continuous, cyclical process is participatory and relies on close collaboration with global, regional, national, and local partners to strengthen service delivery and health systems, more generally. Using this cyclical approach ensures interventions are tailored to address the diverse needs of the communities that the project serves; and, eventually, is scaled up to meet the needs of larger populations beyond the communities where the model was tested. The evidence to action cycle structures the information presented in this brief regarding the scale-up of expanded contraceptive at YF units in Ethiopia.

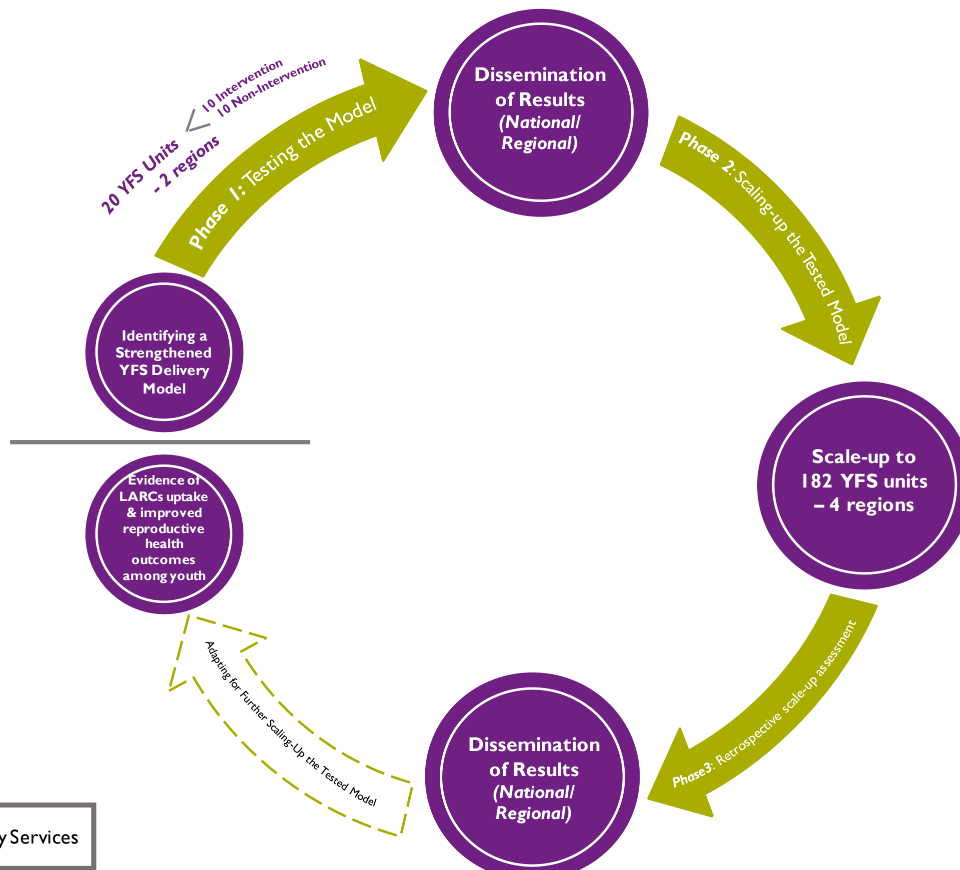
Phase 1: Testing a Service-Delivery Model Providing Expanded Contraceptive Choice to Youth

E2A and the Integrated Family Health Program Plus (IFHP+) conducted the study that tested a model offering voluntary expanded contraceptive choice, including LARCs, to youth in the same place they receive other YFS.[3-4] This approach represented a departure from the standard practice, where YFS providers referred youth to the maternal and child health (MCH) unit to receive LARCs. The piloting of this expanded choice model was in direct alignment with the mission of IFHP+, the implementing partner. IFHP+, a USAID-funded program, implemented by Pathfinder International and John Snow Inc. from 2008-2016, used an integrated model to strengthen RH and maternal, newborn and child health services for rural and underserved populations in Ethiopia. This included targeting youth with RH services[5] at YFS units in 248 health centers across six regions (Amhara; Oromia; Southern Nations, Nationalities and Peoples (SNNP); Tigray; Somali; and parts of Beneshangul Gumuz). A three-pronged service-delivery model that was tested at 20 selected YFS units (10 intervention and 10 non-intervention) in Amhara and Tigray[3-4] addressed:

1. **Supply:** competency-based skills training on LARCs insertion, removal, and infection control to YFS providers (i.e., health officers, nurses or midwives).
2. **Demand:** refresher counseling training for peer educators regarding the safety and effectiveness of LARCs (including dispelling myths and misperceptions) and referrals for services.
3. **Supportive Supervision:** supportive supervision on data collection by the project's monitoring and evaluation (M&E) officers and IFHP+'s AYRH and M&E officers, as well as supportive supervision for services by Regional Health Office and IFHP+ technical staff.

Results of the pilot study showed that training YFS providers to counsel on, and provide, all contraceptive methods, including LARCs, in one location with other RH services—referred to as a 'one-stop shop'—resulted in higher LARCs uptake among all sexually active young women, including those delaying their first pregnancy.[3-4] The number of new LARCs acceptors rose from 116/pre-intervention to 665/post intervention in the intervention arm, as compared to 95/pre-intervention to 263/post-intervention in the control arm.[3] IFHP+ disseminated the results of the study nationally in August 2015

Figure 1: E2A's approach to generating, disseminating and implementing an evidence-based, action-oriented learning strategy.



YFS = Youth Friendly Services

to representatives of the Amhara and Tigray Regional Health Bureaus (RHBs), the FMOH, members of the Ethiopia Society of Obstetricians and Gynecologists, and other high-level stakeholders. Based on study results, IFHP+ urged the FMOH and RHBs to scale up the tested model to other YFS units by training all YFS providers to offer LARCs at YFS units.

Phase 2: Scale-Up the YFS Delivery LARCs Model

IFHP+, in collaboration with the Amhara and Tigray RHBs, scaled up the tested model to 55 YFS units in Amhara and 52 YFS units in Tigray. IFHP+ also worked with the Oromia and SNNP RHBs to scale up the model to an additional 75 YFS units, 49 in Oromia and 26 in SNNP. At these 182 YFS units, YFS providers (health officers, nurses or midwives) were trained to provide LARCs services, peer educators were trained to dispel myths and misperceptions about LARCs, and routine supportive supervision was carried out by IFHP+ and RHB technical staff. The supportive supervision component of the tested LARCs service delivery model was not scaled-up. To the best of our knowledge, YF units in Tigray that were not scaled-up by IFHP+ did not include the peer educator component. It is important to note that addressing systemic health systems challenges, including staff turnover and absences, poor quality of care, commodity security issues, and data quality problems were not components of the tested model or its scale-up.

Phase 3: Assessment of Scale-Up

A review of three systematic scale-up frameworks—ExpandNet's *Nine Steps for Developing a Scaling-up Strategy,*[6] the *Complex Adaptive Systems (CAS)/Paina and Peters Framework*,[7] and the *AIDED/Perez-Escamilla Framework*[8]—show that several key factors are necessary for successfully scaling up (geographically expanding) a 'tested' service-delivery model. The following six elements were synthesized from this literature[6-8] and comprised the analytical framework used for understanding the scale up experience within the context of Ethiopia's health system:

1. Stakeholder engagement
2. Roles and responsibilities
3. Supportive policy environment
4. Mobilizing financial resources
5. Quality of voluntary FP services (counseling and service provision)
6. Data availability and use

These six elements (**See Box 1**) constitute key components of planning and implementing a scale-up strategy. Alone, none of these individual six elements are sufficient for scale up. Rather, it is the interplay between these six elements and the particular characteristics of the health system—including strengths and weaknesses—that determine the effectiveness of scale up efforts. For example, without a supportive policy environment, it would be difficult to invest in strengthened YFS, secure financial commitment for YFS, and engage stakeholders for their support.

Box 1: Study Definitions - Six Scaling-Up Elements

The following four elements of scale-up contribute primarily to the processes involved in gaining and sustaining buy-in: stakeholder engagement, roles and responsibilities, supportive policy environment, and mobilizing financial resources. The remaining two, quality of voluntary FP services (counseling and service provision) and data availability and use, are related to the implementation of tested/pilot models.

Stakeholder engagement: is the process by which organizations involve people who may be affected by the decisions made or can influence the implementation of decisions to develop a common understanding and agree on solutions that help drive long-term sustainability. In scale-up planning and implementation, ensuring stakeholder engagement and buy-in, especially public-sector buy-in, is a necessary element for successful scale-up.

Roles and responsibilities: describe the specific function(s) and associated responsibilities in performing the designated function(s). Clarity in roles and responsibilities among individuals in each of the primary health delivery tiers and implementing partners is a necessary element for successful scale-up

Supportive policy environment: pertains to accessible national policies and/or guidelines supporting the intervention being scaled up. In scale-up planning and implementation, a supportive policy environment is necessary, and stakeholders must be aware of that policy environment.

Mobilizing financial resources: reflects an abiding interest, obligation and responsibility for contributing funds for scale-up implementation and integrating those costs in annual budgetary expenditures. Mobilizing financial resources and its integration in national, regional and sub-regional annual budgetary outlays is a necessary element for successful scale-up and sustainability.

Quality of voluntary FP services (counseling and service provision): directly influences contraceptive uptake at service-delivery outlets. For young clients, quality of care includes ensuring a separate space to maintain privacy and confidentiality and skilled service providers that offer YFS for expanded method choice at one site. Addressing youth needs, in addition to broader quality of care issues, is a necessary factor for successful scale-up and sustainability.

Data availability and use: are implementation factors directly influencing contraceptive uptake. Utilization of quality data can help to assess progress and arrive at solutions for addressing poor performance. Ensuring that public-sector and implementing partners provide supportive supervision to ensure quality, age-disaggregated data collection, analysis, and review at each of the primary healthcare delivery tiers is a necessary factor for successful scale-up and sustainability.

Assessment Design

The assessment of the scale-up effort was designed as an exploratory study to determine what worked and what did not work, and to identify barriers and challenges addressed in the development and implementation of the scale-up approach. The assessment was conducted in Amhara and Tigray, two regions of Ethiopia where the service delivery model was tested.[3-4] These two regions were purposively selected from the four regions where IFHP+[a] (and subsequently Transform: Primary Health Care Project) maintain fully operational YFS programs, enabling day-to-day project oversight.

This retrospective assessment used a mix of quantitative and qualitative data-collection methods, such as qualitative key informant interviews (KIIs) and data extraction from Health Management Information System (HMIS) FP registers. The KIIs were designed to elicit information on the process of scale up of the tested service-delivery model to YFS units. The interviews addressed factors that facilitated and hindered scale up as well as identified solutions to address challenges. E2A interviewed senior managers and technical staff from each health administrative and service delivery level (region, zone, woreda, and health center), as well as staff members from the central and regional offices of the Transform: Primary Health Care Project. Unlike Amhara, however, Tigray KIIs included senior managers and technical staff from Relief Society of Tigray (REST), which is the non-IFHP+ implementing partner in Tigray supporting YFS units. Management personnel included head or deputy head at each health administrative level or implementing partners' central and regional offices. Technical staff included MCH officers, and advisors for youth, FP, and M&E. Interviews were conducted with staff directly involved in the development and/or implementation of scale-up plans, irrespective of whether they continued in the same positions as when the model was scaled up (**See Figure 2**).

The research team conducted 56 KIIs: 43 public-sector and 13 implementing partner interviews. Relevant data covering a period of six months pre-intervention and six months post-intervention (LARCs training of YFS providers), were extracted from FP registers maintained in each of the 8 sampled health centers.

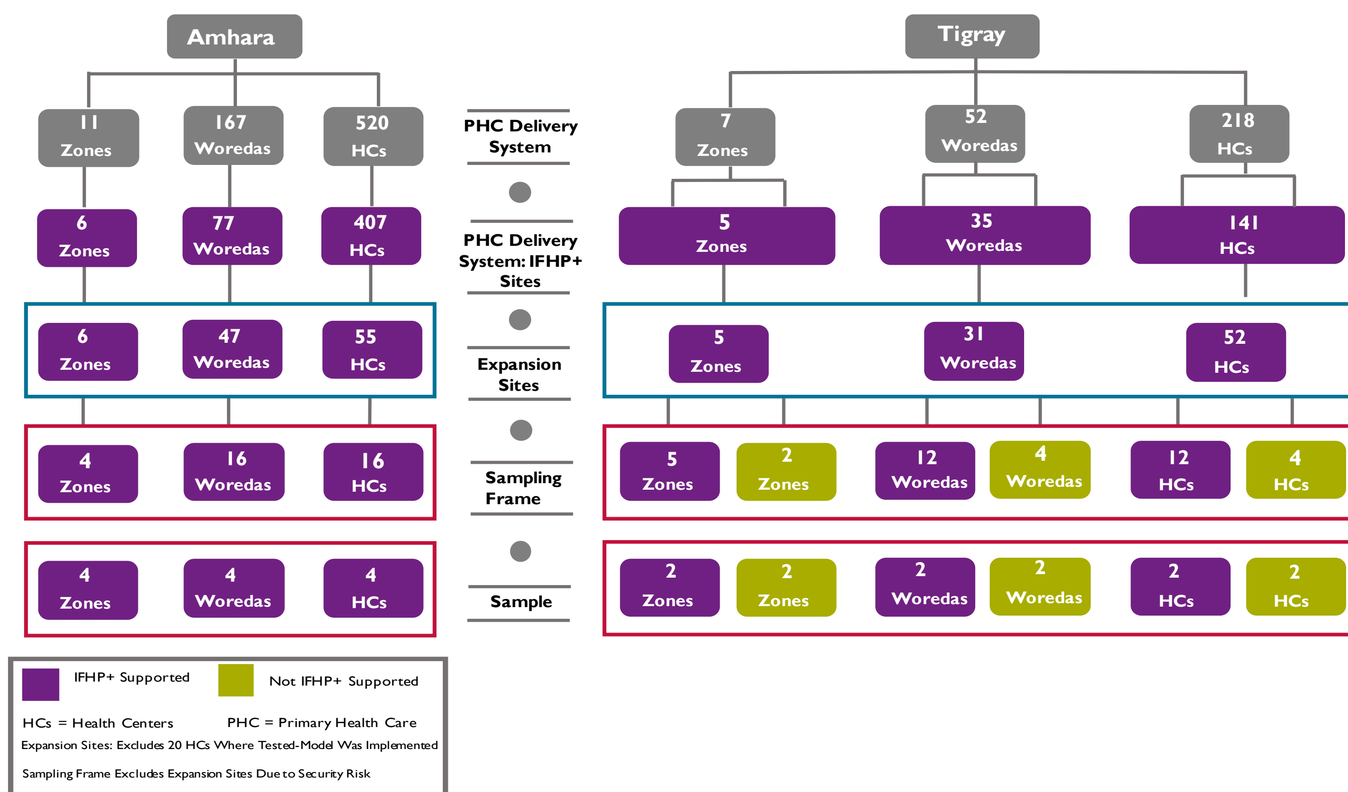
Study Limitations

A limitation of this assessment was the variability of the implementation of the model across health centers in Tigray. The two REST-supported health centers in the study sample did not include a peer education program, while the IFHP+ supported health centers in Tigray and Amhara did. Another limitation is that the study was not designed to draw inferences or generalize about the process and outcome of the scale-up approach, but rather to provide information about a particular scale up experience in these two regions.

Key Findings

The technical report[b] contains extensive qualitative results from KIIs and quantitative results on LARCs uptake from FP registers. Major cross-cutting results from Amhara and Tigray are elaborated below and organized by the six elements of scale up.

Figure 2: Flow chart illustrating the total number of zones, woredas and health centers in the primary health care delivery systems of Amhara and Tigray (first row), cascading to the sampled zones, woredas and health centers (fifth row).



a Pathfinder International directly manages IFHP+ and subsequently Transform: Primary Health Care programs in Amhara and Tigray regions

b Fariyal Fikree, Habamatu Zerihun, and Kidest Lulu, Assessment of Scale-Up | Ethiopia: Expanding Voluntary Contraceptive Methods to include LARCs in Youth-Friendly Service Units, January 2019). Available at https://www.e2aproject.org/publication/assessment-of-scale-up-expanding-voluntary-contraceptive-methods-to-include-LARCs-at-youth-friendly-service-units

Stakeholder Engagement:

The stakeholder engagement process clearly contributed to sustainability and scale-up of the tested service-delivery model, mainly by nurturing government ownership. Key facilitating factors that supported stakeholder engagement included the government's high priority for addressing youth RH in national policies and guidelines, evidence from the pilot test, and mutual understanding between IFHP+ and the public health system, a trusted relationship built over a decade. Public sector stakeholders expressed commitment to the tested service-delivery model and were intimately involved in decisions related to scale-up planning and implementation. The structure and protocols established by Ethiopia's national health system and health-care financing reform guidelines determined how stakeholders were engaged in the scale-up process. The FMOH and the RHB focus on policy, strategy, and technical support. The lower administrative levels, zones and woredas, focus on overseeing management and implementation of policy and strategy at health centers. Irrespective of region (Amhara and Tigray), administrative (RHB, zone, and woreda) and service delivery (health center) levels, and implementing partners (IFHP+ and REST), the principal stakeholder—the government—was directly involved in approving the scale-up plan. IFHP+ sought formal approvals from the respective RHBs by presenting the results of the pilot and scale-up plan. Thereafter, the RHB's deputy head signed the approval letter that also designated the zones, woredas, and health centers selected for scaling up. After receiving formal approval, IFHP+ visited the respective zones, woredas, and health centers to formally discuss implementation of the scale-up plan. The ultimate decision to accept or decline the scale-up plan rested with the woreda health office.

> *"The implementing organization has to communicate with the regional health bureau about their plan. It is after the agreement that the lower health administrative levels are communicated by the regional health bureau. That is the usual flow for any program implementation."*
> – Senior Manager/Woreda: Amhara

> *"We have owned the LARC service and we are trying to make it sustainable through training more professionals."*
> – Senior Technical/RHB: Amhara

> *"There was a demand by the woreda and the regional health bureau to sustain and scale-up the service in the remaining health facilities."*
> - Senior Manager/Woreda: Tigray

> *"There isn't anything that is against youth friendly service; even religion leaders are teaching family planning."*
> - Senior Manager/RHB: Tigray

Roles and Responsibilities:

There were no explicit roles and responsibilities defined for individuals overseeing the management of the scale-up plan. However, roles and responsibilities of the public health system and IFHP+ were well understood, as elaborated in guidelines and implementation protocols and after years of working together. Any friction during implementation was mutually resolved through dialogue.

Supportive Policy Environment:

Informants noted a policy environment that supports access of young people to full contraceptive choice, irrespective of age, parity, and marital status. However, translation of this policy into YFS practice, including the scale-up of LARCs training for YFS providers, continues to be impeded by several factors. Woredas and health centers are confronted with competing priorities, budgetary concerns, infrastructural weaknesses, staff shortages, provider bias, commodity insecurity, and irregular supportive supervision. The public sector and implementing partners attempted to address these challenges through mutual dialogue and understanding, especially during quarterly review meetings.

> *"It is part of the policy to address youth reproductive health needs."*
> – Senior Manager/RHB: Amhara

> *"The policy outlines that all reproductive age people have to have access to different contraceptive methods and it is their right to choose and use a method based on information."*
> – Senior Technical/Woreda: Amhara

> *"Resource allocation to the YFS and reproductive health services of the young people is limited. This may be related to budget limitation and prioritizing other health problems over youth reproductive health service, or lack of commitment."*
> – Senior Technical/Woreda: Amhara

> *"We had to miss some appointments with them for discussion, evaluation, and supervision because of emergency situations we have been facing and overlap of activities. We commented that they have to let us know ahead of time."*
> – Senior Technical/Woreda: Amhara

Mobilizing Financial Resources:

Health services in Ethiopia are primarily financed from four sources: the federal and regional governments; grants and loans from bilateral and multilateral donors; nongovernmental organizations; and private contributions/out-of-pocket payments for services rendered. Despite significant improvement over the years, healthcare financing continues to be a major challenge in Ethiopia. Consequently, it is not surprising that budgetary constraints were a major stumbling block to scaling up the tested YFS service-delivery model. There is no specific budget line item for YFS, and budgetary allocations are split unevenly 70:30/curative:preventive, without delineation for specific preventive services. All maternal and child health and family planning services fall under the preventive services and are provided free of cost.

Informants from the zones, woredas, and health centers cited income-generation activities led by health centers as a mechanism for raising additional funds for health centers. This type of financing is sanctioned by the current healthcare financing law. However, allocation of the funds generated through health center revenues are subject to decisions made by health center administrative boards and need to comply with defined RHB financial protocols.

> *"It is unthinkable; ...cognizant to the critical shortage of the financial resources it would not be possible to allocate budget for specific services like FP. The allocation would be for overall prevention activities in*

the woreda."
- Senior Manager/Woreda:Tigray

*"Using some money from the 30% of revenue to fulfill commodities and materials for YFS needs much effort to convince the board [...*woreda-based management board...*] and needs attention. In this regard, many HFs use very limited amount of it."*
- Senior Manager/Woreda:Tigray

"We constructed a YFS at the health center using our internal revenue."
– Director/Health Center:Amhara

"It needs time to fully fund by the government capacity."
– Senior Technical/IFHP+ Regional Office:Tigray

National policy in Ethiopia indicates a commitment to comprehensively addressing young people's RH needs. However, programs designed to do just that are not adequately funded and often compete with funding for curative and emergency services. RHBs' renewed commitment to enabling young people to access full contraceptive choice is an emerging ray of hope. With its GFF funding[9] and FP2020[10] commitments, the FMOH and RHBs should ensure that the budgetary allocations are incrementally revised to reach a suggested target of a 60:40/curative: preventive split to fulfil its FP2020 commitments[10] regarding strengthening YFS.

"There is a federal level proclamation that indicates that each health facility need to mobilize resource on itself and allocate budget for the services they do want to strengthen. Accordingly, they can invest it on activities related to strengthening LARCs."
– Senior Technical/RHB:Tigray

"I don't know any investment to the strengthening of the LARCs at the YFS unit."
– Director/Health Center:Amhara

"Health facilities retain their revenue and improving the understanding of the need to strengthen YFS unit using their resource is another focus. Thus, influencing allocation of resources to the YFS is the task that needs to be the attention of the public sector."
– Senior Manager/IFHP+ Regional Office:Tigray

"YFS is becoming a center of evaluation for health facilities and woredas in the region."
- Senior Manager/RHB:Tigray

With regards to macro level financial commitments, a measure of Ethiopia's success in leveraging external funding is securing financing from the Global Financing Facility (GFF)[9] to contribute to a reduction in the financing gaps for Reproductive, Maternal and Child Nutrition, and Child and Youth Health. In addition, Ethiopia's FP2020[10] Commitment 3 pledges the country to incrementally increasing and allocating earmarked budget for FP from the SDG pool fund; whereas Commitment 1 pledges Ethiopia to strengthening YFS and referral linkages including improving collection, analysis and utilization of age- and sex-disaggregated data on adolescents and youth – illustrating Ethiopia's coordinated efforts to improve the health status of its youthful population.

Quality of Voluntary FP Services (Counseling and Service Provision):

Key informants mentioned four interlinked factors—providers (training, commitment, and staff turnover), availability of a separate space for YFS, sustainable commodity supplies, and supportive supervision with timely feedback—as the major contributors to quality LARCs/FP services, highlighting heightened awareness of quality of care issues that affect program scale-up and sustainability. One of the cornerstones for achieving sustainable programs at scale is an enabling environment within the context of service delivery and health systems strengthening. Thus, addressing these broader health systems strengthening concerns is paramount to improving quality of FP services, generally, and YFS in particular.

*"They [*young clients*] do not absolutely want to be served in rooms other than the YFS unit."*
– YFS Provider/REST -supported Health Center:Tigray

"We also have unavoidable staff turnover and interruption of the service."
– Senior Manager Woreda:Amhara

"Before the training for LARCs, our focus was short acting family planning methods because we hadn't been confident to counsel for a service that we would not be able to provide them."
– YFS Provider/REST-supported Health Center:Tigray

"We make everything available and near to them so they are getting all information and the service accordingly. The integration of services in one place has also played a major role in improving the quality of the family planning service."
– Director/IFHP+ -supported Health Center:Tigray

"At regional level, there is increasing uptake of LARC by the young girls from almost nothing. This is one achievement."
– Senior Technical/RHB:Amhara

Data Availability and Use:

Key informants from both regions mentioned that data were used for performance monitoring by the implementing partner and the public health sector. Performance monitoring challenges included a lack of data on contraceptive use by method type, forecasting commodity shortfalls, and low performance on a range of monitoring indicators. Other challenges encountered included poor data quality (over or under-reporting), and unavailability of age and method-specific disaggregated data, which inhibited a more realistic assessment of YFS contraceptive utilization. While the national FP register has an age column, the compiled monthly and/or quarterly format does not. This shortcoming has been raised with the FMOH's planning division on several occasions and is being addressed in the roll-out of the new HMIS, DHIS2.

*"The first issue in quarter meeting [...*performance review meeting...*] is whether we are achieving the rate [...*LARCs utilization rate...*] or not. Our plans will then be based on this if the utilization rate is low, we have to improve and expand the services. The data is useful for planning and decision making."*
– Senior Technical/Woreda:Tigray

"We examine the data to find out which methods are increasing and which ones

are decreasing. We try to investigate the reasons."
– Senior Technical/Woreda: Amhara

"The existing reporting format doesn't have age disaggregated method use."
– Senior Manager/Zone: Amhara

"The uptake of LARC has increased. The increasing awareness and change of attitude towards LARC are achievements."
– Director/Health Center: Amhara

LARCs Uptake:

Key informant perceptions, by and large, indicated an increase in LARCs uptake across the eight health centers, although these perceptions were largely uncorroborated by data from FP registers. At only two health centers (one each in Amhara and Tigray), a statistically significant increase in LARCs uptake was documented (**See Table 1**). This could be due to a confluence of the aforementioned challenges to service quality and health systems strengthening.

A major advantage of mixed methods evaluation studies is that the quantitative and qualitative findings corroborate and thereby provide a more holistic picture of the evaluation results. Our findings indicate some contradictions between the qualitative and quantitative results. For example, public sector and implementing partner stakeholders perceived an increase in LARCs uptake among new acceptors post LARCs training even though the quantitative HMIS data did not show statistically significant LARCs increase among new acceptors, except in two of the eight YFS study units. These qualitative results may indicate a social desirability response bias – the tendency of respondents to answer questions that will be viewed favorably by others. In addition, the quantitative findings indicating the lack of statistically significant increase in LARCs uptake could possibly reflect a ceiling effect – LARCs uptake among new acceptors had reached a pre-determined level. Irrespective of social desirability bias or ceiling effect, the low concurrence between our qualitative and quantitative findings might also reflect other contextual factors including seasonal

Table 1: Frequency distribution of new acceptors by method uptake in Amhara and Tigray, disaggregated by intervention period.

Intervention Period[1]	Before		After		P value
	n	%	n	%	
Amhara[2]					
Health Center - 1					
LARCs[3]	6	10.2	10	11.1	0.86
Short-acting[4]	53	89.8	80	88.9	
Health Center - 2					
LARCs	29	54.7	44	58.7	0.66
Short-acting	24	45.3	31	41.3	
Health Center - 3					
LARCs	44	28.6	26	21.3	0.17
Short-acting	110	71.4	96	78.7	
Health Center - 4					
LARCs	66	37.1	37	50.7	0.05
Short-acting	112	62.9	36	49.3	
Tigray[5]					
Health Center – 1					
LARCs	97	50.8	52	41.6	0.11
Short-acting	94	49.2	73	58.4	
Health Center - 2					
LARCs	121	46.4	84	48.6	0.65
Short-acting	140	53.6	89	51.4	
Health Center - 3					
LARCs	16	22.5	10	17.9	0.52
Short-acting	55	77.5	46	82.1	
Health Center - 4					
LARCs	12	15.2	24	33.8	0.01
Short-acting	67	84.8	47	66.2	

1. Intervention Period: six months before (Before); six months after (After) LARCs Training
2. Amhara: Health Centers 1 – 4: IFHP+ -Supported
3. LARCs: Implants and intrauterine devices
4. Short-Acting: injectables, oral contraceptives, and condoms (male); emergency contraceptives not reported by any health center
5. Tigray: Health Centers 1 – 2: IFHP+ -Supported; Health Centers 3 – 4: REST Supported

variability, low peer educator influence, LARCs trained youth-friendly providers influence, staffing shortages, commodity insecurity among other quality of care issues. A combination of these confounding factors might have contributed to the conflicting qualitative and quantitative findings.

Conclusion

The ability to offer Ethiopian youth LARCs in a one-stop-shop where they receive a full range of RH services is paramount to reducing unintended pregnancy, improving maternal health, and achieving SDG 3. Although the Ethiopian government remains committed to improving AYRH, offering youth full contraceptive choice continues to be hampered by limited financial resources and health systems constraints. Without an obligated budget line item for YFS included in regional, woreda and health center budgets, challenges to sustaining and scaling up the tested YFS delivery model in Amhara, Tigray, and beyond will continue. Health systems need to be strengthened so that YFS units can offer adolescents and youth full contraceptive choice in a confidential, comfortable space where they can receive counseling and services that ensures voluntary informed choice by a trained provider by addressing human resource shortages, quality of care, and data availability and use.

Ethiopia has moved forward in updating its FP2020 commitments[10] and leveraging funds[9] to meet the aspirations of its young people. Below, we offer some specific suggestions targeting various policy and health systems challenges. More generally, at the FMOH and RHBs levels, we recommend a continuation and strengthening of policy dialogue aimed at strengthening YFS including incrementally increasing the financial allocation to preventive care; creating and strengthening YFS units; addressing human resource challenges; and improving the quality of care.

Specific Recommendations

Stakeholder Engagement: Stakeholder engagement, through the established RHB, and their MCH and FP technical working groups, should be strengthened as a platform for technical deliberations. These deliberations should be continuous, and occur before, during, and after testing and scale-up of health programs to ensure a common understanding of challenges, lessons learned, and promote adequate resource allocations.

Roles and Responsibilities: Ensure mutual understanding of roles and responsibilities and conflict-resolution processes to facilitate scale-up planning and implementation.

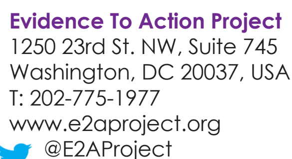
Supportive Policy Environment: Service-delivery protocols for strengthened YFS should be disseminated to all service providers and senior technical staff at health centers and higher administrative levels. Senior managers then must ensure that providers and senior technical staff have access to and are using the guidelines and protocols. The National Adolescent and Youth Health Strategy (2016-2020)[i] broadens the scope of the policy's previous iteration, ensuring application of emerging evidence-based practices. However, periodically FMOH should consider updating the strategy to ensure application of newly emerging evidence-based practices and/or new technology.

Mobilizing Financial Resources: The FMOH and RHB should ensure that funding allocations are appropriately adjusted to address young persons' FP/RH needs. They should also ensure health centers' admin- istrative boards are strengthened to implement the updated health financing reform law that allows health centers to generate and use their own funds. The FMOH and RHB, in accordance with the National Adolescent and Youth Health Strategy (2016-2020)[i] should ensure that investments in youth include resource allocation for youth- friendly FP/RH provision of contraceptive methods. YFS units and YFS-trained providers need to offer an expanded method choice, including LARCs, to young people in a private, confidential, and respectful environment. To effectively harness the demographic dividend of Ethiopia's youth bulge and achieve SDG 3 over the next 20 to 30 years, socioeconomic investments in education, employment, and health must also be made that support youth development.

Quality of Voluntary FP Services (Counseling and Service Provision): Concerted efforts must be made to ensure that the four inter-linked factors (i.e., competent and available providers, separate space, commodity security and supportive supervision with timely feedback) that directly impact quality of FP counseling and service provision are addressed. The RHBs, zones, woredas, and health centers must be tasked with resolving lingering quality of care issues through strengthened supportive supervision, training, and commodity security.

Data Availability and Use: Continued and sustained advocacy and dialogue with FMOH, development partners, and stakeholders will be important to revising the HMIS reporting format to include age- disaggregated data on FP uptake and accelerating the implementation of the revised system.

[i] Federal Democratic Republic of Ethiopia; Ministry of Health. National Adolescent and Youth Health Strategy (2016-2020). Available at: http://corhaethiopia.org/wp-content/uploads/2016/08/NATIONAL-ADOLESCENT-AND-YOUTH-health-strategy-.pdf; Accessed: May 21, 2018


Evidence To Action Project
1250 23rd St. NW, Suite 745
Washington, DC 20037, USA
T: 202-775-1977
www.e2aproject.org
@E2AProject

Pathfinder International
9 Galen Street, Suite 217
Watertown, MA 02472, USA
T: 617-924-7200
www.pathfinder.org

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