Ethiopia

Collaborative Advocacy Action Plan (CAAP)

Delivering on country commitments for women's, children's and adolescents' health and well-being

April 2025

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MINISTRY OF HEALTH - ETHIOPIA

PMNCH for

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Abbreviations and Acronyms

AYH	Adolescent and Youth Health
AHWB	Adolescent Health and Well-being
BMGF	Bill & Melinda Gates Foundation
CAAP	Collaborative Advocacy Action Plan
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CIFF	Children's Investment Fund Foundation
CORHA	Consortium of Reproductive Health Associations
CSA	Central Statistics Agency
CSOs	Civil Society Organizations
EDHS	Ethiopian Demographic and Health Survey
EPHA	Ethiopian Public Health Association
EPHI	Ethiopian Public Health Institute
EPI	Expanded Program for Immunization
EPS	Ethiopian Pediatrics Society
ESOG	Ethiopian Society of Obstetricians and Gynecologists
FGAE	Family Guidance Association of Ethiopia
FGM/C	Female Genital Mutilation/Cutting
MOH	Ministry of Health
MNCH	Maternal Newborn and Child Health
FP	Family Planning
GBV	Gender-Based Violence
GFF	Global Financing Facility
HPN	Health, Population, and Nutrition
HPV	Human Papilloma Virus
HSTP	Health Sector Transformation Plan
IMNCI	Integrated Management of Neonatal and Childhood illnesses
INGOs	International Non-Governmental Organizations
IPAS	International Pregnancy Advisory Services
JSI	John Snow, Inc.
JSC	Joint steering committee
KMC	Kangaroo Mother Care
MCAH LEO	Maternal, Child, and Adolescent Health Lead Executive Office
MOE	Ministry of Education
MOF	Ministry of Finance
MOWSA	Ministry of Women and Social Affairs
MSI	Marie Stopes International
MSPs	Multi-Stakeholder Platforms
NICU	Neonatal Intensive Care Unit
ODA	Official Development Assistance
OSCs	One-Stop Centers
PMNCH	Partnership for Maternal, Newborn & Child Health
PSI	Population Services International
RAC	Research Advisory counsel
RHB	Regional Health Bureau
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBC	Social and Behavior Change
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexually transmitted Infections
TAYA	Talent Youth Association
TWG	Technical Working Group
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization
WCAH	Women, Children, and Adolescent Health
AYFHS	Adolescent and Youth Friendly Health Service

Section 1 |CAAP overview

The CAAP process

The aim of the Collaborative Advocacy Action Plan (CAAP) initiative is to improve accountability for women's, children's, and adolescents' health (WCAH) commitments (specifically related to Maternal Newborn and Child Health (MNCH), Sexual and Reproductive Health (SRH) and Adolescent Health and Well-Being issues(AHWB) through the collaborative efforts of partners. In Ethiopia, the Clinton Health Access Initiative (CHAI) coordinated the process, with the leadership of the Federal Ministry of Health and support from Partnership for Maternal Newborn and Child Health (PMNCH).

The CAAP process in Ethiopia

Ethiopia's commitments were made largely in the global framework of the Sustainable Development Goals (SDGs), particularly those relating to health and well-being of women, children and adolescents. There was a specific focus on the involvement of all relevant stakeholders with the health system strengthened while ensuring synergy of action between different sectors. Representatives from all 10 constituencies were involved in the CAAP process in Ethiopia.

CHAI convened two meetings to develop the CAAP in September and December 2024. The first meeting was conducted by inviting stakeholders from different institutions and organization representing all ten constituencies to develop the CAAP.

Meeting attendees included Ministry of Health (MOH) representatives from different lead executive offices including Minister's office, Regional Health Bureau (RHB) representatives, United Nations (UN) organizations and intergovernmental org., universities, partner organizations, Youth led organization, professional associations, donors and foundations, relevant ministries representatives, and public private partnership (Ethiopian Health Care Federation).

At the second meeting in December 2024 where the CAAP was refined, selected stakeholders were invited from the first meeting.

The CAAP validation meeting was organized in April 2025 with representatives from key stakeholders from the MoH, UN organizations, partner organizations, and youth led organizations to name a few constituency groups. The contribution of the participants to the advocacy action plan has guided the development of this document.

This CAAP plan was developed in April 2025 and reflects priorities and activities identified at that time with present partners. It is a living document and will be updated regularly. Its implementation depends on partners, and we invite you to join efforts to achieve advocacy goals by collaborating on the listed and additional activities.

For further exchanges on CAAP implementation, MSP membership and PMNCH country partners, partners are invited to join the Ethiopia Country Digital Advocacy Hub and contact PMNCH (pmnch@who.int).

Section 2 |Background

Overview of women's, children's and adolescents' health in Ethiopia

Ethiopia, the second most populous country in Sub-Saharan Africa, has made significant strides in healthcare and gender equality over the past decade. Maternal healthcare services have improved, resulting in a decline in maternal mortality rates from 420 per 100,000 live births in 2013 to 401 per 100,000 live births in 2017. In the last decade, Ethiopia has made significant progress towards achieving its national and international development goals regarding under-5 and infant mortality rates (under-5 mortality rate is 67 deaths per 1,000 live births, and the infant mortality rate is 48 deaths per 1,000 live births).[1]

With a population of 107.3 million and a growth rate of 2.6% per annum, the country has focused on improving the health and well-being of rural and young populations.[2] Adolescents and youths in Ethiopia, comprising 42% of the population, face significant sexual and reproductive health challenges, with rural areas bearing the brunt.[3] These challenges include risky sexual practices, child marriage, early childbearing, unintended pregnancy, unsafe abortion, and sexually transmitted information (STIs), contributing to maternal deaths among young age groups. Despite efforts to address these issues, barriers persist, such as limited access to modern contraception, high rates of teenage childbearing, and low comprehensive HIV knowledge among rural females. The quality and availability of health services for adolescents are also inadequate, particularly in rural areas. The government has taken measures, including establishing adolescent and youth-friendly services and implementing policies and strategies. However, high rates of child marriage and unmet family planning needs persist, especially in rural areas, and barriers prevent access to quality sexual and reproductive health.

The quality of the current health services for adolescents and youth is challenged by an inadequacy of infrastructure including equipment and supplies. In some cases health workers' lack of skill and failing to provide compassionate and respectful care, among others. In addition, services for adolescents are highly fragmented, poorly coordinated, and uneven in quality.[1]

1. Ethiopian Public Health Institute (EPHI) & ICF. (2021). Ethiopia mini demographic and health survey 2019: Final report. EPHI and ICF.
2. Ministry of Health. (2023). Health sector medium-term development and investment plan: 2023/24–2025/26.
3. Central Statistics Agency. (2013, July). Population projections for Ethiopia: 2007–2037. Central Statistics Agency.

Achieving reductions in maternal and neonatal mortality during institutional deliveries remains an important objective. However, access to health facilities is more difficult in rural areas than in urban areas because of distance, scarce transport, and a lack of appropriate facilities. Although institutional delivery has been promoted in Ethiopia, home delivery is still common, primarily in hard-to-reach areas. 48% of live births were delivered in a health facility.[1]

Improvements in SRH services have been notable, reaching vulnerable groups and reducing unintended pregnancies and adolescent marriages. Efforts to provide SRH services for adolescents and youth have led to declines in new HIV infections and female genital mutilation/cutting (FGM/C).

Efforts to promote gender equality include revising laws and implementing gender-sensitive policies, leading to increased women's participation in education, the labor force, and decision-making roles. While progress has been made, gender disparities persist in employment, widening with higher education levels. Ethiopia has made substantial progress in addressing various social issues, including child marriage, forced marriage, gender-based violence (GBV), FGM/C and support for vulnerable populations.

Ethiopia has seen a significant decrease in child marriage rates due to government initiatives like legal reforms, media campaigns, community dialogues, and economic incentives. However, challenges persist, with about 4 in 10 marriages involving underage individuals. Forced marriage, once common, has declined but remains a challenge, particularly in certain regions where it is deeply entrenched in cultural norms.

Ethiopia has enacted laws and policies to combat GBV, but implementation remains a challenge due to resource constraints and coordination issues. Efforts to end FGM/C have shown progress, with a decline in prevalence, but more work is needed to fully eliminate the practice by 2030. The country has established One-Stop Centers (OSCs) in urban areas to provide services to GBV survivors, but challenges exist in their functioning and availability, particularly in rural areas. Legal aid centers offer support, but access to mental health and psychosocial services is limited.

The FMOH, in collaboration with its stakeholders, took measures to put in place frameworks and structures to prevent and respond to GBV. Among them, the major actions are development of GBV guidelines and protocols, establishment of OSCs, MOH engagement in coordination efforts, incorporating GBV in the teaching curriculum of medical schools, banning FGM/C, and training and awareness creation efforts. EDHS 2016 showed that 65 % of women and girls aged 15–49 years, 47 % of girls aged 15–19 years,

and 16 % of girls under 15 years are circumcised.[4] Ethiopia is home to 25 million women and girls who have experienced FGM/C.[5] EDHS also showed a decrease in the national prevalence of FGM/C over the past 15 years i.e., from 80 % in 2000 to 65 % in 2016.[4]

Ethiopia has the 15th highest rate of child marriage in the world. However, it is one of the top five countries in terms of numbers of girls who married as children (child brides), estimated at more than 2.1 million. This is because of its due in part to its large and growing population.[6]

Adolescents (10-19 years) and youths (10-24 years) constitute 42% of the population in Ethiopia.[3] Most Ethiopian adolescents and youth reside in rural areas (80%). Among those aged 10 to 14, ~82% reside in rural areas, while ~75% of all young people aged 25 to 29 reside in rural areas.[7]

Evidence has shown that the major sexual and reproductive health problems among adolescents and youth in Ethiopia include risky sexual practices, child marriage, early childbearing, unintended pregnancy, unsafe abortion, and its complications, and sexually transmitted infections (STIs) including HIV. The EDHS 2016 estimated maternal death among young age groups 15-19 years and 20-24 years contributed to 17% and 29% of all the deaths respectively.[4] The survey also revealed that the median age at first marriage was 17.1 years among women and 23.7 years among men.[4] While roughly 13-15% of males had sex before the age of 18, 27% of urban females and 52% of rural females experienced first sex before the age of 18, which is likely due to earlier marriage among females.[4] It also stated that 13% of young women aged 15-19 years have already begun childbearing; 10% of these young women are mothers and an additional 3% are pregnant with their first child.[4]

Over one-third (37%) of sexually active adolescent girls in Ethiopia who wish to avoid pregnancy lack access to modern contraceptive methods.[8] This group accounts for 90% of all unintended pregnancies among adolescents in the country. This unmet need is more pronounced among married adolescents compared to their unmarried, sexually active peers—39% versus 26%, respectively.[8]

Teenage childbearing is more common in rural than in urban areas (15% vs 5%) and varies from region to region; in Afar (23%) and Somali (19%) and lowest in Addis Ababa (3%).[4] Furthermore, more than 90% of married males from the rural areas reported that no health extension worker visited them for family planning consultation.[9] The comprehensive knowledge of HIV among adolescents and youth, especially among rural females is very low.[4] Only 19% of rural females had comprehensive HIV knowledge, compared to 37% of rural males, 42% of urban females and 48% of urban males.[4]

4. Central Statistical Agency (CSA) [Ethiopia] & ICF. (2016). Ethiopia demographic and health survey 2016. CSA and ICF.
5. United Nations Children's Fund (UNICEF). (2020). A profile of female genital mutilation in Ethiopia. UNICEF.
6. Erulkar, A. 2022. Changes in the prevalence of child marriage in Ethiopia, 2005–2016. Reproductive Health, 19(Suppl 1), 195. / to update on APA
7. Ministry of Health. (2020). Health sector medium transformation plan II: 2020/21–2024/25. Ministry of Health.
8. Guttmacher Institute. (2018). Adding it up: Investing in contraception and maternal and newborn health for adolescents in Ethiopia, 2018. Guttmacher Institute. https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-adolescents-ethiopia
9. Ministry of Health, Reproductive Health, Family Planning and Adolescent Health Desk. (n.d.). Adolescent and youth health program. Ministry of Health. https://www.moh.gov.et/en/initiatives-4-col/Adolescent_and_Youth_Health_Program

Currently 45% of all health facilities provide youth friendly services and only 11% have at least one staff member who received training on adolescent health services in the last two years.[9]

To alleviate the SRH problems of young people, various efforts have been made by the government of Ethiopia and its partners which includes the establishment of Adolescent and youth-friendly services (AYFS) (also called youth-friendly services, YFS). This intent was reinforced by the Government through a commitment in response to the UN Secretary General's call for national and global commitments to deliver the Rescue Plan for People and Planet at the SDG Summit 2023 and against the '7 asks' of the Agenda for Action for Adolescents announced during the Global Forum for Adolescents in October 2023.

The MOH has developed various policies and strategies to address the unique health needs of young people. Building on the National Youth Policy, Youth Development Package, Adolescent and Youth Health Strategy and the Minimum Package for Youth Friendly Health Services illustrate the efforts made by the government and despite this, high rates of child marriage, unmet need for family planning, and adolescent childbearing persist, particularly in rural areas. There is an ample evidence that adolescents faces numerous barriers to access health service at health facilities. Recognizing this, the Government of Ethiopia is working to expand Youth-Friendly Health Services (YFHS) to improve access and reduce these barriers by ensuring services meet the needs and preferences of adolescents and youths. In addition, the MOH, through its Health Extension Program is implementing innovative counseling approaches that support married adolescents to use contraceptives to delay their first pregnancy. Furthermore, in collaboration with the education sector, efforts are underway to integrate basic SRH information and education into school curricula. However, more work is needed to improve health literacy among adolescents including younger adolescents aged (10–14 years) to support their health and wellbeing during the transition period from childhood to adulthood.

While access and use of high-quality SRH services could prevent or mitigate many of the poor health outcomes experienced among adolescents and youth, many women in Ethiopia die due to preventable, delay-related causes. These include delays in decision-making at the community and family level to take mothers to health facilities, delays in transporting mothers to health facilities and delays in getting appropriate care at the health facility level. Access to health facilities is more difficult in rural areas than in urban areas because of distance, scarce transport and cost, and a lack of appropriate facilities.

A wide range of barriers prevent young people and women from accessing high-quality, SRH services. These include:

- Structural barriers, such as laws and policies requiring parental or partner consent, distance from facilities, costs of services and/or transportation, long wait times for services, inconvenient hours, lack of necessary commodities at health facilities, and lack of privacy and confidentiality.
- Sociocultural barriers, such as restrictive norms and stigma around adolescent and youth sexuality; inequitable or harmful gender norms; and discrimination and judgment by communities, families, partners, and providers.
- Individual barriers, such as incomplete or incorrect knowledge of SRH, including myths and misconceptions around contraception; limited self-efficacy and individual agency; constrained ability to navigate internalized social and gender norms; and lack of access to information about what SRH services are available and where to seek services.
- Awareness and knowledge barriers in decision making at the community and family level to bring mothers to the appropriate care.
- Lack of transportation to take mothers to the health facilities.
- Lack of trained healthcare workers and unavailability of essential medicines and equipment to provide appropriate care at the health facility level.
- Barriers in enforcement of laws which criminalize both child marriage and FGM/C.
- Religious challenges in some regions regarding child marriage and FGM/C.

Section 3 |Collaborative Advocacy Action Plan

Summary of Advocacy Goals in Ethiopia

The following advocacy goals outline strategic actions to mobilize financial, policy, and programmatic support across critical areas of maternal, newborn, child, and adolescent health in Ethiopia. These goals are aligned with national priorities and global commitments, including the SDGs, and seek to address systemic barriers through evidence-based advocacy, coordinated multi-sectoral engagement, and equitable resource allocation.

Importantly, the advocacy issues identified are those that can be effectively led by MOH, leveraging the existing national advocacy strategy to enhance impact. In addition to financial investment, the advocacy efforts will also focus on driving policy change and encouraging innovation where needed. Evidence and data to support these advocacy actions can be drawn from existing national frameworks, such as the SDG 3 Acceleration Plan, ensuring that interventions are grounded in credible and actionable insights.

Advocacy platforms include formal and informal structures through which policy dialogue, resource mobilization, accountability, and stakeholder engagement are facilitated. These platforms are instrumental in advancing the health and well-being of women, children, and adolescents and include the following:

- Ministry of Health-led Technical Working Groups (TWGs) such as the Safe Motherhood TWG, Child Health TWG, Adolescent and Youth Health TWG, and Family Planning and Advocacy TWG, which bring together key technical experts and partners to discuss and coordinate advocacy-related actions.
- Quarterly, biannual and annual joint review meetings led by the MOH, where regional health bureaus (RHBs), development partners, and sectoral ministries assess performance, identify gaps, and agree on policy and budget recommendations.
- The Reproductive, Maternal, Newborn, Child, and Adolescent Health Multi-Stakeholder Platform (RMNCAH-MSP), which facilitates coordination across the ten CAAP constituencies, including CSOs, donors, academia, and the private sector.
- High-level ministerial and parliamentary engagements, including policy dialogues, pre-budget hearings, and strategic consultations with the Ministry of Finance (MoF), Ministry of Education (MoE), Ministry of Women and Social Affairs (MoWSA), and parliamentary standing committees.
- Media and communication channels, such as health sector public relations departments, journalist training programs, and public media partnerships, which are used to disseminate advocacy messages and generate public support.
- The PMNCH Digital Advocacy Hub, which provides a virtual collaboration platform for stakeholders involved in CAAP implementation to share tools, updates, and success stories.

These platforms are leveraged not only to advance advocacy goals but also to enhance transparency, accountability, and policy coherence. When advocacy targets and audiences overlap, shared platforms may be used to maximize efficiency and alignment.

Section 3 | Advocacy Goals

Summary of Advocacy Goals in Ethiopia.

Advocacy Goal	Description
Advocacy Goal 1: Maternal Health Increase the allocation and efficient use of federal, regional and global resources dedicated to maternal health commodities by 50% from baseline by 2025 to reduce maternal mortality from 267 to at least 140 for the national target (SDG target is 70 per 100,000 LB by 2030).	The current funding allocation for maternal health in Ethiopia is inadequate, facing new and existing challenges related to both the amount of funds and delays in release, which directly impacts the timely procurement and distribution of life-saving maternal health commodities and supplies. Our advocacy efforts will ensure that at least 50% of the allocated budget for maternal health is released on time each fiscal year. Furthermore, these advocacy efforts should extend to the MOF, Parliamentarians, National Bank, MOH, and other relevant agencies responsible for budget allocation and disbursement. Equally important is the need to strengthen collaboration with international partners and stakeholders. Their support is crucial not only to ensure coordinated action and better resource management but also to provide sustainable support for maternal health initiatives in Ethiopia. Addressing these gaps is essential to ensure timely and efficient maternal health service delivery. Advocacy efforts will focus on improving stakeholder awareness, particularly among policymakers at federal and regional levels, and fostering collaboration with agencies like the MOF, Parliamentarians, National Bank, and MOH. This multi-stakeholder approach will enhance resource allocation and management, supporting sustainable maternal health outcomes.
Advocacy Goal 2: EPI Increase funding for immunization programs in Ethiopia by 10% from baseline, from both domestic and international sources, to reduce the number of zero-dose children by 50% by 2030.	Ethiopia is one of the 10 countries that accounts for 62% of the global zero-dose children, with an estimated 3.9 million zero-dose children according to the WHO/UNICEF Estimates of National Immunization Coverage (WUENIC) 2022 report. Alarmingly, nearly one-third of surviving infants in Ethiopia are not receiving any vaccines, which significantly impacts child health outcomes nationwide. Therefore, advocacy efforts will aim to increase funding for immunization programs in Ethiopia by 10% from baseline, from both domestic and international sources, to reduce the number of zero-dose children by 50% by 2030.

Advocacy Goal	Description
Advocacy Goal 3: Children Under 5 Reduce the prevalence of pneumonia and diarrhea among children under five in Ethiopia to less than 3/1000 by 2030, through integrated efforts focusing on IMNCI, and community-based interventions.	Different evidence shows that pneumonia and diarrhea are the leading causes of death in Ethiopia. To target child survival at the community and health facility level, Ethiopia has adopted several programmatic strategies, including the integrated management of newborn and childhood illnesses (IMNCI) approach. The MOH recently developed the National Newborn and Child Development Strategy 2021–2025, which aims to reduce the national under-five mortality rate from 59 to 43 deaths per 1,000 live births; the infant mortality rate from 47 to 35 deaths per 1,000 live births; and the neonatal mortality rate from 33 to 21 deaths per 1,000 live births, all by 2025. This strategy plays a key role in Ethiopia's contribution to Sustainable Development Goal 3.2 to end preventable newborn and child deaths by 2030. Alongside the 2021–2025 strategy, the government is now collaborating with development partners to improve child survival through the implementation of a national action plan that addresses pneumonia and diarrhea, key contributors to child mortality. The action plan will address critical gaps and challenges in the health system, particularly as they relate to pneumonia and diarrhea control.
Advocacy Goal 4: Newborn Health Expand quality level 2 care special newborn care unit (SNCU), Kangaroo Mother Care (KMC) plus and essential newborn care services in all public facilities across Ethiopia by 2030, ensuring all that all health facilities have access to essential health care services, level 2 care SNCU services for small and sick newborns.	Neonatal mortality remains a major public health challenge in Ethiopia. The country's neonatal mortality rate is among the highest in sub-Saharan Africa, and many newborns die from preventable causes such as prematurity, birth asphyxia, and infections. However, Ethiopia's access to Neonatal Intensive Care Units (NICUs) is limited, with NICU services primarily available in tertiary hospitals located in urban centers, leaving rural and underserved areas without access to life-saving neonatal care. using different strategies and platforms by collaboration with partners and stake holders working on child health. Advocacy and implementation efforts require using different strategies and platforms by collaboration with partners and stakeholders working on child health.
Advocacy Goal 5: SRH Advocate to the MoF and Parliamentarians to proportionally increase funding for family planning (FP) commodities by 2030, ensuring that allocations from the treasury rise from $1.82 million in 2022/23 to $10.3 million by 2030.	While effectively tracking these investments through the Ethiopian National Health Accounts, challenges persist in the prioritization and timely allocation of funds for SRH activities, despite the government's commitment. It is crucial to ensure that earmarked funds are not only allocated but also released promptly to facilitate effective program implementation. Health sector leaders at all levels often overlook FP in budgeting, perceiving it as a low priority for various reasons, including the belief that the sector is adequately funded by donors and partners. Additionally, there is a pressing need to raise awareness about SRH and family planning issues across all sectors, as these issues impact multiple areas of development. Therefore, it is essential to enhance knowledge and awareness among policymakers and budgeting institutions to foster a high-priority budgeting practice for FP Commodities in the coming years.

Advocacy Goal	Description
Advocacy Goal 6: AHWB Advocate to MOH, MOE and MOWSA for the reduction of teenage pregnancy rates from 13% to 7% by providing tailored information and services to adolescents by 2030 through enhancing coordinated effort with and among stakeholders.	In Ethiopia, teenage pregnancy is a complex issue intertwined with broader challenges such as lack of access to education and healthcare, socio-economic difficulties, cultural norms, and limited access to contraception. These factors cannot be addressed solely through health sector interventions. The current teenage pregnancy rate of 13% is particularly alarming for marginalized groups, highlighting the urgent need for comprehensive strategies that extend beyond healthcare. Meeting policy targets, such as the FP 2030 commitment to reduce the unmet need for FP among adolescents, and the to decrease teenage pregnancy among adolescent girls from 13% to 7% by 2025 and to 3% by 2030 is crucial. These efforts are essential not only for improving the health and well-being of adolescents and youth but also for reducing maternal and child mortality by preventing pregnancy-related complications and deaths. Investing in adolescent and youth health yields high returns, often referred to as the demographic dividend, by fostering a healthier, more productive population. Additionally, reducing teenage pregnancy can significantly lower healthcare costs associated with treating pregnancy-related complications, freeing up resources that can be redirected to rehabilitate health facilities damaged during conflicts. This multifaceted approach underscores the importance of coordinated efforts among stakeholders to create a supportive environment for adolescents, ensuring they receive the tailored information and services they need to make informed decisions about their reproductive health.

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Activity	Decision-Makers	Influencers	Timeline/ Milestones [Implementation till December 2027]	Linked accountability mechanisms, as applicable
Advocacy Goal 1: Maternal Health. Increase the allocation and efficient use of federal, regional and global resources dedicated to maternal health commodities by 50% from baseline by 2025 to reduce maternal mortality from 267 to at least 140 for the national target (SDG target is 70 per 100,000 LB) by 2030				
Develop advocacy communication strategies (advocacy briefs, media engagement, conduct stakeholder sensitization workshop, create and disseminate through media campaigns, and collaborate with media influencers and journalists to train journalists on maternal health challenges and solutions) on the importance of fulfillment of government financial commitment for betterment of maternal health	MOH, RHB	Partners and MOF	March/April 2025	Safe motherhood TWG & Quarterly performance review by MoH
Conduct parliamentary hearing and media dissemination to advocate for Reprioritization of health within existing government budget by increasing government expenditure on health from 8.3 % to 15% by per the Abuja declaration of maternal (federal) - health within the health sector	Ministry of Finance at federal and regional level, Ministry of Health and RHBs (allocation between programs)	Members of Parliament, Standing Committee for Social Services, MOWSA, Media, Professional Associations, Partners	June/July 2025	Quarterly performance review by MoH
Convene policy dialogue with SDG contributors, RHB, and MOH before budget planning for 2018 EC to advocate for incremental budget allocation by regions so that regions that allocate additional resources will get a matching fund from an extra budget allocated to the SDG pool fund for this purpose. This will require availing extra resources by SDG contributors and enable alignment of financial contributions of government, donor and community resources dedicated for maternal health	RHBs, MoH, SDG contributors	MoH, SDG contributors, House of Federation	September/October2025	Biannual performance review by MoH
Convene policy dialogue to advocate for enhancing efficiency of budget utilization performance of federal and regional health bureaus on achieving stated goals at all levels	MoF, MoH	General Audit, HPR	November/December2025	Biannual performance review by MoH

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Activity	Decision-Makers	Influencers	Timeline/ Milestones [Implementation till December 2027]	Linked accountability mechanisms, as applicable
Advocacy Goal 2: EPI. Increase funding for immunization programs in Ethiopia by 10% from baseline, from both domestic and international sources, to reduce the number of zero-dose children by 50% by 2030				
Develop advocacy communication strategies (advocacy briefs, media engagement, conduct stakeholder sensitization workshop, create and disseminate through media campaigns, on vaccination challenges and solutions)	MOH, RHB	Partners and MOF	August 2025	EPI TWG & Quarterly performance review by MoH
Organize advocacy workshop for parliamentarians and MOF on immunization	Ministry of Health, Ministry of Finance, and parliamentarian are target audience critical influencer Women and children affairs Ministry and Ministry of plan development, Ethiopian Inter-religious Council	Members of Parliament, Standing Committee for Social Services, Ministry of Women and Social Affairs, Media, Professional Associations, Partners	Every yearly preferably in October/November	Quarterly performance review by MoH
Organize advocacy workshop for HPN Donors and partners and CSOs on immunization	HPN donors, partners, CSOs are target, key influencer MoF and MoH	HPN donors, partners, CSOs are target, key influencer MOF and MOH	Every yearly preferably in October/November	Quarterly performance review by MoH
Organize advocacy workshop for media people, professional associations on immunization	Key public and Private medias are targeting audience, Ministry of communication key influencer and MOH	Ministry of Communication and MOH	Every yearly preferably in October/November and June July	Quarterly performance review by MoH
Organize advocacy workshop for regional state, cabinet and regional parliament and health insurance bureau for immunization	Regional state cabinet, and Parliament, Regional HB, Community based Insurance agency,	MOH, CSO and Partners	Every yearly preferably in October/November	Quarterly performance review by MoH
Tailored key advocacy messages development workshop on immunization	National EPI, and Child health TWGs members	Donors, INGOs, CSOs, and Professional Associations	Every yearly preferably in May	Quarterly performance review by MoH

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Activity	Decision-Makers	Influencers	Timeline/ Milestones [Implementation till December 2027]	Linked accountability mechanisms, as applicable
Advocacy Goal 3: Children Under 5. Reduce the prevalence of pneumonia and diarrhea among children under five in Ethiopia to less than 3/1000 by 2030, through integrated efforts focusing on IMNCI, and community-based interventions				
Develop advocacy communication strategies (advocacy briefs, media engagement, conduct stakeholder sensitization workshop, Create and disseminate through media campaigns, on under 5 children health challenges and solutions)	MOH, RHB	Partners and MOF	August 2025	Child health TWG & Quarterly performance review by MoH
Organize advocacy workshop for HPN Donors and partners and CSOs to support the diarrhoea and pneumonia initiative	HPN donors, partners, CSOs are target, key influencer MoF and MoH	CSOs, Ethiopian Pediatrics Society (EPS), and MoH	Every yearly preferably in October/November	Quarterly performance review by MoH
Organize advocacy workshop for media people to reduce morbidity and mortality due to pneumonia and diarrhoea.	Key public and private medias	MOH	Every yearly preferably in October/November and June July	Quarterly performance review by MoH
Organize advocacy workshop for regional state, cabinet and regional parliament to reduce morbidity and mortality due to diarrhoea and pneumonia.	Regional state cabinet, and Parliament, RHB	MOH, Ethiopian Pediatrics Society (EPS), CSOs, Media	Every yearly preferably in October/November	Quarterly performance review by MoH

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Activity	Decision-Makers	Influencers	Timeline/ Milestones [Implementation till December 2027]	Linked accountability mechanisms, as applicable
Advocacy Goal 4: Newborn Health. Expand quality level 2 care SNCU, KMC plus and essential newborn care services in all public facilities across Ethiopia by 2030, ensuring all that all health facilities have access to essential health care services, level 2 care SNCU services for small and sick newborns				
Develop advocacy communication strategies (advocacy briefs, media engagement, conduct stakeholder sensitization workshop, Create and disseminate through media campaigns, on neonatal health challenges and solutions)	MOH, RHB	Partners and MOF	August 2025	Child health TWG & Quarterly performance review by MoH
Organize advocacy workshop for Health Population and Nutrition (HPN) donors and partners and CSOs to expand Neonatal Level 2 care and KMC plus services	HPN donors, partners and CSOs	MOH and Ethiopian Pediatrics Society (EPS)	Every yearly preferably in October/November	Quarterly performance review by MoH
Organize advocacy workshop for selected private facilities to expand Neonatal Level 2 care and KMC plus services	Private company, public profitable company	MOH and Ethiopian Pediatrics Society (EPS)	Every yearly preferably in October/November	Quarterly performance review by MoH
Organize advocacy workshop for media professionals to expand Neonatal Level 2 care and KMC plus services	Key public and Private medias	MOH and Ethiopian Pediatrics Society (EPS)	Every yearly preferably in October/November and June July	Quarterly performance review by MoH
Organize advocacy workshop for regional state, cabinet and regional parliament to expand Neonatal Level 2 care and KMC plus services	Regional state cabinet, and Parliament, Regional HB	Regional state cabinet, and Parliament, Regional HB	Every yearly preferably in October/November	Quarterly performance review by MoH

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Activity	Decision-Makers	Influencers	Timeline/ Milestones [Implementation till December 2027]	Linked accountability mechanisms, as applicable
Advocacy Goal 5: SRH. Advocate to the MoF and Parliamentarians to proportionally increase funding for FP commodities by 2030, ensuring that allocations from the treasury rise from $1.82 million in 2022/23 to $10.3 million by 2030				
Develop advocacy communication strategies (advocacy briefs, media engagement, conduct stakeholder sensitization workshop, Create and disseminate through media campaigns, on FP challenges and solutions)	MOH, RHB	Partners and MOF	May2025	SRH and Adolescent health TWG & Quarterly performance review by MoH
Identify and map key stakeholders and influencers at all levels and sectors	MOH, RMNCH Lead Executive Office (LEO)	Donors, UN Agencies, INGOs, CSOs, professional associations	June 2025	The quarterly meetings of the Family Planning and Advocacy Technical Working Groups will be presented at the bi-annual Joint Steering Committee (JSC) meeting
Develop advocacy engagement and communications plan	Minister's office, RHBs and RMNCH LEO	Donors, INGOs, CSOs, professional associations	July 2025	
Organize and facilitate field visit to parliamentarians and decision makers from the ministry of finance	Minister's office, RHBs and RMNCH LEO	Donors, INGOs, CSOs, professional associations, Regional Health Bureaus	August 2025	
Develop evidence-based advocacy brief on sustainable family planning financing	Minister's office, RHBs and RMNCH LEO, RAC	Donors, INGOs, CSOs, professional associations, higher learning institutions, EPHI	End of September 2025	
Develop key messages tailored to key decision makers and influencers	Minister's office and RHBs RMNCH LEO	Donors, INGOs, CSOs, professional associations, higher learning institutions, EPHI	End of September 2025	
Organize high level consultative workshop among key stakeholders and influencers	Minister's office and RHBs RMNCH LEO	Donors, INGOs, CSOs, professional associations	End of December 2025	

Ethiopia Collaborative Advocacy Action Plan

Activity	Decision-Makers	Influencers	Timeline/ Milestones [Implementation till December 2027]	Linked accountability mechanisms, as applicable
Advocacy Goal 6: AHWB. Advocate to MOH, MOE and MOWSA for the reduction of teenage pregnancy rates from 13% to 7% by providing tailored information and services to adolescents by 2030 through enhancing coordinated effort with and among stakeholders				
Develop advocacy communication strategies (advocacy briefs, media engagement, conduct stakeholder sensitization workshop, create and disseminate through media campaigns, on teen age pregnancy challenges and solutions)	MOH, RHB	Partners, MOH, RHB and MOF	May 2025	SRH and Adolescent health TWG & Quarterly performance review by MoH
Develop and present the advocacy plan to the senior management teams of the MOH, MOE, MoWSA to secure high-level buy-in and ensure leadership commitment existed.	Minister of health/MOH, MoWSA and Minister of Education/MOE	State Minister of Health programs/State Minister and MCAHS LEO	June-25	Align with MOH budget plan & follow up by AYH TWG and MSPs
Identify and decide on key stakeholders and multisectoral partners at national and regional levels through systematic mapping exercise.	AYH advocacy team	TWGs (AYH, FP & Communication & advocacy)	July-24	
Develop a communication plan and targeted advocacy tools to effectively engage stakeholders and promote the reduction of teenage pregnancy rates.	AYH advocacy team	MOH, MoWSA, MOE	August, 2025	
Engage the public relation of the health sector and other medias to highlight advocacy milestones and raise awareness.	Media personnels,	MOH	ongoing	
Conduct advocacy workshops at national and regional levels with key stakeholders to expand AY-responsive health system and integrate culturally sensitive RHE into school health programs.	MOH, MoE, MoWSA, MoF	Donors	September, 2025	
Organize high level consultative workshop among key stakeholders and influencers	Minister's office and RHBs RMNCH LEO	Donors, INGOs, CSOs, professional associations	End of December 2025	

ANNEX 1: WHAT IS A QUALITY COMMITMENT?

Commitments should be of the highest quality, including as many as possible of the following attributes:

Scope

- Government-led financial, policy and/or service delivery pledge to advance WCAH through MNCH, SRHR and/or AHWB. Commitments may be supported by Official Development Assistance (ODA);
- Commitments are made in support of national campaign targets as well as global or regional financing, policy, programmatic, or accountability processes and platforms generated by Member State-led institutions or initiatives in support of these processes;
- A specific focus on WCAH, and a subsequent link to the national social development plans, policies, and budgets.

Context and format

- Context-specific, highlighting concrete and measurable results that can be monitored through established institutionalized accountability mechanisms;
- SMART – Specific, Measurable, Achievable, Relevant, Time-bound;
- 'New' or 'Additional' commitments, where possible.

ANNEX 2: MNCH, SRHR, and AHWB Sub Domains

MNCH	SRHR	AHWB
High-quality MNCH services for mothers, newborns and children, including stillbirths: essential antenatal, childbirth and postnatal packages of care, including emergency obstetric and newborn care, and the prevention of stillbirths. Maternal: • Preconception care • Antenatal care • Skilled birth attendants • Postnatal care • Emergency obstetric care Newborn • Small and vulnerable newborn care • Prevention of stillbirths Child: • Child health services including • Breastfeeding and child nutrition • Immunization services **MNCH interventions embedded in UHC schemes, including financial protection and MNCH financing.** • UHC Schemes • Country health expenditure per capita on MNCH financed from domestic sources and ODA for MNCH • Out-of-pocket expenditure for MNCH services (% of current health expenditure) **Health systems strengthening including MNCH data and accountability, human resources for health – especially midwifery and nursing – and essential medicines and commodities** • MNCH information systems and accountability mechanisms including birth registration and disaggregation of data (sex, age)	**Access and choice to effective contraception methods (family planning).** • Family planning needs satisfied • Strengthened autonomy and access to contraceptive services • Comprehensive sexual health education **Access to safe and legal abortion services.** • Legalized abortion and access to safe abortion services **Prevention and treatment/referrals for Sexual and Gender-Based Violence.** • Legal mechanisms for addressing GBV • Training and support for health workers on GBV • Violence against women and girls including intimate partner violence **Prevention, detection and management of reproductive cancers, especially cervical cancer.** • Cervical cancer screening programs • HPV vaccine programs **Inclusion of essential packages of SRHR interventions within UHC and PHC schemes, including financial protection and SRHR financing.** • Coverage of all essential SRH interventions • Country health expenditure per capita on SRHR financed from domestic sources and ODA for SRHR • Out-of-pocket expenditure for SRHR services (% of current health expenditure	**Policy: National policy and programs for adolescent well-being (10-19 years) offering information and services in the public sector (e.g., health, education including CSE, nutrition, financial protection, and vocational training)** • Health education for children and adolescents – including mental health • Provision of quality education and training opportunities to ensure their future employability • Nutrition programs and physical activity for children and adolescents • Pregnant adolescent support • Financial protection for adolescent health **National standards for delivery of AHWB information and services to adolescents, including on user fee exemption** • Health services for adolescents – user fee exemptions for health services (contraceptives, immunizations) **Legal systems to protect the rights of adolescents (both female and male) with a specific focus on minimum age of consent (e.g. for marriage, sexual activity, and medical treatment without parental consent)** • Legal provisions against child marriage • Interventions to eliminate female genital mutilation • protection from violence (including physical, sexual, gender-based and electronic violence) and injury.

• Training and support for health workers for service delivery • Essential medicines, vaccines, commodities, technologies and innovations • Health information systems • Health system financing • Leadership and governance **Intersectoral approaches for MNCH across the life-course, including nutrition, WASH, environment, and gender equality** • Nutrition schemes and food security across the life course: pregnancy nutrition, breastfeeding support, child nutrition, adolescent nutrition • Financing for WCAH • Education • Shelter • WASH facilities and services • Protection from pollutants and toxicants and excessive heat • Social protection • Child Protection • Women in the workforce and leadership positions		**AHWB is embedded in national policies and plans with dedicated financing for AHWB programs** • Country health expenditure per capita AHWB financed from domestic sources and ODA for AHWB • Out-of-pocket expenditure for AHWB services (% of current health expenditure)

ANNEX 3: Partners participated in the CAAP process

No	Participant Name	Name of Facility/Organization
1	Dr Tekeste Demissie	AHRI
2	Dr Tewolde Wubayehu	WHO
3	Dr Mahbub Ali	UNFPA
4	Genet Ayele	MOPD
5	Eyob Getachew	FMOH
6	Hawa Adem	Afar RHB
7	Fisseha Moges	Pathfinder
8	Teshale Assefa	Central Ethiopia RHB
9	Ayeru Getnet	Benishangul Gumuz RHB
10	Abraham Wondimu	Southern Ethiopia -RHB
11	Nega Tesfaye	MSI
12	Zerihun Birhanu	Sidama RHB
13	Melat Tekalign	BMGF
14	Dave Schade	CDC
15	Tesfaye Lejio	Central Ethiopia RHB
16	Deng Ochimi	Gambela RHB
17	Mekonnen Nura	CORHA

18	Dr Birkety Mengistu	USAID
19	Yohannes Lakew	MOH
20	Wondesen Regimen	FBC
21	Bilen Mengistu	AMREF
22	Dr Rhael Belete	CHAI
23	Bilala Hagos	GFF
24	Kalkidan Leulseged	IFA
25	Eyob Mohammed	ESOG
26	Ambchew H/Michale	Tigray RHB
27	Abayneh Desta	Plan International
28	Amanda Tiffany	US CDC
29	Emala Lamcha	Sidama RHB
30	Lulit Yonas	Taya
31	Nibret Eyassu	Amhara RHB
32	Meselu a Atnafi	Dire Dawa RHB
33	Leuse Mekonen	Oromia RHB
34	Dr. Lidiya Tafera	BMGF
35	Lucy Boyonch	UNICEF
36	Mariamawit Tassew	CIFF

37	Abdi Farah	Somali RHB
38	Tesfa Dimesse	EPHA
39	Amanuel Lulu	AHRI
40	Kumie Alene	CDC
41	Dr. Solomon Shifreaw	AAU
42	Etenesh G/Yohanese	MOH
43	Zemzem mohammed	MOH
44	Yonas Zola	MOH
45	Tadele Kebede	MOH
46	Dinksera Debebe	GFF
47	Dr Mequanint Melese	University of Gondar (UOG)
48	Ahmed Mohammed	MOH
49	Siyane Anitay	STBF
50	Tsige tesfaye	MOH
51	Anteneh Mebratu	MOH
52	Tigist Tesahun	MOH
53	Zelalem Assefa	MOH
54	Tafesse Bersisa	MOH
55	Sindu Mekuria	AACAHB

56	Dinkineh Bikila	CHAI
57	Yalewlayker Yilma	CHAI
58	Habtamu Tezera	CHAI
59	Dr Zelalem Demeke	CHAI
60	Pramanik Mohit	PMNCH
61	Dr Solomon Worku	MOH Minister's Office
62	Dr Siyoum	Engender health
63	Dr Abdisa Kabeto	CHAI

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