of care and regions	Identify core package of life saving EmONC and BEmONC functions for exemption and develop a guide/frame for the implementation of fee exempted services at all levels					
	Revise the HCF policy to allow exempted services for lifesaving EmONC functions across all levels of care and regions					
	Create an adequate reimbursement protocol to facilities implementing free maternity services with priority for MNH commodities					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Strengthen systematic engagement of the private sector, non-governmental organizations (NGO) and charity-based organization (CBO) to enhance service delivery in RH	Ensure mechanisms to implement free ambulance services in all facilities					
	Develop RH policies, strategies and guidelines with consideration of the specific contexts of the private sector (profit and non-profit [NGOs and CBOs])					
	Ensure representation of the private sector (profit and non-profit [NGOs and CBOs]) in TWGs, taskforces and joint monitoring missions at MOH and lower levels					
	Disseminate policies, strategies and guidelines to the private sector, NGOs and CBOs					
	Encourage private investors to contribute on RH services through expanding infrastructure, pharmaceutical and diagnostic facilities					
Improve use of research and evidence for decision making for better RH care	Provide orientation and training on data quality for providers and data managers					
	Training on operations research technique for M&E units at different levels					
	Train HEWs on Community Health Information System implementation					
	Orient Woreda council and Kebele management on Community Health Information System					
	Undertake operations research on MNH quality					
	Undertake operations research on RH care utilization determinants					
	Undertake operations research to see equity of services across income, educational and geographic variations					
	Regular supportive supervision					
	Conduct community/facility surveys to generate information on key areas of data utilization for local decision-making					
	Conduct survey to generate data for monitoring progress of MNH strategy					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Improve use of technologies and innovation for better MNH outcomes	Establish a unit within the Infrastructure Directorate that synthesizes findings around the world on new products, processes, services, technologies or ideas to transform Maternal and Newborn Health					
	Initiate toll free line for ambulance /referral/emergency service/awareness creation in selected urban towns					
	Initiate the application of mhealth services (referral services and for consultation) by HEWs in selected remote and hard- to-reach areas					
	Evaluate and document the mhealth practices (successes and challenges)					
Improve resource mobilization, allocation and utilization for MNH	Advocate for increased allocation of Government finances for MNH					
	Enhance the scaling up of the health insurance schemes					
	Scale-up health facility financing reform (revenue retention and revolving drug fund)					
	Support the revision and implementation of HCF strategy to ensure a more robust reproductive health financing approach					
	Establish partnership forum for leading and coordinating MNH programs financing					
	Harmonize and align MNH plans and priorities and develop joint and comprehensive MNH plans (inclusive of all stakeholders) as a component of the MCH program in line with the One-Plan, One-Budget, One-M&E principle					
	Mobilize resources at all levels by involving development partners to disclose their resources as an effort to increase/improve transparency					
	Ensure accountability of different partners for MNH through a framework ensuring active and regular engagement in MOH/MCH directorate's program leadership (such as compliance to TWG membership)					
	Advocate for increased community resources and investment in RMNH					
	Advocate for fund mobilization from existing and new donors for high-impact interventions on MNH					
	Strengthen Public-Private Partnerships for better resource mobilization, allocation and utilization in MNH					
	Enhance multi sectoral approach for resource mobilization and allocation for MNH					
	Mobilize for social and community maternal and newborn health insurance including fee waiver system for RMNH services: total fee exemption, third party reimbursement					
Strengthen logistics and supply chain management for increased availability of essential and lifesaving MNH commodities	Support PFSA and conduct annual forecasting, quantification and procurement planning of MNH commodities including supplies and consumables					
	Work with PFSA in the routine pipeline monitoring of lifesaving MNH commodities; identify gaps such as stock-outs and implement immediate remedial actions					
	Conduct regular assessment of lifesaving MNH commodity stock status in health facilities jointly with PFSA					
	Collaborate with PFSA and FMHACA for procurement specification, inspection, quality testing, storage and distribution, pharmaco-vigilance)					
	Collaborate with PFSA and provide trainings on the integrated pharmaceuticals logistics system for MNH program staff and service providers (F/Q, LMIS, ICS)					
	PFSA and MOH will work together to build and equip regional warehouses/hubs					
	Implement an appropriate ICT technology for advance monitoring of stock-outs of lifesaving MNH commodities					
	Enhance the generation, aggregation and reporting of information for demand-driven supply and quality control					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Improve the capacity and motivation of HDA's and HEWs	Provide basic training for newly recruited HDA's on MNH					
	Provide refresher training for all HDA's in action on MNH					
	Provide family health-card for all HDA's and households					
	Organize HDA festival in all kebeles and provide recognition for the best performers					
	Upgrade level III HEWs to level IV					
	Train and deploy Level I and Level II HEWs by training HDAs					
	Conduct IRT for HEWs					
	Strengthen supportive supervision in all kebeles					
Empowering women, men, and families to recognize pregnancy-related risk and importance of facility birth	Hold monthly meetings with all pregnant women to discuss birth preparedness and facilitate the participation of health workers from the PHCU					
	Support HDAs and HEWs as a vehicle to disseminate information on pregnancy/ANC, birth/SBA, PNC and FP					
	Promote institutional delivery through community mobilization by HDAs					
	Ensure representation of women groups into the governing structure of PHCUs					
	Promote male involvement as part of shared responsibility and collective action to improve household health-seeking behavior					
	Involve community opinion leaders such as religious leaders, tribal leaders and elders to enhance acceptance of MNH services					
	Design and implement context-specific interventions in pastoralist and agrarian communities including mobile clinics					
	Create mechanisms for households in establishing accessible maternity waiting homes at their respective PHCU					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Increase awareness and positive attitude towards elimination of HTP	Raise awareness on harmful consequences of HTPs of all households through HDA interaction and other social networks					
	Support HDAs and HEWs as a vehicle to disseminate information and awareness on the negative health and social consequences of HTPs associated with pregnancy and delivery					
	Design, develop and implement IEC/BCC messages and materials for community members (men, women, adolescents) on specific HTPs of MNH					
	Enlist religious and other community leaders to institute and apply cultural sanctions or disincentives that discourage FGC and early marriage					
	Work with law enforcement bodies to harness legal protection against HTPs					
	Effectively implement, monitor and evaluate the FGC elimination initiative					
Ensure access to quality package of essential MNH care through HEP	Develop job aids on pre referral management of MNH emergencies before referral to next higher level					
	Create mechanisms such as redesigning health facilities, establishing mobile service outlets and outreach services to make services accessible to vulnerable and marginalized groups (disabled, displaced, out of school youth, agrarian, etc.)					
	Establish a mechanism for midwives to mentor HEWs in educating the community on pregnancy/birth and its complications, including birth preparedness and estimated date of delivery by creating forums at Kebele level					
	Pre-deployment training for newly graduating Level III HEWs on new MNH initiatives					
	Strengthen level IV HEW training facilities through equipping them with skill labs for MNH-related issues					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Quality MNH cont'd……	Link health posts with health centers for functional referral system for improved MNH outcome					
	Establish mechanisms for communications and feedback between health posts and health centers					
	Ensure Provision of FANC including PMTCT and nutrition during motherhood to all pregnant and lactating women					
	Strengthen the existing Community-Based Newborn Care (CBNC)					
	Strengthen Integrated Community Case Management (ICCM) for neonates					
	Introduce birth notification system from health facility to HP and HP to community					
	Ensure provision of comprehensive PNC including treatment of post-natal complications					
	Introduce performance improvement system/CQI in all health posts					
	Ascertain newborn care services are routinely provided at health post					
	Promote early initiation of breastfeeding through media messages, group education and training of HEWs					
	Make sure that women with all forms of puerperal problems including infections, psychosis and fistula are appropriately identified and referred by all health posts from the community					
	Implement surveillance mechanism/mapping to identify pregnant women in all kebeles					
	Implement maternal and perinatal death surveillance and response mechanisms at community level					
	Implement kangaroo mother care for preterm and low BWT infants, and newborn sepsis management in all households/ kebeles					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	HEWs and HDAs to include the issue of obstetric fistula in their regular community-level meetings with all pregnant women, religious leaders, TBAs and other opinion leaders at Kebele level to discuss and promote MNCH issues including obstetric fistula					
	Use IEC, media and group education to educate pregnant women on importance of EBF and additional meals during pregnancy and postpartum					
	Supplement pregnant women with iron/foliate tablets.					
	De-worming of pregnant women after third month of pregnancy					
	Promote Preconception Care including healthy lifestyles					
	Promote Preconception Care including healthy lifestyles					
	Step up campaigns to reduce adolescent pregnancy					
	Promote healthy timing and spacing of pregnancy					

11.1.4. REPRODUCTIVE ORGAN CANCERS (ROCs), STI/HIV, SOCIAL DETERMINANTS OF RH, AND PELVIC ORGAN

Strategic priorities	Activity	2016	2017	2018	2019	2020
Improve public awareness of ROCs risk factors and prevention modalities	Promote physical exercise and diet diversification to reduce risk of obesity and its complications					
	Promote early detection and treatment of ROCs primarily cervical cancer, breast cancer and ovarian cancer in women, and penile and testicular cancer in men					
	Develop and use IEC/BCC materials to raise public's awareness of ROCs risk and symptoms:					
	Raise public awareness on the advantages of having a single sexual partner, marriage and delivery between 20 and 35 years, limiting the fertility rate, breast feeding, and avoiding obesity and the use of alcohol					
	Raise women's awareness of suggestive symptoms for the common ROCs like cervical cancer, breast cancer, and testicular cancer					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Describe breast self-examination techniques and advocate early reporting of suspicious lumps/lesions					
	Promote precancerous and cancer screening programs for early detection via all possible public media:					
	Promote the importance of VIA screening for cervical precancerous lesion					
	Promote the advantages of having mammography and/or fine needle aspiration for breast lesions and lumps					
	Raise public's awareness of the advantages of participating in the national cancer surveillance					
	Introduce and scale up HPV vaccination for girls aged 9-13 years to ensure its universal accessibility:					
	Advocate the benefits of HPV vaccination, primarily to reduce the risk of cervical cancer					
	Promote integration of HPV vaccination in the adolescent youth health					
	Plan and implement school-based and out of school HPV vaccination programs					
Build the capacity for precancerous lesions screening and treatment (the case of cervix and breast)	Establish VIA screening set up for precancerous cervical lesion and cryotherapy in all hospitals and health centers, and/or LEEP therapy set up in general and specialized hospitals					
	Build health workers' capacity to identify and treat precancerous cervical and breast lesions:					
	Improve health care providers' knowledge and skills in performing VIA, mammography and breast examination					
	Capacitate the health providers' skills in performing cryotherapy and/ or LEEP therapy through the provision of pre-and in-service training programs					
	Establish effective referral system for the management of patients with precancerous cervical and breast lesions					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Improve the ROCs detection and management capacity at different levels	Support the development of breast cancer screening guidelines					
	Strengthen the referral and management system for patients with ROCs:					
	Improve the referral system to link the ROCs patients from the lower health facility to the level of oncology center					
	Provide appropriate surgical treatment for ROCs in the general and specialized hospitals; radiotherapy, chemotherapy and palliative care in the oncology centers					
	In collaboration with partners, improve the system and the capacity of ROCs detection:					
	Strengthen the national cancer prevalence survey and cancer registry					
	Build health workers' capacity in detecting the early signs of ROCs					
	Strengthen the tissue processing and transportation facility to a specialized hospital					
Strengthen the integration of STI/HIV prevention, detection and treatment in the RH services	Keep the momentum on advocating the STI/HIV prevention behaviors and practices					
	Increase public awareness of the advantages of early diagnosis and early initiation of treatment for STIs including HIV					
	Ensure integration of STI/HIV prevention and detection services at all levels of reproductive health care platforms					
	Provide STIs diagnosis, treatment and counseling services to couples/ partners as part of a comprehensive reproductive health package in the clinics of antenatal care, general gynecologic, ART, family planning and adolescent and youth health:					
	Provide HIV testing, counseling and linking to the ART clinic to couples/ partners as part of a comprehensive reproductive health package					
	Ensure adequate capacity at all levels for the provision of integrated STI/ HIV related services in all reproductive health care platforms:					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Advocate for the provision of integrated STI/HIV services in all reproductive health clinics					
	Build the health care providers' capacity to counsel, diagnose and treat STIs including HIV					
	Enhance positive attitude towards HIV-positive patients and denounce HIV related stigma and discrimination among the health professionals, and within the community					
	Provide essential physical facilities, drugs and supplies to strengthen and sustain the integrated STI/HIV services					
	Advocate for gender mainstreaming and women empowerment so that each sector will address the issues of gender and RH in their policies, strategies and plans as crosscutting issues					
Improve advocacy and partnership to enhance gender empowerment and decision making power on RH matters	Strengthen intersectoral collaborations with other sectors such as: Ministry of Education (MOE), Ministry of Women, children and Youth Affairs (MOWCYA), Ministry of Finance and Economic Development (MOFED) and Micro Finance Enterprises to improve women education, employment and income-generating activities					
	Strengthen partnership with other governmental organizations, non-governmental organizations (NGOs) and private sector to mobilize resources and maximize efforts					
	Advocate for the implementation of affirmative action for women in education and employment					
	Improve women's participation in decision-making related to reproductive health matters, starting from planning through implementation, monitoring and evaluation.					
	Maximize the utilization of Medias, including Mass-Media, to promote the importance of women empowerment and seek attention from all actors					
	Strengthen community-based behaviour change interventions to raise community awareness on female education					

Strategic priorities	Activity	2016	2017	2018	2019	2020
Build the capacity of women and girls leaders to enhance their leadership roles in all gender and RH matters	Strengthen the capacity of women leaders by providing leadership trainings for women leaders in collaboration with the Ministry of Women, Children and youth Affairs and other donors					
	Work with MOE to strengthen the capacity of in school gender clubs' leaders by organizing and providing Training of Trainers (TOT) on leadership, life skills and peer education on Gender equality and Sexual and Reproductive Health (SRH). This should be passed on to all gender club leaders of all universities and should be cascaded to the remaining adolescents and youth					
	Strengthen families', teachers', girls' and other communities' forums working on gender and sexual and reproductive health by arranging awareness raising forums and community conversations to ensure their full participation					
	Strengthen the offices of Gender club leaders by equipment and IEC/BCC materials on gender and SRH					
Advocate for the re-enforcement of the implementations of the legal frameworks that protect and advance women's reproductive health rights	Advocate for the implementation of existing laws that protect reproductive rights such as family health law, abortion law, and laws related to harmful traditional practices					
	Organizing sensitization and advocacy workshops for law reinforcing bodies					
	Distribute the necessary framework documents (family health law, abortion law and guidelines) to all responsible bodies and offices					
	Work closely with the law-enforcing bodies (ministry of justice, police and others) in protecting reproductive rights and taking corrective measures against the perpetuators and rehabilitative care for the victims					
	Ensure that the victims of GBV are able to get quality care in a timely manner and with acceptable and affordable cost (preferably free of charge)					
	Mobilize the community and raise their awareness about the existing laws related to RH rights and build their active participation in the implementation of existing laws and policies					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Mobilize resources for the implementation of strategies targeted towards protecting RH rights by the government, bilateral and multilateral agencies					
	Advocate for the integration of RH rights into the school curricula including secondary and pre-service trainings.					
	Promote operational and population based researches on GBV, health system and other social determinants of RH including their magnitudes and root causes for the evidence-based and effective implementation of the designed interventions					
Work towards the elimination of the incidence of all forms of harmful traditional practices	Raise awareness on negative consequences of HTPs of all households through HDA interaction and other social networks					
	Use HDA and HEWs as a vehicle to disseminate information and awareness on the negative health and social consequences of HTPs associated with pregnancy and delivery.					
	Design, develop and implement IEC/BCC messages and materials for community members (men, women, adolescents) on specific HTPs					
	Strengthen social mobilization and community conversations on HTPs and cultural community norms that promote HTPs (early marriage, FGC and others)					
	Involve schools and other institutions that have significant role in influencing the knowledge and attitude of the adolescents and youth on HTPs and their effects					
Bridge the inequity gaps in the physical and financial access to quality RH services by all segments of the population	Enlist religious and other community leaders to institute and apply cultural sanctions or disincentives that discourage FGC and early marriage					
	Ensure that equity is taken in to account while expanding infrastructure and power deployment, particularly working on RH					
	Strengthen special incentives (hardship allowances) as motivation and retention mechanism for health workers in the rural/remote health facilities, particularly developing regional states and agrarian communities					

Strategic priorities	Activity	2016	2017	2018	2019	2020
	Follow on the implementation of fee-exempted policy for RH services and basic health care for all women in general and for adolescents and poor women in particular					
	Strengthen and scale up the implementation of the health insurance scheme so that the poor women can benefit.					
	Scale up maternity waiting homes initiatives at health centers for the women from the remote areas to get quality care in a timely fashion.					
	Advocate and closely work with the Ministry of Transportation so that equity is taken into account while planning road constructions, increasing emphasis to rural and developing regional states					
	Provide context-specific and culturally acceptable RH care services including mobile clinics/outreach services for pastoralists/agrarian communities, particularly adolescents and youth					
Improve the pelvic organ prolapse (POP) detection, management and prevention capacity at different levels.	Improve the detection of women living with POP in the community and link them with hospitals where they can get the treatment.					
	Strengthen the health facilities' capacity to diagnose and refer or treat women with POP.					
	From the perspective of POP, raise public's awareness of the advantages of marriage and delivery between 20 and 35 years, limiting the fertility rate, having skilled person attended delivery and avoiding chronic cough, constipation and heavy physical work.					

Intervention	2015	2016	2017	2018	2019	2020
Family planning						
FP methods	42	45	47	50	52	55
Safe abortion						
Safe abortion	40	47	54	61	68	75
Management of abortion complications						
Post-abortion case management	45	54	63	72	81	90
Management of ectopic pregnancy care						
Ectopic case management	15	32	49	66	83	100
Pregnancy care - ANC						
Daily iron and folic acid supplementation	19	50	70	80	90	100
Tetanus toxoid (pregnant women)	78	80	83	85	88	90
Syphilis detection and treatment	32	44	55	67	78	90
Basic ANC	67	73	78	84	89	95
Pregnancy care - Treatment of pregnancy complications						
Hypertensive disorder case management	55	62	69	76	83	90
Management of pre-eclampsia Management of other pregnancy	41	51	61	70	80	90
complications	41	51	61	70	80	90
Deworming (pregnant women)	58	64	71	77	84	90
Childbirth care - Facility births						
Chlorhexidine	0	18	36	54	72	72
Antenatal corticosteroids for preterm labor	41	51	61	70	80	90
Antibiotics for pPRoM	41	51	61	70	80	90
Induction of labor (beyond 41 weeks) Operative delivery for dystocia and other	41	51	61	70	80	90
pregnancy complications	41	51	61	70	80	90
Labor and delivery management	60	66	72	78	84	90
Active management of the 3rd stage of labour Pre-referral management of labor	41	51	61	70	80	90
complications	41	51	61	70	80	90
Management of eclampsia (Magnesium sulphate)	41	51	61	70	80	90
Neonatal resuscitation (institutional)	41	51	61	70	80	90
Management of obstructed labor	41	51	61	70	80	90
Kangaroo mother care	1	19	37	54	72	90
Feeding counselling and support for LBW infants	12	28	43	59	74	90

Childbirth care - Home births						
Clean practices and immediate essential newborn care	8.8	9	9	10	10	10
Postpartum care - Treatment of sepsis						
Maternal Sepsis case management	41	51	61	70	80	90
Postpartum care - Treatment of newborn sepsis						
Treatment of local infections	1	20	39	57	76	95
Newborn sepsis - Full supportive care	10	27	44	61	78	95
Newborn sepsis - Injectable antibiotics	1	20	39	57	76	95
Postpartum care - Other						
Clean postnatal practices	41	51	61	70	80	90
Mastitis	41	48	55	61	68	75
Treatment of postpartum hemorrhage	41	51	61	70	80	90
PMTCT						
PMTCT	87	89	91	93	95	97
Obstetric Fistula						
Obstetric fistula case screening	10	28	46	63	81	99
Obstetric fistula case identification	10	28	46	63	81	99
Obstetric fistula case treatment	10	28	46	63	81	99
Other sexual and reproductive health						
Treatment of syphilis	38	41	44	47	51	54
Treatment of gonorrhea	38	41	44	47	51	54
Treatment of chlamydia	38	41	44	47	51	54
Treatment of trichomoniasis	38	41	44	47	51	54
Treatment of PID (Pelvic Inflammatory Disease)	12	12	30	40	49	58
Treatment of urinary tract infection (UTI)	50	54	57	61	64	68
Cervical cancer screening	21	26	31	36	41	46
Basic breast cancer awareness	5	8	22	53	67	70
Feeding counselling and support for LBW infants	3	9	15	21	27	33

	2015	2016	2017	2018	2019	2020	Total
Family planning							
Pill	292,065	322,990	348,490	382,496	412,052	457,331	2,215,425
Condom	63,491	78,639	93,938	113,082	132,569	159,066	640,785
Injectable	4,425,414	4,575,145	4,545,525	4,548,379	4,362,963	4,165,688	26,623,114
IUD	69,435	113,352	125,162	201,224	297,695	347,461	1,154,329
Implant	569,945	733,251	818,185	979,511	1,069,071	1,328,551	5,498,513
Female sterilization	39,760	96,734	117,100	148,248	171,690	223,443	796,976
Safe abortion							
Safe abortion	204,853	237,807	271,361	297,109	325,431	341,769	1,678,329
Management of abortion complications							
Post-abortion case mgt	19,359	23,581	28,888	24,275	24,675	20,506	141,283
Management of ectopic pregnancy care							
Ectopic case management	18,275	21,360	24,578	27,043	29,825	31,551	152,633
Pregnancy care - ANC							
Daily iron and folic acid supplementation	169,755	435,108	600,807	661,059	729,053	771,249	3,367,030
Tetanus toxoid	3,167,672	3,180,242	3,230,315	3,200,126	3,225,506	3,155,109	19,158,970
Syphilis detection and treatment	1,299,558	1,724,609	2,153,543	2,509,019	2,886,754	3,155,109	13,728,592
Basic ANC	2,720,949	2,871,711	3,050,853	3,147,542	3,291,783	3,330,393	18,413,231
Pregnancy care - Treatment of pregnancy complications							
Hypertensive disorder case management	111,681	122,621	134,596	142,729	152,806	157,755	822,189
Management of pre-eclampsia	8,325	10,087	11,899	13,146	14,728	15,776	73,961
Management of other pregnancy complications	49,952	60,520	71,395	78,876	88,370	94,653	443,766
Deworming	2,355,448	2,531,536	2,769,956	2,892,133	3,092,951	3,155,109	16,797,133
Childbirth care - Facility births							
Chlorhexidine	0	304,441	750,349	1,209,358	1,697,814	2,129,357	6,091,320
Antenatal corticosteroids for preterm labor	166,506	201,732	237,982	262,921	294,567	315,511	1,479,219
Antibiotics for pPRoM	83,253	100,866	118,991	131,461	147,283	157,755	739,609
Induction of labor (beyond 41 (weeks	83,253	100,866	118,991	131,461	147,283	157,755	739,609
Operative delivery for dystcoia and other complications	49,952	100,866	118,991	157,753	235,653	94,653	757,868
Labor and delivery mgt	2,436,671	2,610,646	2,808,970	2,929,693	3,092,951	3,155,109	17,034,039
Active mgt of the 3rd stage of labour	1,665,058	2,009,406	2,364,216	2,644,236	2,953,031	3,155,109	14,791,057
Pre-referral mgt of labor complications	249,759	302,598	356,973	394,382	441,850	473,266	2,218,828
Management of eclampsia	33,301	40,346	47,596	52,584	58,913	63,102	295,844

Management of obstructed labor	116,554	121,039	118,991	131,461	117,827	220,858	826,729
Kangaroo mother care	3,323	58,560	106,991	142,648	176,570	198,460	686,552
Feeding counselling and support for LBW infants	39,878	86,299	124,341	155,857	181,474	198,460	786,308
Childbirth care - Home births							
Clean practices and immediate essential newborn care	265,852	264,180	260,249	278,067	272,484	259,425	1,600,256
Postpartum care - Treatment of sepsis							
Maternal Sepsis case mgt	123,863	134,732	141,113	136,253	130,792	140,089	806,842
Postpartum care - Treatment of newborn sepsis							
Treatment of local infections	3,021	56,769	105,219	142,648	179,545	205,296	692,498
Full supportive care	3,021	3,646	5,344	6,446	7,014	7,147	32,617
Injectable antibiotics	3,021	15,675	26,276	31,700	34,584	32,778	144,034
Postpartum care - Other							
Clean postnatal practices	1,238,626	1,497,020	1,763,907	1,946,470	2,179,871	2,334,822	10,960,717
Mastitis	24,773	28,179	31,808	33,924	37,058	38,914	194,656
Treatment of postpartum hemorrhage	83,253	100,866	118,991	131,461	147,283	157,755	739,609
PMTCT							
PMTCT	3,514,521	3,520,417	3,550,226	3,493,096	3,497,980	3,400,506	20,976,745

Obstetric Fistula							
Obstetric fistula case screening	242	658	1,064	1,401	1,766	2,055	7,185
Obstetric fistula case identification	242	658	1,064	1,401	1,766	2,055	7,185
Obstetric fistula case treatment	242	658	1,064	1,401	1,766	2,055	7,185
Other sexual and reproductive health							
Treatment of syphilis	6,924,699	7,793,646	8,628,254	9,500,724	10,620,407	11,581,635	55,049,364
Treatment of gonorrhea	6,924,699	7,793,646	8,628,254	9,500,724	10,620,407	11,581,635	55,049,364
Treatment of chlamydia	6,924,699	7,793,646	8,628,254	9,500,724	10,620,407	11,581,635	55,049,364
Treatment of trichomoniasis	3,447,920	3,882,288	4,299,251	4,735,397	5,295,006	5,775,641	27,435,502
Treatment of PID	343,837	627,944	925,676	1,272,671	1,606,534	1,958,989	6,735,651
Treatment of urinary tract (infection (UTI	11,988,744	13,506,319	14,707,252	16,224,640	17,536,275	19,189,844	93,153,074
Cervical cancer screening	1,164,897	1,549,097	1,914,417	2,304,693	2,721,544	3,166,240	12,820,888
Basic breast cancer awareness	840,474	1,444,380	4,117,026	10,281,881	13,476,974	14,600,578	44,761,313
Identification and mgt of infertility	250,714	323,939	398,555	477,252	560,101	647,367	2,657,929
Total	**64,646,732**	**73,590,169**	**84,011,435**	**97,810,108**	**109,511,695**	**118,013,116**	**547,583,254**

	2016	2017	2018	2019	2020	Total
Family planning						
Pill	31,509,608	33,997,274	37,314,764	40,198,130	44,615,352	187,635,128
Condom	5,654,449	6,754,514	8,131,074	9,532,248	11,437,493	41,509,778
Injectable	265,770,069	264,049,438	264,215,229	253,444,397	241,984,751	1,289,463,884
IUD	2,553,978	2,820,070	4,533,856	6,707,484	7,828,768	24,444,156
Implant	149,794,619	167,145,480	200,102,524	218,398,626	271,407,263	1,006,848,512
Female sterilization	34,092,527	41,270,266	52,247,989	60,509,736	78,749,150	266,869,668
Safe abortion						
Safe abortion	27,858,969	31,789,759	34,806,100	38,123,993	40,038,021	172,616,842
Management of abortion complications						
Post-abortion case mgt	10,421,642	12,766,832	10,728,030	10,904,917	9,062,568	53,883,990
Management of ectopic pregnancy care						
Ectopic case management	13,386,267	15,444,884	17,039,402	18,842,335	19,986,140	84,699,027
Pregnancy care - ANC						
Daily iron and folic acid supplementation	8,047,345	11,111,972	12,226,328	13,483,876	14,264,297	59,133,819
Tetanus toxoid	17,940,226	18,222,697	18,052,398	18,195,566	17,798,448	90,209,334
Syphilis detection and treatment	10,380,795	12,912,193	14,984,770	17,173,107	18,695,615	74,146,480
Basic ANC	3,553,510	3,775,185	3,894,829	4,073,316	4,121,092	19,417,932
Pregnancy care - Treatment of pregnancy complications						
Hypertensive disorder case management	21,550,668	23,655,308	25,084,536	26,855,717	27,725,495	124,871,723
Management of pre-eclampsia	1,803,987	2,126,100	2,346,628	2,626,525	2,810,548	11,713,789
Management of other pregnancy complications	4,713,757	5,359,176	5,698,029	6,134,286	6,303,134	28,208,382
Deworming	48,605,382	53,183,046	55,528,833	59,384,524	60,577,961	277,279,746

Childbirth care - Facility births						
Chlorhexidine	2,374,643	5,852,728	9,433,005	13,242,967	16,609,006	47,512,348
Antenatal corticosteroids for preterm labor	16,294,925	19,223,059	21,237,514	23,793,690	25,485,459	106,034,647
Antibiotics for pPRoM	22,642,886	24,920,831	25,553,810	26,412,791	25,916,461	125,446,780
(Induction of labor (>41 wks	1,615,873	1,906,239	2,106,000	2,359,481	2,527,244	10,514,837
Operative delivery for dystcoia and other complications	53,059,025	62,573,565	82,930,596	123,843,455	49,727,471	372,134,112
Labor and delivery management	337,178,585	362,793,099	378,385,158	399,470,715	407,498,783	1,885,326,341
Active mgt of the 3rd stage of labour	8,058,880	9,481,872	10,604,913	11,843,361	12,653,809	52,642,835
Pre-referral mgt of labor complications	86,678,929	102,254,792	112,970,446	126,567,722	135,566,889	564,038,778
Management of eclampsia	7,920,465	9,347,107	10,330,343	11,577,882	12,405,550	51,581,347
Neonatal resuscitation	27,385,911	31,390,271	33,670,281	36,622,671	38,063,758	167,132,893
Management of obstructed labor	106,265,867	104,467,855	115,415,424	103,445,584	193,901,278	623,496,008
Feeding counselling and support for LBW infants	12,434,152	17,915,370	22,456,216	26,147,274	28,594,599	107,547,610
Childbirth care - Home births						
Clean practices and immediate essential newborn care	8,797,194	8,666,279	9,259,633	9,073,713	8,638,840	44,435,658
Postpartum care - Treatment of sepsis						
Maternal Sepsis case mgt	196,271,001	205,566,230	198,486,813	190,532,053	204,075,547	994,931,644
Postpartum care - Treatment of newborn sepsis						

Postpartum care - Treatment of newborn sepsis						
Treatment of local infections	5,642,033	12,982,033	21,023,246	30,769,445	40,108,805	110,525,562
Full supportive care	2,262,376	3,316,146	3,999,897	4,352,463	4,435,255	18,366,137
Injectable antibiotics	2,577,577	4,633,506	5,966,879	6,921,106	6,949,698	27,048,766
Postpartum care - Other						
Clean postnatal practices	8,632,093	10,171,014	11,223,701	12,569,536	13,463,010	56,059,354
Mastitis	1,429,256	1,613,318	1,720,643	1,879,582	1,973,713	8,616,512
Treatment of postpartum hemorrhage	32,978,315	38,904,389	42,981,322	48,154,612	51,578,482	214,597,119
PMTCT						
PMTCT	252,952,699	255,094,548	250,989,586	251,340,532	244,336,757	1,254,714,122
Obstetric Fistula						
Obstetric fistula case screening	23,936	38,738	51,018	64,278	74,797	252,767
Obstetric fistula case treatment	324,029	524,412	690,652	870,151	1,012,547	3,421,792
Other sexual and reproductive health						
Treatment of syphilis	300,641,293	332,836,451	366,492,113	409,684,085	446,763,642	1,856,417,584
Treatment of gonorrhea	36,963,058	40,921,368	45,059,243	50,369,583	54,928,417	228,241,670
Treatment of chlamydia	459,707,711	508,937,018	560,399,567	626,443,996	683,141,990	2,838,630,281
Treatment of trichomoniasis	18,479,405	20,464,119	22,540,142	25,203,842	27,491,629	114,179,136
Treatment of PID	72,105,699	106,293,765	146,138,601	184,475,548	224,947,343	733,960,956
Treatment of urinary tract infection (UTI	180,444,062	196,488,493	216,760,763	234,284,173	256,375,804	1,084,353,295
Cervical cancer screening	10,698,072	13,220,973	15,916,222	18,794,996	21,866,064	80,496,327
Total	**2,930,477,750**	**3,219,183,782**	**3,511,729,063**	**3,815,700,068**	**4,118,518,743**	**17,595,609,406**

Activity	2015	2016	2017	2018	2019	2020
Training	6,222,002	76,921,542	269,796,825	83,134,623	247,406,553	45,895,807
Supervision and coordination	1,952,697,074	2,148,887,615	2,364,353,795	2,601,464,926	2,862,400,252	3,149,559,158
M&E and research	32,806,663	193,322,757	73,753,478	58,192,725	59,613,745	32,492,526
Infrastructure and equipment	15,741,006	345,418,515	307,446,005	253,743,349	248,903,792	169,576,196
Communication, media & outreach	38,444,857	293,273,941	252,407,198	197,698,663	202,411,117	107,231,708
Advocacy	68,459,025	532,270,341	456,495,712	355,002,999	363,850,574	187,091,622
General programme management	142,917,384	1,102,173,319	946,232,919	735,433,563	753,814,944	386,715,996
Other activities	278,091,101	2,190,454,033	1,892,697,294	1,479,880,806	1,517,035,057	796,491,645

SN	Indictor	Type	2015 Base-line	Yearly Targets					Periodic-ity	Source of Data
				2016	2016	2018	2019	2020		
I	**Improving health status**									
1	(Maternal Mortality Ratio (MMR	Impact	353					199	Years 5	UN estimate
2	(Neonatal Mortality Rate (NMR	Impact	28					10	Years 5	EDHS/Vital registration
3	Stillbirth rate per 1000 pregnancies lasting 7 months or above	Impact	18					10	Routine/5 Years	HMIS/EDHS
4	HIV infection among children born to HIV+ve mothers (%)	Impact	12					0	Years 5	Special facility survey
5	(Total fertility Rate (TFR	Impact	4.1					3	Years 5	EDHS
II	**Improving access to quality RH services**									
6	(%) Unmet need for modern contraceptives	Out-come	25.3					10	years 5	EDHS
7	(%) Adolescent pregnancy Rate	Out-come	12					3	years 5	EDHS
8	(%) Contraceptive Prevalence Rate (CPR) any method	Out-come	42	45	48	50	53	55	Annual/5 years	PMA/EDHS
9	LARC (%) as share of modern contraceptive methods ((% method mix	Out-come	6.1					46	Annual/5 years	PMA/EDHS
11	of pregnant women having 1st ANC visit within the % first 4 months	Outcome	18					95	Routine /5 years	HMIS/EDHS
12	of pregnant women having at least 4 ANC visits %	Outcome	65	72	78	84	90	95	years 5	EDHS
13	of pregnant women who received at least 2 doses of % TT during pregnancy	outcome	72	81	83	85	88	95	Routine/5 years	HMIS/EDHS
14	of deliveries attended by skilled professionals %	Outcome	58	66	73	79	85	90	Routine/5 years	HMIS/EDHS
15	of births by caesarean section among all live births % ((C/S rate	Outcome	1.6					8	Routine/5 years	HMIS/EDHS
16	of women who attended post natal care at least % once during the early post-partum period (within 7 days .(after delivery	Outcome	84	86	89	91	93	95	Routine/5 years	HMIS/EDHS
17	Case fatality rate due to direct obstetric complications (%) at facility	Outcome	NA					1>	Routine/2-3 years	HMIS/special survey
18	(Prevalence of obstetric fistula (number of cases	Outcome	NZ					1,600>	years 2-3	Special Popn survey
18	Prevalence of obstetric fistula (%) among mothers having obstructed labor	Outcome	NA					1>	Routine	HMIS
19	of pregnant women attending ANC having blood test % for HIV & known their status	Outcome	90.5					100	Routine	HMIS
20	of HIV-Positive pregnant and lactating women who % received ART at ANC+ labor & delivery + PNC for the .+first time based on option B	Outcome	57					95	Routine	HMIS
21	of infants born to HIV-infected women receiving a % virological test for HIV	Outcome	NA					95	Routine	HMIS
22	Proportion of pregnant women supplemented with folic acid and iron folate	Outcome	19	50	70	80	90	100	Routine/5 years	HMIS/survey
23	Prevalence of iron deficiency anemia among women of child bearing age	Outcome	16.6					5 >	years 5	EDHS

III	Improve health infrastructure and referral for RH services	Type	Base- 2015 line	Target 2020	Periodicity	Source of Data
24	of facilities (health centre & Hospitals) having running % water supply all the time	Input	75	100	Annual/2-3 Years	Admin. Report/SPA+/ Special facility survey
25	of facilities (health centre & Hospitals) having electric % power supply all the time	input	50	100	Annual/2-3 Years	Admin. Report/SPA+/ Special facility survey
26	of health facilities equipped as per the norms for RH % (services (EmONC	Input	17	100	Years 2-3	SPA+/ Special survey
27	of all health centers providing the 7 BEmONC signal % functions	Input	56	100	Years 2-3	SPA+/ Special survey
28	of HCs that established functional newborn corner %	Input		95	Years 2-3	SPA+/ Special survey
29	of hospitals having all the 9 CEmONC signal func- % tions	Input	83	100	Years 2-3	SPA+/ Special survey
30	of hospitals having NICU %	Input		95	Years 2-3	SPA+/ Special survey
31	(met need for direct obstetric complications (EmONC %	Output		100	Years 2-3	SPA+/ Special survey
32	of facilities having and utilizing guidelines for MNH %	Input		100	Years 2-3	Admin report
33	of HCs and hospitals providing comprehensive abor- % tion care services	Input		100	Annual/5years	Admin report/ Special survey
34	of the health facilities using standard referral slip %	Output		100	Annual/5years	Admin report/ Special survey
35	of HCs addressing referral in their monthly joint plan- % ning and performance review meeting with HPs	Output		100	Annual/5years	Admin report/ Special survey
36	of health facilities that established referral and con- % .sultation networking	Output		80	Annual/5years	Admin report/ Special survey
37	health facilities having pre referral management insti- % tuted and escorted to next higher level	Output		99	Annual/5years	Admin report/ Special survey
38	public/private primary hospitals having access to % safe whole blood	Input		100	Annual/5years	Admin report/ Special survey
39	of general and specialized public/private hospitals % having access to the majority of blood products for transfusion	Input		100	Annual/5years	Admin report/ Special survey
40	of all zonal administrations established at least one % blood bank	Input		100	Annual/5years	Admin report/ Special survey
41	of SDPs offering at least 4 modern contraceptive % methods	Input		100	Years 3-5	Facility survey
42	of hospitals and health centers offering IUCD and % implants	Input		100	years 3-5	Facility survey
43	of Hospitals offering VSC services for male and % female	Input		100	years 3-5	Facility survey
44	of private service outlets proving all forms of contra- % ception	Input		100	years 3-5	Facility survey
45	of health facilities suitable for clients with disabilities %	Input		100	years 3-5	Facility survey
46	of referral/specialty hospitals providing comprehen- % sive service for couples with infertility	Input		50	years 3-5	Facility survey

IV	Improve regulatory system for quality improve- ment in RH	Type	Base- 2015 line	Target 2020	Periodicity	Source of Data
47	of pre-service training of health providers' cur- % riculum that included essential RH competencies ((MNH, FP, AYH, ROC, STI/HIV	Output		100%	years 3-5	Special survey
48	of medical schools that started producing subspecial- # ists on reproductive endocrinology and infertility	Output		3	years 3-5	Special survey
49	Roadmap for quality improvement of preservice educa- (#) tion on MNH care developed and implemented	Output		1	years 3-5	Special survey
V	**Improve logistics supply and management for RH**					
50	of primary level health care facilities having all the % recommended essential drugs	Input	90	100	Annual	LMIS/ Special study
51	of secondary level health care facilities having the % recommended essential drugs	Input	90	95	Annual	LMIS/ Special study
52	of tertiary level health care facilities having the rec- % ommended essential drugs	Input	90	90	Annual	LMIS/ Special study
53	MNH drugs and supplies wastage rate	Input	8	2	Annual	LMIS/ Special study
54	of direct delivery of MNH pharmaceuticals to health % facilities	Input	67	100	Annual	LMIS/ Special study
55	of essential MNH drugs procured from local manu- % facturers	Input	25	60	Annual	LMIS/ Special study
56	of health facilities with stock-out of essential MNH % drugs	Input		0	Annual/5 years	Admin report/ special survey
57	of service delivery points (public, private, NGOs) % with adequate supplies of contraceptives (recommend- (ed for its level	Input		100	Routine/Annual	Facility reports/ PMA 2020
58	of service delivery points (public, private, NGOs) % experiencing stock-outs to their level	Input		0	Routine/Annual	Facility reports/ PMA 2020
V	**Improve resource mobilization and utilization**					
59	of government's share of healthcare financing for % RH	Input	8.5	15	Annual/5 years	Admin report/NHA
60	of RH funding out of the total health care financing %	Input	25	50	Annual/5 years	Admin report/NHA
61	of spending from internal revenue through health % care financing	Input		25	Annual/5 years	Admin report/NHA
62	Joint partners planning and coordination meetings (quarterly (% implemented	Output		100	Annual	Admin report
63	regional governments having budget line for con- % traceptive commodities and supplies procurement that could cover at least 15% of their respective commodity .cost	Input		100	Annual	Admin report
VII	**Improve development and management of HRH**	**Type**	**Base- 2015 line**	**Target 2020**	**Periodicity**	**Source of Data**
64	National health professionals density per 1000 popula- tion	Input	0.84	1.6	Annual	Admin report
65	of urban and rural Health centers staffed with 3 & 2 % midwives, respectively	Input		100	Annual	Admin report
66	of primary hospitals staffed with 2 (IESO), 3 anes- % .thetists and 3 midwives	Input		100	Annual	Admin report
67	of general hospitals staffed with at least 5 Obs-Gyn % .specialist 7 anesthetists and 13 midwives	Input		100	Annual	Admin report
68	providers at all levels having the required continuing % professional development (CPD) course Annual	Output		100	Annual	Admin report

69	Competency based in-service training curriculum developed for all MNH care providers (% of health (training institution	Output		100	Annual	Admin report
70	of MNH service providers trained on BEmONC, % PMTCT of HIV, CAC, neonatal resuscitation	Output		90	Annual	Admin report
VIII	**Enhance use of technology and innovations**					
71	A unit in the infrastructure directorate will be established to improve the use of technologies and innovation	Output		1	Annual	Admin report
72	of urban kebeles initiated toll free line for ambulance, # referral, emergency service or awareness creation by 2016	Output		200	Annual	Admin report
73	of kebeles initiated m-health services (referral ser- # vices and for consultation)by HEWs) by 2016	Output		200	Annual	Admin report
74	Effectiveness of m-health evaluated and a documenta- (tion of practices will be produce (# of evaluation	Output		1	Annual	Admin report
IX	**Enhance leadership and good governance**					
75	RH issues got full attention in developing sectorial/ (intersectorial policies and plans (% implemented	Output		100	Annual	Admin report
76	Task force established for intersectorial collaboration (#) on RH at F	Output		1	Annual	Admin report
77	of primary level health care units having regular % review forum to address quality and other MNH issues	Output		90	Annual	Admin report
78	facilities conducting regular supervision of catch- % ment facilities and providing feedback	Output		100	Annual	Admin report

12. Annex 3: Detail strategies on MNH, FP, AYH and others

1. Maternal and Neonatal Health (MNH) Strategy, 2016-2020
2. Family Planning and Fertility Strategy, 2016-2020
3. Costed Implementation Plan for Family Planning, 2016-2020
4. Adolescent and Youth Health Strategy, 2016-2020

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