National Health Promotion Strategic Plan

(2021/2-2025/6)

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MINISTRY OF HEALTH, ETHIOPIA

National Health Promotion Strategic Plan

(2021/2-2025/6)

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Acronyms

AMR	Antimicrobial Resistance
ANC	Antenatal Care
ASDR	Age Specific Death Rate
BCC	Behavior Change Communication
CDR	Crude Death Rate
CSOs	Civil Society Organization
CVD	Cardiovascular disease
DALY	Disability Adjusted Life Years Lost
EDHS	Ethiopian Demographic Health Survey
EFDA	Ethiopian Food, Drug Authority
EPHI	Ethiopian Public Health Institution
EPHS	Essential package of health services
FeFol	Iron-folic acid
FGM	Female Genital Mutilation
GDP	Gross Domestic Product
HEC	Health Education & Communication
HEP	Health Extension Program
HEPHC	Health Extension and Primary Health Care
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HPS	Health Promotion Strategy
HPE	Health promotion and education
HPV	Human papillomavirus
HSDP	Health Sector Development Plan

HSTP	Health Sector Transformation Plan
ICT	Information Communication Technology
IEC	Information, Education & Communication
INGOs	International Non-Governmental Organizations
IPC	Interpersonal communication
ITN	Impregnated Treated Net
MCC	Motivated, competency and compassionate care
mCPR	Modern Contraceptive Prevalence Rate
MDGs	Men Development Groups,
MDGs	Millennium Development Goals
MoH	Ministry of Health
MOU	Memorandum of Understanding
NCDs	Non-Communicable Diseases
NGO	Non-governmental Organization
NHPCS	National Health Promotion & Communication Strategy
NTDs	Neglected Tropical Diseases
PHC	Primary Health Care
PHCUs	Primary Health Care Units
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
PYDGs	Positive Youth Development Groups,
TT	Tetanus Toxoid
RHB	Regional Health Bureau
SBC	Social and Behavior Change

SBCC	Social and Behavior Change Communication
SDGs	Sustainable Development Goals
SM	Social Mobilization
SMS	Short Message Service
SOPs	Standard operating producers
SWOT	Strength, Weakness, Opportunity & Threat
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal health coverage
VHLs	Village Health Leaders,
WASH	Water, Sanitation, and Hygiene
WDGs	Women Development Groups,
WHO	World Health Organization

Foreword

The National Health Promotion strategic plan (2021/2-2025/6) provides the basis for health promotion regulations, systems and information for people to use these for their own benefit, to advocate for and encourage enablement for those who cannot. It is designed to support the national health policy objectives i.e to direct towards improving people's ability to control the factors that determine their health and to live better lives.

This strategic plan is intended as a resource and guide for all relevant stakeholders and interested parties concerned with promoting health in Ethiopia. It also fulfills the important commitment set out in the National Health Policy and HSTP II in line with the Ministry's slogan 'Healthier citizens for prosperous nation.'

This strategic plan identifies strategic objectives, which will contribute to the overall health improvement of the population. It must be stressed however that many of the strategic objectives cannot be achieved solely by the health sector, but will require an inter-sectoral and multidisciplinary approach to put health promotion on everyone's agenda. By implementing this strategic plan, Ministry of Health aims to assist in improving quality of life and encompasses educational, motivational, and economic components, including individual and group change, and social influence techniques.

Ministry of Health is committed to implement this strategic plan and bring a change in the public health status by using the available resources. The strategic plan will not only contribute towards further improving the quality of life of people, but will also pave a way forward for other innovative health promotion strategies that can be replicated across various public health interventions.

I would encourage all stakeholders to embrace the plan so that individuals, communities and population groups can have greater opportunities to attain and sustain health. I also would like to take this opportunity to thank everyone who contributed to the preparation of this document.

Dereje Duguma,MD.MPH
State Minister of Health
Addis Ababa, Ethiopia

Executive Summary

Health is regarded by the World Health Organization (WHO) as a fundamental human right, and health promotion is defined as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health".

Health promotion has a significant role to play in reducing the burden of disease to the health system, by addressing the key social, behavioural and structural determinants of health.

This National Health Promotion Strategic plan (2021/2– 2025/6) is both an ambitious and practical strategic plan. It is ambitious in that it seeks to re-conceptualize the role of health promotion in the health sector and other sectors; places families and communities at the center of planning and action; elevates the practice of health promotion; and focuses on the actions of a partnership of agencies. It is practical in that it establishes the building blocks of enhanced health promotion capacity; explains roles and responsibilities; builds on national and international best practices. This Strategic plan is built on a solid foundation of National Health Policy, Health Sector Transformation Plan (HSTP) II, Health Extension Program (HEP) Optimization Roadmap and Community Engagement strategy.

Improved intra and inter-organizational coordination is required to ensure that resources are used efficiently and interventions are implemented effectively. The Strategic plan spells out the role of health promotion in the health and other sectors. It also highlights the need for collaborative efforts between the health sector and all other stakeholders.

Organization of the Strategy Document:

The National Health Promotion Strategic plan (2021/2– 2025/6) comprises of the following eight major sections:

Section One - Introduction

Provides background information on the health promotion and findings that led to the development of the Strategy

Section Two - Country contexts

Reviews essential background information and provides context for the Strategy development

Section Three - SWOT Analysis

The Strategy identified lessons and challengs/ gaps in health promotion during the previous Strategy period

Section Four - The Rationale and Policy Framework for Revision of the Strategy

The section states the justification for the strategy and describes the basic assumptions underlying its development, as well as the health interventions recommended for priority actions.

Section Five - National Health Promotion Strategic plan (2021/2-2025/6)

Describes Strategic - Vision, Mission, Core Values, Goal, Guiding Principles, Scope, Approaches, Framework, Directions, Objectives and Interventions are the main parts of the strategy.

Section Six – Strategic plan Implementation Modality

The implementation of this strategic plan requires coordination with stakeholders across all levels. Each partner may have a specific area of focus. As a result, there is a need for an integrated Health Promotion Strategic plan under which all stakeholders work.

Section Seven - Monitoring and Evaluation

To monitor the implementation of each proposed intervention, a framework with a set of performance indicators are crucial.

Section Eight –Implementation Action Plan

This National Health Promotion Strategic plan is a five years strategic plan. An estimated ETB 2.08 billion (approximately US$43.4 million) is needed to execute this strategic plan over the five years. Considering the cumulative economic loss from preventable diseases morbidity and mortality (both human capital and health care service cost), the estimated cost to execute this strategic plan should be seen as an investment rather than a cost, in particular given the dire projections of preventable diseases and its expected impact on citizens health and the country's GDP. On the other hand, lessons from effective health promotion implementation prove that when quality health promotion is sustained, health outcomes are improved. Therefore, for the success of this Strategic plan, both government decision-makers and national and international partners have a role to play.

SECTION I:
INTRODUCTION

1.1. Background

Global Historical Perspective of Health Promotion

Health is regarded by the World Health Organization (WHO) as a fundamental human right, and health promotion is defined as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health".[1]

Health is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'[2] This clearly implies the need for promoting 'holistic' well-being and comprehensive healthcare that enables people to increase control over improving their own health and to be a productive citizen. This process entails raising health awareness, enabling informed choice, disease prevention and control. Therefore, actions in health promotion requires that efforts move beyond the boundaries of an absolute biomedical approach, towards one that takes into account the wider determinants of health including social, economic, political, cultural and ecological factors.

The principles of the Alma Ata Declaration of 1978 laid the foundation for health education as the precursor to health promotion, and advocated for the primary health care (PHC) approach. Health promotion began to gain acceptance worldwide after the launching of the Ottawa Charter for Health Promotion at the first international health promotion conference held in Ottawa, Canada 1986.[3] Since then, it is considered as a cost-effective approach and a socially justifiable investment. The Shanghai Declaration on promoting health in the 2030 Agenda for sustainable development also emphasized that health and well-being are essential for sustainable development.[4]

Health and development today face unprecedented threats. The financial crisis threatens the viability of national economies in general and of health systems in particular. Health promotion has the potential to bring huge positive impact on health, yet it is given low priority. Health promotion is indeed more relevant today than ever in addressing public health problems. In the 21st century with ever-increasing public health threats and challenges, the health sector is at a unique crossroadsas the world is facing a 'triple

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1 Ottawa Charter for health promotion. First International Conference on Health Promotion, Ottawa, Canada. 21 Nov 1986.

2 Preamble to the Constitution of the WHO as adopted by the International Health Conference, New York: WHO,19-22 June, 1946.

3 Ottawa Charter for health promotion. First International Conference on Health Promotion, Ottawa, Canada. 21 Nov 1986.

4 The Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development. Geneva: WHO; 2016

burden of disease'[5] constituted by the unfinished agenda of communicable diseases, newly emerging and re-emerging diseases, emergence and rise of antimicrobial resistance as well as the unprecedented rise of noncommunicable chronic diseases and injuries (NCDIs). Thus, as traditional individualistic information provision and behavioral interventions are no longer enough in preventing and controlling major public health problems efficiently and effectively, an innovative health promotion approach is imperative.

Health Promotion history in Ethiopia

In 1968 health education was institutionalized and incorporated into the organizational structure of Ministry of Health to facilitate health promotion services in the country. The acceptance of Alma-Ata declaration in 1978 where health education was placed among the components of primary health care also played a major role in the development of the health education unit within the MOH. The unit was upgraded to a department in 1988 and in 1995 this department was restructured to become the Health Education Center. In 2005, the Health Eduction Center was merged with the Health Extension Program and was named the Health Education and Extension Center. However, in 2007 as a result of the newly implemented Business Process Reengineering (BPR), the Center was dissolved. This was major setback to the development of health promotion interventions and created a structural and institutional gap within the MOH as well as at decentralized levels (regional/zonal/ Woreda levels). In recent years, efforts have been made to strengthen health promotion and education under the HEP/PHC directorate. Currently, a Health Promotion team has again been established within the MOH with the responsiblitiy to coordinate health promotion activities at national level.

This National Health Promotion strategic plan will cover the period between 2013/14-2017/18 Ethiopian Fiscal Years (July 2021/2 – June 2025/6) and will be implemented for the next five-years in line with HSTP II, HEP Roadmap and Community Engagment Strategy. In this strategic period, the health sector envisions to build on the successes, lessons learned and consolidate the gains from the implementation HSTP-I. The interventions seek to promote healthy behaviours and empower individuals, families and communities to take necessary actions and to reinforce the desired structural changes through policies, legislation and regulations.

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5 Disease burden from communicable and non-communicable diseases as well as related to injuries.

SECTION II:
COUNTRY CONTEXT

This section provides contextual information, such as the geographic, demographic, and socioeconomic profile of Ethiopia, that need to be considered when assessing the potential effectiveness of the health promotion strategic plan and outlining neccessary health promotion strategic priorities.

2.1. National Geographic and Demographic Profile

Ethiopia is located in the Horn of Africa, with a total surface area of 1,104,300 sq. km (land: 1,096,570 sq. km and water: 7,730 sq. km) and with border to Djibouti, Eritrea, Sudan, South Sudan, Kenya, and Somalia. It has ten regional states, namely, Afar, Amhara, Benishangul-Gumuz, Gambella, Harari, Oromia, Sidama, SNNPR, Somali and Tigray, and two city administrations, namely Addis Ababa and Dire Dawa. Each regional/City Administration state is autonomous and is headed by a State President /Mayor elected by the respective regional/city council. Ethiopia is the second most populous country in the continent of Africa, after Nigeria, and the 12th most populous country in the world,[6] with a projected population of about 104 million in 2021.[7] The population is characterized by rapid population growth (2.6%), young age structure and a high dependency ratio with large differences between rural and urban areas. The total fertility rate is 4.6 births per woman (2.3 in urban areas and 5.2 in rural areas) and a corresponding crude birth rate of 32 per 1000 in 2016. The average household size is 4.68. In total, 47 % of the population is between 0-14 years and 48% between 15-64, while only 5% of the population is 65 years or older. The male to female ratio is 0.96 to 1.

Life expectancy at birth increased from 58 years in 2007 to 65.5 years in 2016 with annual rates of increase ranging from 1.98% in 2007 to 0.7% in 2016. Life expectancy at birth is currently higher for females (67.3 years) compared to that of males (63.7 years).[8]

Ethiopia is on track to a population age structure that may enable a demographic dividend. However, harnessing this dividend depends on the country's ability to scale up investments in human capital by addressing disparities among different equity dimensions.[9] With enhanced efforts to reduce health and education disparities between urban and rural, literate and illiterate population as well as among regional states, the country can gain a sizable demographic dividend that can fuel the reforms towards improving the quality of life of the people through promotion of planned family size, protection of environment, etc. Effective implementation of supporting policies, strategies and reform agendas are critical if Ethiopia is to realize the opportunity of the demographic dividend.[10]

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6 https://www.statista.com/statistics/1121246/population-in-africa-by-country/ accessed on 16.03.2021

7 Central Statistical Agency, Population Projections for Ethiopia, 2007-2037, Addis Ababa, July 2013

8 Central Statistical Agency/CSA/Ethiopia and ICF, 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA and ICF

9 HSTPII,2020-2025

10 CSA,2016

Ethiopia has a rich diversity of cultures, religions, and languages. More than 80 different languages are spoken, which has implications for the delivery of health services in such a diverse population. Religious practices in the country are predominantly Orthodox Christian(40.5%), Muslim(35.4%), Protestant(19.6%), Traditional belifes(3.1%), Catholic(0.8%) and other(0.7%).[11]

2.2. Socioeconomic Situation

Ethiopia is engaged in rapid and comprehensive development activities aiming to move the country from poverty to sustainable and reliable growth. Ethiopia has registered commendable progress towards reaching the Millennium Development Goals (MDGs), mainly in reducing poverty, achieving universal primary education, narrowing gender disparities in primary education, reducing child and neonatal mortality, and combating HIV, TB and malaria. The reduction in maternal and under-5 mortality is also notable. These gains have been a result of improvements in social determinants of health and increased access to health services. Despite encouraging improvements, however, pre-mature death and suboptimal quality of life still constitute major development challenges in Ethiopia. In addition, neonatal mortality has not shown significant reduction over recent years.[12,13]

Ethiopia is classified by the World Bank as a low-income country with gross domestic product (GDP) 9% and per capita income of US$850 in 2019, up from about US$340 in 2010. The country has been one of the fastest growing economies in Africa, experiencing rapid economic growth with an average of about 9.8% annual growth rate between 2008/09 and 2018/19.[14] The main contributors to the growth in GDP include agriculture, industry and service sectors.

While there was an expansion of schools and Universities in the past two decades, the literacy rate still stands at a national average of 50%.

According to Ethiopia's poverty assessment report, households have experienced a remarkable reduction in poverty rate from 39% of the population living below US$1.25 purchasing power parity a day in 2004/05 to 29% in 2010. The poverty levels fell by around 20% between 2011 and 2016.[15] However, even with these improvements, poverty, income inequality and unemployment remain persistent challenges. The government has launched a new 10-year perspective plan which will run from 2020/21 to 2029/30.

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11 CSA, 2007, Population and Housing Census Results

12 Federal Democratic Republic of Ethiopia Ministry of Health. Health Sector Transformational Plan II: 2020/21-2024/25

13 World Health Statistics, 2019. https://www.who.int/gho/mortalityburdendisease/lifetables/haletext/en/

14 https://www.worldbank.org/en/country/ethiopia/overview , accessed on 17.03.2021

15 World Bank, 2019

2.3. Media and ICT Landscape

Health promotion uses a mix of strategies to promote, facilitate and support critical changes for improving health outcomes. It is concerned with reaching different population segments/ groups to exchange health-related information, ideas, and methods in order to influence, engage, empower, and support individuals, communities, health care professionals, patients, policymakers, organizations, special groups and the public, so that they will introduce, adopt, champion or sustain a healthy behavior, practice, or policy that will ultimately improve individual, community, and public health outcomes.

2.3.1. Mass Media

Media is one of the most powerful social institutions in modern society. It affects and defines societal culture, family structure, politics, history, religion, identities, and normative order. Media has an important role in awareness creation on health matter by disseminating messages accurately to the general public, and potentially influencubg behavioral and policy change. In Ethiopia, there are electronic and print media, including numerous emerging regional, private and local community FM radio stations transmitting in local languages. The use of mobile phone to listen radio programs has increased particularly in the rural areas which has enhanced accessibility and reach. Radio is the main source of information in Ethiopia (80%).[16]

Ethiopia has, for quite some time, had limited access to mass media alternatives. The public sphere is mainly catered by the Ethiopia radio and TV broadcast, which is a state owned media outlet. These days, Fana Broadcasting Corporation (FBC), Walta and other private radio and TV channels also play a significant role, including in transmitting health programs in different vernaculars and formats. It is also important to ally with the educational media structure (the Medium wave Educational Radio Stations and Educational Satellite TV transmitting stations located in the different parts of the country). The radio stations broadcast school curriculum in different vernacular, and the Satellite TV broadcast secondary school education from Addis Ababa, reaching secondary schools all over the country. More importantly, both the Radio and TV stations broadcast health education for free. Hence, it is imperative to consider them for health program production and dissemination in consultation with Ministry of Education.

The fact that mass media has the potential to reach a large proportion of the population in a very short period of time means that mass media should be considered as a key communication channel for health promotion.

16 BBC Media Action Radio for Development, 2019

2.3.2. The Information Communication Technology (ICT) Policy

The Government's ICT Policy has identified health services as one of its strategic areas of focus. The policy has the overall aim of contributing to socioeconomic transformation and development and seeks to improve the effectiveness of the national health policy and strategy through dissemination of health information on ways to promote health, prevent communicable and non-communicable diseases using the Internet.

Mobile apps, SMS messaging and the internet are increasingly being used to disseminate health information to the general public. There is a family health guide mobile app developed by MOH. In addition, many ICT platforms are becoming valuable resources for health professionals to continuously remain updated on the latest health developments, to identify best practices around the globe, and to improve the quality health services delivery.

2.3.3. Social Media Analysis

Nowadays, a significant proportion of the population are active on different social platforms, particularly in urban community. New social media platforms are emerging and current platforms are also constantly evolving. Many of these plafroms can be used to engage users in conversations regarding health matters.

According to Digital Ethiopia 2021 Report; Ethiopia has:[17]

- More than 46.75 million active mobile connection subscribers, which is equivalent to 41% of the total population. This can creates an opportunity to reach key parts of the population through text messaging or Short Message Service (SMS).
- 23.96 million (20.6%) internet users and
- 6.70 million social media users which accounted for 5.8% of its entire population.

Therefore, social media can be used to reach service providers and younger populations in urban community while SMS in local languages can be an effective way of reaching the general population.

2.4. Education

Compared to the rest of the world, Ethiopia has low literacy and school enrollment rates, particularly in rural areas. High levels of attrition rate across the country is a challenges for the Ethiopian education sector. According to UNESCO, in 2017, Ethiopia had an adult literacy rate of 51.77% and has seen improvements in recent years. While the male literacy rate is 59.24%, the rate among women is 44.42%.[18] Educational attainment (years) is 3.2%. As of 2020, 45.4% of children are enrolled in pre-primary classes.[19]

17 Digital Ethiopia 2021 Report

18 UNESCO Institute for Statistics (http://uis.unesco.org/)

19 Ethiopian Ministry of Education, Education Statistics Annual Abstract, 2019/20

Investing in education is investing in health. Education and literacy are key determinants of health, but do not ensure health literacy. There is a well-known, strong and persistent link between education and health.[20] Health literacy relate specifically to a wide range of skills that improve the ability of people to act on information in order to live healthier lives. Literacy and higher levels of educational attainment of the mother and household head are positively associated with improved outcomes in health.[21] There are substantial and important positive causal effects of education on health. Education as a personal attribute, includes not only subject-matter knowledge, reasoning, and problem-solving skills, but also awareness of one's own emotions and those of others and control of one's emotions (i.e., "emotional intelligence") and associated abilities to interact effectively.[22] Education improves health because it increases effective agency, enhancing a sense of personal control that encourages and enables a healthy lifestyle. Education's beneficial effects are pervasive, self-amplifying, and often accumulates over a person's life course. Hence, understanding and harnessing the positive effect of education on health outcomes can be important in improving public health. Furthermore, health and related school clubs, and /or incorporating health education/promotion in the primary and secondary school curriculum, for example science and biology classes, can also be used to dissemintate important health information and improve health outcomes, in line with the WHO's health promotive recommendations.

2.5. Health Situation–Health Status, Risk Factors and Burden of Disease

Ethiopia has completed the first health sector transformstion plan (HSTP-I), marked by several positive results and achievements. Morbidity and mortality from common communicable diseases, including malaria, HIV, tuberculosis (TB), and vaccinepreventable diseases, declined dramatically, However, the same period witnessed a substantial rise in the prevalence of non-communicable diseases.

In terms of disease risk factors, there has been a relatively high level of reduction in unsafe sex behaviour. The prevalence of stunting, underweight, and wasting have been reduced from 51% to 37%, from 33% to 21%, and from 12% to 7% respectively, between 2005 and 2019. However, risks from water, sanitation, and hygiene (WASH) and dietary factors, alcohol use, and high blood glucose level showed a lower rate of reduction. [25]

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20 Health Impacts of Education: a review, the Institute of Public Health in Ireland , 2008

21 CSA and UNICEF Ethiopia (2020), Faces of poverty: Studying the overlap between monetary and multidimensional child poverty in Ethiopia.

22 Bradberry T, Greaves J. Emotional Intelligence 2.0. San Diego, CA: Talent Smart; 2009.

Furthermore, Ethiopia is facing a triple burden of disease with increasing prevalence of lifestyle and environmental related non communicable diseases (NCDs). Cardiovascular diseases, diabetes, cancers, mental health, high levels of tobacco use and alcohol abuse, as well as all forms of accidents and injuries including road traffic injuries have increased disproportionately. The increase in the number of NCD cases not only burdens families but also have direct bearing on the country's health expenditure.

The burden of disease, disability and premature deaths in Ethiopia continues to be disproportionately high. Yet most of the causes are preventable. Lifestyle related risk factors for chronic diseases tend to be more prevalent in the younger age groups, resulting in higher premature mortality compared to the developed world.[23] Sedentary lifestyle is common among adolescents.[24] In Ethiopia behavioral risk factors such as dietary risks, unsafe sex, alcohol use, and tobacco use, constitute five of the top ten risk factors contributing to the most disability adjusted life years lost (DALYs). In addition, harmful traditional practices such as; Female Genital Mutilation (FGM), early marriage, food taboos, ovulectomy, milk tooth extraction, laboring in the bush, etc. need to be identified and addressed with effective health promotion interventions. There is also a need to correct myths and misconceptions around competent health practices by creating an enabling environment.

In Ethiopia, health care utilization remains low. For example, according to the mini DHS 2019, ANC, ITN use, mCPR, PNC and health seeking for children age of five for fever remain low, especially among rural dwellers, socioeconomically deprived communities such as pastoralist communities, and those without formal education.[25] Misperceptions regarding the causes, outcomes, and remedies of diseases are some of the factors that contribute to low health seeking behavior. In addition, diverse socio-cultural beliefs and practices also influences decisions regarding health facilities use.

The low health and health system literacy, where community is not fully aware of existing services at the different levels of the health system, also contributes to the low demand and utilization of health services. The HEP 2019 assessment has indicated that low awareness of communities regarding services that are already available at HPs, 41% of the community was not aware about available HEP services - indicating low health literacy.

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23 Ethiopian Public Health Association (EPHA). Emerging public health problems in Ethiopia: Chronic non-communicable diseases. Addis Ababa; EPHA, 2012.

24 Health Sector Transformational Plan II: 2020/21-2024/25

25 Alene M, Yismaw L, Berelie Y, Kassie B: Health care utilization for common childhood illnesses in rural parts of Ethiopia: evidence from the 2016 Ethiopian demographic and health survey. BMC Public Health 2019; 19(1):57.

Table 1: Summary of Ethiopian Health Situation based on four DHS (2005-2019)[26]

Key Indicators		EDHS 2005	EDHS 2011	EDHS 2016	EMDHS 2019
Under-5 mortality		123	88	67	55
Infant mortality		77	59	48	43
Neonatal mortality		39	37	29	30
Received any ANC from skilled provider		28	34	62	74
Had 4+ ANC visits		12	19	32	43
Births attended in a health facility		5	10	26	48
Contraceptive use(any modern method)		14	27	35	41
Stunted		51	44	38	37
Underweight		33	29	24	21
Wasted		12	10	10	7
Exclusive breastfeeding		49	52	58	59
WASH[27]	Improved water cover		50	64.8	77
	Improved Latrine		8.8	6.3	18
	Handwashing practice		8		

Analysis of Ethiopian DALYs in 2019 showed that, 58% of DALYS were due to maternal, neonatal and communicable diseases and malnutrition, while 35% were due to NCDs.[27, 28]

Ethiopia has a high burden of NCDs, and the number of DALYs lost due to NCDs has increased three times in 25 years (1990-2015)[29] and by 18% between (1999-2019), fig.2. Increasing urbanization and the associated change in lifestyle among individuals and communities is expected to further accelerate the epidemiologic shift.[30,31] Behavioural and social determinants of health are associated with modifiable risk factors for diseases causation.

Modifiable risk factors, such as unhealthy diets, physical inactivity (sedentary lifestyles), tobacco use and harmful use of alcohol are the main contributors to NCDs in low and middle income countries, including Ethiopia. These factors will be a strategic focus of the health promotion strategy.

26 EMDHS 2019

27 JMP 2019

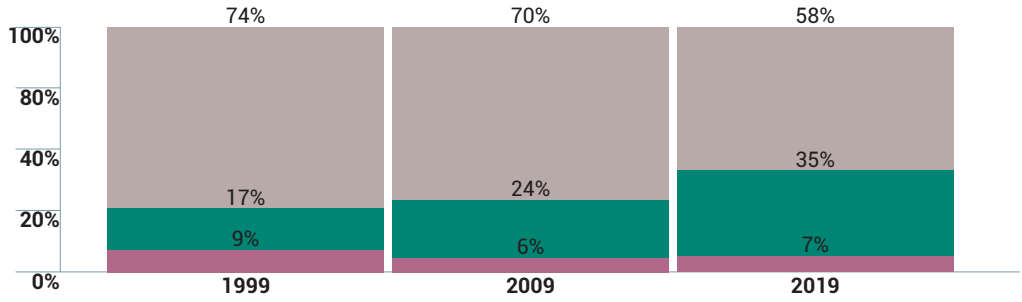
28 HSTPII,2020-2025

29 HSTPII,2020-2025

30 Institute for Health Metrics and Evaluation. Global Burden of Disease (GBD) Country Profile for Ethiopia. http://www.healthdata.org/ethiopia. Published 2017. Accessed 20 March 2019.

31 Federal Ministry of Health of Ethiopia, A Roadmap for Optimizing the Ethiopian Health Extension Program 2020 – 2035, Addis Ababa, Ethiopia, July 2020

Figure 1: Relative share of DALYs in Ethiopia, 1999 to 2019



Formative assessment Understanding of the determinants of health through will help to identify priority behaviours contextualized and adapted to local context. It also has utmost importance to design effective strategies of health promotion using effective channels of communication and messages.

2.6. Community engagement strategy

The government of Ethiopia introduced the Women Development Army (WDA) in 2011 where women are organized and mobilized in groups to share actionable messages and influence each other to improve their reproductive, maternal, newborn and child health (RMNCH) and hygiene practices with support from HEWs.

Community engagement has been a primary principle and strategy for achieving the strategic objectives of Ethiopia's health sector transformation plans. HEWs conduct home visits and outreach services to promote preventive health actions supported by the community engagement platform and have brought commendable improvements in reduction of maternal and child morbidity and mortality, reduction of morbidity and mortality attributed to major communicable diseases and improvements of environmental health and hygiene.

The Women Development Army (WDA) serves as a primary community engagement platform at the grassroots level. WDA has been scaled up to almost universal coverage in agrarian settings and partial coverage in urban settings. In pastoralist settings, social mobilization committees serve as community engagement platforms. There have been interventions to build the capacity of WDAs through competency-based trainings, with nearly half a million WDA leaders trained (MOH, 2019).

However, in recent years, the functionality of these structures has shown signs of decline. According to the 2019 National HEP Assessment and program reviews and reports:

- WDA leaders did not demonstrate model behaviors
- low capacity and acceptability among WDA leaders
- increased workloads and decreasing motivation of HEWs which affect the household and community level services provisions. Inadequate engagement of critical segment of the population such as men and youth, informal community structures, non-functionality of WDGs,
- Overdependence on the WDA structure has resulted in underutilization of other community resources, including those of men, religious leaders, and traditional leaders.
- Political connotations attached to it, frustrations about their future fate,
- Opposition from their husbands, lack of incentives, challenges in terms of perceived assertiveness and self-confidence.

The limmitations of the WDG strategy can have a significant negative impact on the progress towards Universal Health Coverage (UHC) and the achievements of sustainable development goals (SDGs) targets. For example; although there are various community engagement platforms at kebele level, their contributions towards improved utilization for health related activities has been either suboptimal or minimal.

In an effort to address the identified challenges and limitations, a new community engagement strategy is currently being developed and piloted for further massive implementation.

Women Development Groups (WDGs), Men Development Groups (MDGs),Village Health Leaders (VHLs), Positive Youth Development Groups(PYDGs), School Clubs and social structures, such as religious organizations, Iddirs and other structures are seen as key players in the strategy.

2.7. Global Health Days

Use of global health days are useful to raise public awareness and advocacy for concrete actions to address timely issues. The advantage of this approach is twofold: it provides an opportunity for an immediate benefit attached to the message as well as being a continuous reminder for action. Activities under this approach include production of branded items like T-shirts, caps, billboards, calendars, and umbrellas. Particularly, a calendar of events that

includes planned activities for different special global health days/events can enable the creation of an environment for behavioral change. These include important world health days to align health promotion activities. The following table highlights some of important special world health days to align health promotion activities.

Table 2: Some of important events to align health promotion activities.

S/N	The Official Health Days	Dates in the year
1	**Cervical Cancer Awareness Month**	January
2	**World Cancer Day**	February 4
3	**Anti-TB Day**	February 24
4	**World Water Day**	March 22
5	**World Health Day**	April 7
6	**World Antimalarial Day**	April 25
7	**The World Immunization Week**	Last week of April
8	**Women's Health Month**	May
9	**World No Tobacco Day**	May 31
10	**World Mothers Health Day**	May 28
11	**Antimicrobial Resistance Day**	June 15
12	**World Hepatitis Day**	July 28
13	**World Breastfeeding Week**	August 1 - 7
14	**World Mental Health**	October 10
15	**Global Handwashing Day**	October 15
16	**World Diabetes Day**	November 14
17	**Antibiotic awareness Week**	November 18 - 24
18	**World toilet Day**	November 19
19	**World AIDS Day**	December 1

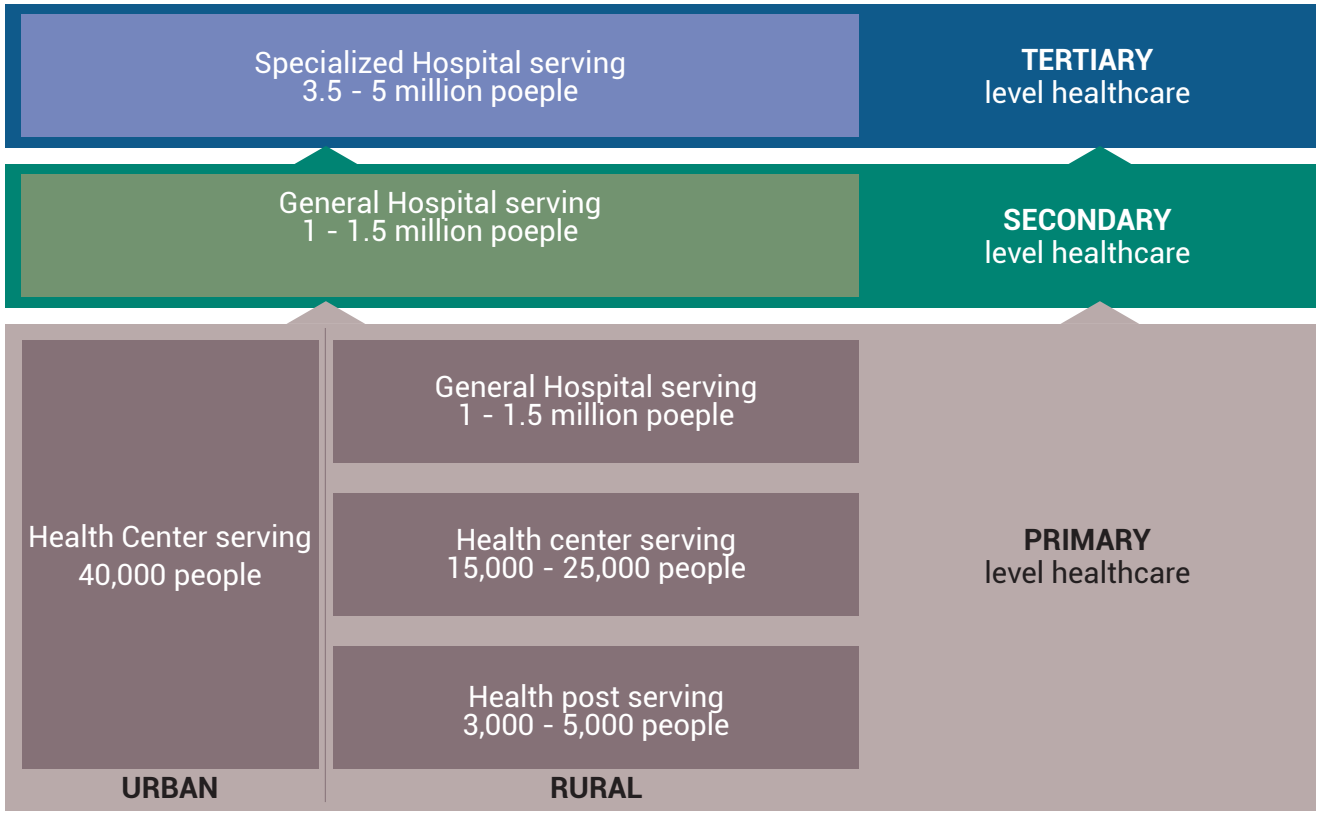
These days are important because they offer a worldwide platform to shed light on public health problems all over the world. No other platform unifies countries on matters of public health like World Health Days. They are important for disseminating information to the population and mobilizing action.[32]

32 https://www.worldatlas.com/articles/official-health-days-declared-by-the-world-health-organization.Retrived on April 5, 2021.

2.8. Health service delivery arrangements

Health service delivery in Ethiopia is organized in a three-tier system providing primary, secondary, and tertiary level of care. At the bottom of the tier system, there are Primary Health
Care Units (PHCUs) supported by a Primary Hospital (PH). The PHCU is composed of one health center serving up to 25,000 and 40,000 population in rural and urban settings, respectively and five community Health Posts each serving up to 3,000 and 5,000 population in
pastoralist and agrarian settings, respectively. The PH provides comprehensive primary level care for 60,000-100,000 populations. The second level of the tier system includes general hospitals which serve as referral centers for PHCUs. Each general hospital is expected to serve 1 - 1.5million people. The top-tier, tertiary level consists of specialized hospitals which serve as referral centers for general hospitals and serving 3.5 - 5million people.[33]

Figure 2. Ethiopian Health Tier System



33 FMoH. Health sector Transformation Plan from 2015 to 2020. 2015.

2.9. Institutional Arrangement for Coordination

The WHO Regional Office for Africa region requests member states to establish structures in the Ministry of Health at national and subnational levels with adequate human and financial resources to coordinate and manage implementation of multisectoral and multi-disciplinary health promotion actions across programmes and sectors.[34]

In Ethiopia, Health Promotion teams are often understaffed and overburdened with responsibilities for a wide range of public health priorities. The previous Health Extension and Education Center (HEEC) served as a center for training in health education and communication and played an important role in designing, producing, and disseminating health education materials. Currently, the Health Extension and Primary Health Care (HEPHC) Directorate is mandated to coordinate the HEP including primary health services and health promotion activities. The Health Promotion Case Team, organized under the HEPHC Directorate (see the organogram below), is responsible for the coordination of the planning, implementation, monitoring, and evaluation of the health promotion strategic plan. The case team has also established a national health promotion Technical Working Group (TWG) having an advisory role for the Ministry and coordinate with partners in planning and implementing health promotion activities. The TWG has made promising progress in harmonization, alignment, and capacity building for sustained health promotion in the country. The Health Promotion Case Team has vertical and horizontal relationships with many different Health Directorates within the MOH, which can make it challenging to coordinate health promotion activities in a harmonized way.

Figure 3: Organogram of Health Extension and Primary Health Care Directorate

The existing health promotion teams at the regional level often do not fulfill the human resource and technical requirements to achieve targets and reach strategic goals. In many teams, the focal person is only temporarily assigned to work on health promotion. Capacity and coordination gaps are even wider at the zonal and district levels.[35]. Addressing human resource constraints will enable the implemention of high-quality health promotion programming at scale. Resources are needed to recruit more dedicated and appropriately trained personnel to support health promotion activities.[36]

34 WHO Regional Office for Africa, Health Promotion Strategy for the African Region, Brazzaville 2013.

35 Assessment of SBCC for Health Interventions in Ethiopia: Survey of System, Organizational and Individual Levels Capacities for SBCC Ministry of Health and UNICEF December, 2020 Addis Ababa, Ethiopia,

36 RBM. The RBM Partnership to End Malaria: The Strategic Framework for Malaria Social and Behaviour Change Communication 2018-2030.

SECTION III:
LESSONS LEARNT AND SWOT ANALYSIS

Ethiopia's health promotion performance can be assessed against the community participation and ownership pillar in the HTSP that emphasizes the need for evidence-based health promotion initiatives.

The following lessons and challenges/gaps including strengths, weaknesses, opportunities, and threats (SWOT) were identified from the previous NHPCS (2016-2020) implementation experience.

3.1. Achievements of the NHCPS (2016-2020)

- Established national and sub national Health Promotion TWG and advisory groups
- Developed different guidelines and manuals on health promotion. Including;

  National Health Communication Material Development Guideline (HCMDG)

  Core Message Harmonization Guide (RMNCH, NCD & Mental Health, NTD & Hygiene, Public Health Emergency Diseases, Malaria, TB, and HIV) for different health problems)

  Risk communication and community engagement guideline and trainings were delivered at regional and lower level.... for their response during emergency

  Family Health Guide and distributed to enhance healthy behaviour and health service utilization through delivering key health messages to the urban and rural household/ community and guide health workers as job aid to educate the house hold/community.

  SBCC Quality Assurance Guideline was developed to ensure the quality of SBCC interventions, through systematic quality assurance process during the design, implementation, and M&E of SBCC programs.

- Capacity building trainings were provided to support health promotion practitioner and its partners in creating impactful SBCC programming and implementation.
- Facility based health promotion initiative was implemented at 697 health facilities, including efforts to equip health facilities with audio-visual materials (Radio, TV, DVD players and batteries).
- Assessment of the health promotion program planning has been conducted by Regions in collaboration with their stakeholders.
- Ethiopia organized the first International and National Social and Behavioral Change Communication (SBCC) Conference. The conferences were aimed at exchanging of SBC related knowledge and best practices as well as elevating the science and art of SBCC.
- National organizational capacity assessment on SBCC program design, planning, implementation and M&E capacity at system, organization and individual level was conducted.

- Applied innovative approaches to reach individuals and families with standardized health messages: introduce Family Health Mobile app, developed text message guide and transmitting free text messaging using 952.
- In order to promote healthy workplaces and environment, situational analysis were conducted at factories and prisons and different SBCC interventions were conducted.

In general, lessons learned from the implementation period of the last strategy,

- Delayed launch and distribution of the strategy at all level led to sub-optimal final outcome of the implementation.
- Strong partnership and coordination with health programe owners, other sectors, partners and concerned stakholders is very critical for the health promotion programe implementation and outcome. Addressing social determinant of health needs a multisectoral approach)
- There is a need to conduct a M&E indicators and Behavioural survey.

A detailed analysis at national and regional level has been done and the results are summarized in the SWOT analysis below.

3.2. Challengs/Gaps in Health promotion

3.2.1. Gaps at Individual Level

- Low health literacy
- Low self-efficacy, outcome efficacy, perceived behavioral control, skills, knowledge and wrongly held beliefs about communicable and non-communicable diseases.
- The knowledge, attitude and behavior change gaps due to social determinants of health/behavior (gender, urban/rural, educated/uneducated, access to media, social status, etc)
- Health promotion programs not well designed/planned, targeted and inappropriate media mix (between source, audience, channel, message and context).

3.2.2. Gaps at Interpersonal and Social networks level

- Poor interpersonal communication (IPC) skills among frontline community health agents (HEWs, WDG and community volunteers) and primary health workers.
- Inadequate knowledge and skills of community health workers.
- Community health workers and leaders not good role models in their community.
- Few household visits by community health workers (the HEP assessment identified that only 22.3% in pastoralist settings and 56.6% in agrarian settings ever had a visit by HEW)[37]
- The family health guide is not widely translated to local languages, not disseminated nor utilized as expected.
- There are gaps in reaching majority of the Ethiopian population with key health messages, particularly in the rural and pastoral areas, but also urban areas such as Addis Ababa.

3.2.3. Gaps at Organizational Level: Gaps related to institutional arrangement and staffing

Settings approach builds on the principles of community participation, partnership, empowerment and equity and replaces an over reliance on individualistic methods with a more holistic and multidisciplinary approach to integrate action across risk factors.

- **Communication gap:** lack of routine, structured interactions between health programmers/ practitioners, policy makers, and the health promotion team;
- **Expectations gap:** lack of an overall sense of clarity and balance between health programmers and health promotion and education practitioners regarding what is expected and rewarded in their respective domains. Confusion exists in the relationship between health education activities and the broader area of health promotion. Identified gaps include: 1. No multidisciplinary teams in primary care that address health promotion capacity development of human resources. 2. Limited opportunities for professional development in health promotion. 3. Limited familiarization with the health strategies, guidelines/standard tools, including such as SBCC quality assurance guideline.

37 Teklu AM, Alemayehu YK, Medhin G, et al. National assessment of the Ethiopian Health Extension Program. Addis Ababa, Ethiopia:2020.

- **Gaps in creating health literacy friendly health facility environment:** One of the HSTP transformational agenda is creating caring, respectful and compassionate health professions/ Compassionate Medical Care. There is a gap in client-professional interaction at the health facility level to advance age, gender or culturally appropriate friendly services. Re-orienting the health facilities to make them health literacy friendly is required.

3.2.4. Gaps at community, policy and environmental level

- Low community participation and ownership (for example: only 14.9% of women in agrarian settings and 8.0% of women in pastoralist settings reported being aware of a model family. Enrolment and graduation rates were very small, with only 2.9% of agrarian and 2.1% of pastoralist households reporting having ever been enrolled).
- Lack of evidence-based planning for health promotion interventions
- Low transparency and accountability on health promotion interventions
- Weak intersectoral collaboration to foster sustainable behavior change
- Lack of coordination between different bodies/directorate/program in the health sector.
- Weak collaboration with public health academic institutions.
- Limited identification, documentation, and sharing knowledge about societal values/traditional means of communication such as Idirs, Equb, Dagu in Affar, coffe ceremony, etc and best practices for health promotion
- Gaps in creating health promotion in urban settings and work place environments
- Gaps in identification, sensitization and advocacy for implementation of existing public health laws and legal frameworks. There are numerous national public treaties, such as International Health Regulations (IHR, 2005) and Framework Convention on Tobacco Control (FCTC) in place in the country. However, most of the public is not well informed and sensitized, and the laws are not well enforced.
- Gaps in sustaining health promotion interventions: Health promotion interventions are implemented just like campaign modes sometimes with development partners interests and their sustainability are not monitored and evaluated using rigorous indicators.

3.3. SWOT Analysis for Health Promotion

The strengths and weaknesses of health promotion in Ethiopia, and the opportunities and threats in the wider context are analyzed as follows:

Table 4: Health Promotion in Ethiopia:SWOT Analysis

Strengths	Weaknesses
• Existence of national health promotion and communication strategies and implementation guidelines (message and material development guidelines, SBCC quality assurance guidelines, core message harmonization guides, public health emergency risk communication guidelines) • Established and improved linkages and partnerships with various media and health communication actors • Improved Health Promotion planning using the strategy • Adoption of Mhealth • Existence of active technical working groups (TWG) and coordination platform at both national and regional level • Increased availability and utilization of family health guide • Supportive policies such as the HEP initiative, expansion of health infrastructures at all levels, and production of health care providers of different mix and in great numbers to ensure access and quality of care and to enable the attainment of the nationally and globally set targets. • Revision of HEP and community engagement strategies • Improved mass media engagement, • Adoption of new technologies,	• Inadequate staffing: ▯ Inadequate multidisciplinary staff ▯ Inappropriate task shifting in health programs. • Insufficient organizational structure arrangement: ▯ Structural and role ambiguities at all levels; ▯ Poor horizontal alignment of work plans and implementation. ▯ Inadequate attention for health promotion within the health system ▯ Inadequate leadership and follow up of health promotion interventions • Capacity related weakness: ▯ Capacity limitations to plan and implement the strategy at all level; ▯ Capacity limitations to use existing guides and tools at different levels in the system ▯ Limited activities in identifying, documenting, and sharing societal values and practices for health ▯ Inadequate preparedness to respond to health threats of international concern ▯ Inadequate monitoring and evaluation mechanisms ▯ Inadequate multi-sectoral collaboration ▯ Limited IPC capacity among health workers and poor provider behavior ▯ Low health and health system literacy

Opportunities	Threats
• Increasing number of media outlets including community radio/TV, social media outlets and print media with capacity to accommodate multiple languages • Availability of grass root level structures and social networks in the community (HEWs, WDGs, Iddirs etc.) • Increasing community participation in health activities and organized health infrastructures. • Existence of strong partners; sharing and use of expertise and resources with partners • Public-private partnerships to promote healthy life styles • Growing ICT infrastructures, including the mobile and electronic media • Expansion of educational institutions and improvements in literacy rate • Commemorate of global health days such as World Health Day, Antimalarial Day.... • Increasing demand for health information and services	• Escalating broadcasting fees for health development programme; considering like marketing programme • Recurring emergency situations and outbreaks. • Instability • Lack of budget • Epidemiologic shift in disease etiology • Unhealthy urbanization and/or industrialization as a risk factor to sedentary life situation. • Climate changes and its effect on health

3.4. STAKEHOLDER ANALYSIS

Stakeholders are key players in the health promotion and their analysis is crucial to the success of the health program. During the planning process of the health promotion interventions, it is important to take into account the needs and interest of those who have a 'stake' in the health sector.

Table 5: Stakeholder analysis

Stakeholders	What we expect from them	Their needs	Resistance issues	Institutional response
Community	Participation, engagement and Ownership Service utilization Healthy life style	Access to evidence based health messages and empowermer them to control their own health, creating an enabling environment	Myths and misconceptions Disatsfaction Low trust and service utlization	Community mobilization, ensure participation Evidence based behaviour change interventions Advocacy
Ethiopian Food and Drug Authority (EFDA)	Mainstream health promotion plans and action in their strategies and annual plan Enforce and regulate narcotic and substance abuse Protect consumer's health by regulating safety, efficacy and quality of medicinal products. Support introduction and enforcement of food labeling	Engage in health issue identification, health promotion planning, implimentation and M&E	Fragmentated efforts Low attention on the implimentation of prohibiting unhealthy diet/ product related advertisement	Strengthen engagement in the process of planning, implementation, M&E of health promotion,

Stakeholders	What we expect from them	Their needs	Resistance issues	Institutional response
Line Ministrers (Ministry of Education, Ministry of Agriculture and Natural Resource, Minister of Science and Higher Education (Universities), Ministry of Water, Irrigation and Electricity, MoFED etc.)	Inter-sectoral collaboration Mainstream health promotion into sectors policy, strategies and plans. Develop comprehensive health promotion policy Incorporate/reinforce curriculum on promoting healthy behaviours Strengthen health literacy into non-formal education curriculum Support safe and healthy environment in school, working environment and living environment Ensure adequate and capacitate staffing for sectors to implement health promoting interventions Effective and efficient use of resources & coordination Support implementation of local level health promotion initiatives	Effective and efficient use of resources & coordination, engaging in planning, M&E	Fragmentated efforts , Considering the importance of health as low priority	Advocate for mainstream of health promotion in all policies and strategies with strictly follow up on implementation Advocacy, capacity building, strengthen collaboration

Stakeholders	What we expect from them	Their needs	Resistance issues	Institutional response
Civil Society (professional assns.), training and research institutions	Provide in-service trainings and capacitate professionals with newly emerging HP scinces and innovationes Harmonize and align to national priorities and plans, engage in provision Produce health professionals with the required Knowledge, skills and engage in operational research Promote professional code of conduct	Policy support and guidance, collaboration, Continuous Professional Development (CPD) research, Involvement in planning, implementation and M&E Participation	Curriculum revision, Fragmentation Withdrawal	Strengthen collaboration in research, CPD, Advocacy
Development Partners	Harmonize and align to national priorities and plans, engage in the Implimentation Participation, resource & TA support Support monitoring of progress of implementation of NHPS.	Financial system accountable and transparent, Involved in planning, implementation and M&E	Fragmentation, inefficiency	Build implementation capacity for targeted response, ensure accountability, transparency & efficient use of resources, build financial management system, increasing domestic resource mobilization

Stakeholders	What we expect from them	Their needs	Resistance issues	Institutional response
Ethiopian Broadcast Authority / Mass Media Agencies/ Organizations	Mainstream health promotion plans and activities Allocate percentage of free air time and print space for health related public service announcements Support in developing good quality media materials to support targeted health promotion interventions. Implement policies relating to restrictions of advertising alcohol, tobacco and unhealthy foods. Promote social responsibility for health among private media companies.	Engage in health issue identification,health promotion planning, implementation and M&E	Fragmenation and intermittent efforts, High air time cost	Strengthen forums with media and collaboration, advocacy, capacity building

SECTION IV:
RATIONALE FOR THE REVISION OF THE STRATEGIC PLAN

There are several factors that justify a shift in the strategic approach towards health promotion and the need for a new health promotion strategic plan. For example, the HEP assessment conducted in 2019 highlighted to the need to revise current social and behavior change theories and strategies in a way that considers variability in the needs of specific behavioral outcomes and cultural contexts. The MOH is currently revising its community engagement platforms such as women's development group (WDG).

Furthermore, emerging global pandemics and frequent public health emergencies such as COVID-19, malaria resurgence, zoonotic diseases (Brucellosis, Scabies, Anthrax, avian flu) and increasing burden of the NCDIs both in the urban and rural areas require a more specific, robust and coordinated preparedness and response strategies, which need to be analyzed and addressed in a revised national health promotion strategic plan.

Therefore, considering shifts and concurrent contexts in the health sector, a new health promotion strategic plan needed to be developed to guide meaningful and efficient implementation of HP interventions. Investing in health promotion is an important aspect of realizing Universal Health Coverage (UHC). UHC will be financially feasible only when Ethiopia implement strong evidence-based health promotion programs. However, challenges are many and careful consideration and analysis is neccessary. Therefore, this Health Promotion Strategic plan (2021-2025) was developed through a participatory process involving partners from the MOH, Regional Health Bureaus (RHBs), Universities and partners who are implementing health promotion activities on the ground, with the goal of outlining health promotion prioritity areas.

The Strategic plan was designed to align with existing policy framework; its aim is health promotion and disease prevention[38], to contribute to the sustainable development goal (SDG) agenda 2030; to ensure healthy lives and promote well-being for all at all ages (SDG 3)[39]. The policy documents that have informed the need to revise the existing National Health Promotion and Communication Strategy (NHPCS 2016-2020) are: The Second Health Sector Transformation Plan (HSTP II, 2021–2025),The Health Extension Program (HEP) Optimization Roadmap(2020-2035) and the introduction of community engagement implementation strategy which emphasize the need to recognize, prioritize and scale up health promotion interventions in the implementation of the essential health package to address health problems and to effectively utilize technologies in conveying key message to the end users.

38 FDRE draft Health Policy, 2019

39 United Nations (2015) Resolution adopted by the General Assembly on 25 September 2015, Transforming our world: the 2030 Agenda for Sustainable Development

4.1. The Health Policy

According to the national health policy, in order to improve the health and healthy life style at individual, family and community levels, there needs to be a focus on health promotion and disease prevention interventions. Some of the strategies emphasized within the policy are:

- Improve and strengthen health promotion strategies to enhance facilitator factors for healthy lifestyle and healthy behavior at individual, family and community levels.
- Strengthen sustainable behavior change through enhancing intersectoral collaboration and implement technology based health promotion.
- Decrease premature mortality and morbidity through reduce risk factors through risk communication interventions and promotion of healthy behaviours.
- Implement strategies to reduce workplace related health risks and health problems
- Empower community to understand health problems with their cause and solution through improved knowledge, positive attitude and practices.
- Recognize cultural, life style, traditional and other differences of the community and enhance community participation on designing and implementation of health strategies that are need based (contextualized)
- Improve active participation of formal and informal networks/associations on health service.
- Improve health literacy through disseminate health messages using mass media and accessible channels.
- Advocate for laws and regulations on healthy environment

4.2. Health Sector Transformation Plan II

The importance of health promotion, disease prevention, and behavioral change communication, are included in the HSTP II as key components of the HEP to achieve increased demand of health services and community empowerment for the sustainability of health outcomes.

- HSTP I performance analysis showed that, behavioral risk factors including malnutrition, dietary risks, unsafe sex, alcohol use, and tobacco use, constitute five of the top ten risk factors contributing to the most DALYs lost. Modification of lifestyle and health-related behaviors and health care utilization remains low.

- The HSTP II (2021-2025) highlighted the need for innovative Health Promotion and community engagement interventions tailored to the changing needs and contexts at community and facility levels. Two out of 14 strategic directions of the HSTP II are directly linked to the health promotion: ensure community engagement and ownership and enhance health in all policies and strategies.

4.3. The Health Extension Program (HEP) Optimization Roadmap (2020-2035)

Ethiopia has made remarkable achievements in health outcomes through the implemention high impact interventions mainly through its flagship community focused HEP. The country has been successful in mobilizing and sustaining momentum for change in the health sector through the implementation of the four transformation agendas; namely, Woreda Transformation, Information Revolution, Transformation in Quality & Equity and Compassionate, Respectful and Caring health workers. Respectful and Caring health workers engendered momentum with the health sector to transform critical barriers of the health system. The HEP Optimization Roadmap and the recently introduced community engagement strategy initiatives signifies the commitment of the Government of Ethiopia (GoE) to reach out to families, encourage community empowerment and sustain the uptake of health services and to succeed in achieving the ultimate goal of UHC.

4.4. The need for Inter-sectoral collaboration

Effective health promotion strategies require action to be taken outside the health sector in order to promote healthy living, to improve access to information, to reduce risk factors for disease, and to improve the quality of the environments in which people live. The Ottawa Charter for Health Promotion[40] stated that: The prerequisites for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: governments, health and other social and economic sectors, nongovernmental and voluntary organizations, local authorities, industry and media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a responsibility to mediate between differing interests in society for the pursuit of health. Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

40 Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, Canada, 17–21 November 1986. Geneva: World Health Organization; 1986

Taking into account of the role of other sectors and initiatives in contributing to health promotion and health literacy, this strategy will consider advocacy with and strategic alliances with relevant sectors including the education sector. Recognizing that health promotion and health literacy requires more than the transmission of information, it will explore the latest developments in participatory approaches to determine how people can develop the skills, knowledge and efficacy to act on that knowledge in order to maintain good health. In this regard, the health promotion strategy have been informed by evidence generated from the information revolution roadmap of HSTP.

Consequently, in addition to lessons learnt and analysis of the strengths and weaknesses of the NHPCS (2016 – 2020) , the nation's long-term socio-economic strategic directions and priorities, the global situation and country's commitments to SDGs, and the dynamics of structural and social determinants of health were taken into consideration during the development of this national health promotion strategic plan.

SECTION V:
NATIONAL HEALTH PROMOTION STRATEGIC PLAN (2021/22-2026-7)

5.1. vision

To see a health litrate and healthy society

5.2. Mission

To promote health and well-being of individuals by increasing knowledge, informed decision making and positive behavior change

5.3. Goal

Enable individuals, families and communities to adopt healthy behaviours and lifestyle

5.4. Core Values

Community first

Integrity, loyalty, honesty

Transparency, accountability, and confidentiality

Collaboration

Professionalism

Change/innovation

Evidence based health promotion and

Respect the diverse norms and culture of the society

5.5. Scope of the Strategic plan

The Strategic plan focuses on providing famwork, guidance and support to specific health programs and the promotion of partnership within the health sector and across other sectors for the implementation of health promotion interventions, within various settings and levels of government. The users for the Strategic plan are health and health promotion programers/experts within the public health sector and in the the non-health sector, including public, private, non-governmental and CSOs sector partners of the MOH.

5.6. Guiding Principles

This strategic plan will be guided by the following principles.

- **Ownership:** It is vital to align health promotion interventions with national and regional priorities. Gains achieved through health promotion need to be sustained through community engagement including but not limited to generation of local resources. Therefore, it is indispensable to promote ownership of health promotion interventions at all levels. Clear accountability is also important for effective and efficient implementation of the strategic plan. Ownership will also ensure sustainability.
- **Audience-centered:** The design and development of messages, materials, and communication interventions will rely on a thorough understanding of the audiences for which they are intended. Development of health promotion guidelines, manuals, and materials needs to be carried out in a way that is understood by the intended audience and contribute to behavior change processes and the creation of enabling environment at individual, family, community, and society levels.
- **Partnership and Coordination:** By their very nature, health promotion interventions demand coordination of different sectors, program implementers, communities and individuals at all levels. Therefore, there is a need for establishing effective coordination mechanisms among various government sectors, partners, bilateral, multilateral organizations, and private sectors to enhance implementation and capacity among stakeholders.
- **Integration:** Health promotion interventions need to work in harmony with the relevant programmatic units and services in order to ensure that activities are aligned with realities on the ground. Health promotion demand active engagement of various sectors. Therefore, it is crucial to make sure that effective integration is in place.

- **Evidence-Based:** Health promotion interventions and strategies must be based on research and lessons learned from previous and ongoing programs. It is essential to work with higher education institutions and research centers in conducting health promotion related studies to understand the impact and progresses made in health promotion efforts. It is important to make necessary changes in health promotion strategies and interventions based on evidence generated through different studies.
- **Multiple means of communication:** Health promotion interventions should effectively make use of a mix of complementary media channels, communication tools, and approaches to achieve holistic and desirable behavioral and social changes.
- **Cost effectiveness:** Health promotion interventions must be cognizant of the resource need of the interventions in relation to the expected impact.
- **Empowerment:** Enable individuals and communities to claim their right and control over the personal, socioeconomic and environmental factors that affect their health
- **Holistic approach:** Fostering physical, mental, social and spiritual health and well-being through a life cycle approach
- **Ensuring equity in Health:** Equitable(guided by a concern for equity and social justice)

5.7. Strategic Approaches

Health Promotion programs can improve health at every setting and stage of life. To facilitate effective Health Promotion implementation, the following strategic approaches are crucial:

- **Capacity building:** Building the capacity of stakeholders such as government health structures, partners, and media houses on health promotion is crucial for the effective implementation of the strategic plan.
- **Multisectoral Engagement:** The behaviorial determinants of health are numerous and intertwined. Hence, public health problems are too complex to be addressed by the health sector alone. The implementation of strategic plan therefore requires deliberate engagement with relevant sectors such as education and agriculture and other sectors to jointly achieve a policy outcome.
- **Life Cycle Approach:** The strategy emphasizes prevention and early intervention at every stage of life (intrauterine period, early childhood, adolescence and youth, middle age, and old age) to promote the health of the population. It also works to address problems around the Continuum of Care.

- **Targeted/Focused:** Tailoring interventions to a particular audience, issue or setting is instrumental for the strategy to be effective. The strategy therefore uses a mix of population and context based approaches to ensure impact
- **Community Empowerment:** Communities need to be empowered and effectively engaged in improving their health. Thus, the strategy supports the design, implementation as well as monitoring and evaluation of interventions that enable communities to play key role. This helps to ensure ownership and sustainability.
- **Mass Media:** Mass media play crucial role in disseminating health information and increasing awareness about health education. The strategy uses national and community level mass medias to disseminate basic health information. The strategy also promotes and advocates for strengthening media's capacity and engagement on health promotion.
- **Mobile or Digital Platforms:** The strategy will promote the application of mobile or digital technologies to promote healthy behavior.

5.8. Strategic Framework

5.8.1 Determinants of health

The health of individuals and communities are greatly influenced by many determinants (Figure 1). In addition to personal factors, the context of people's lives(at individual, family, community environmental and structural level) determine their health. To blaming individuals for having poor health or crediting them for good health is inappropriate. The reality is that health cannot be achieved by individuals adopting desired behaviors and practices alone. The determinants of health are best understood within a socio-ecological framework that recognizes the interconnected influences of family, peers, community and society on health seeking behaviours.

Individuals ability to pursue good health is limited by varying degrees of knowledge, information, behavior, community support, economic means as well as macro-level environment which can either promote or deter behaviors; including social and cultural norms, Health policies, Economic policies and Educational policies. Therefore, multiple factors needed to be addressed for health promotion to be effective in mitigating the triple burden of disease in Ethiopia.

Based on the analysis of the national context and understanding of health promotion gaps at individual, community, social, and environmental levels, including enforcement of public health laws, a socio ecologic framework for the national health promotion pathway towards the goal of improved health status is constructed to identify domains of health promotion interventions.

The framework further illustrates how expected outcomes corresponding to each domain of health promotion interventions. Moreover, the framework delineates areas for designing health promotion interventions strategies with envisaged outcomes at initial stages of strategy implementation and in the long run (refer to the strategic framework below).

Figure 4. Determinants of Health - The Social Ecological Model

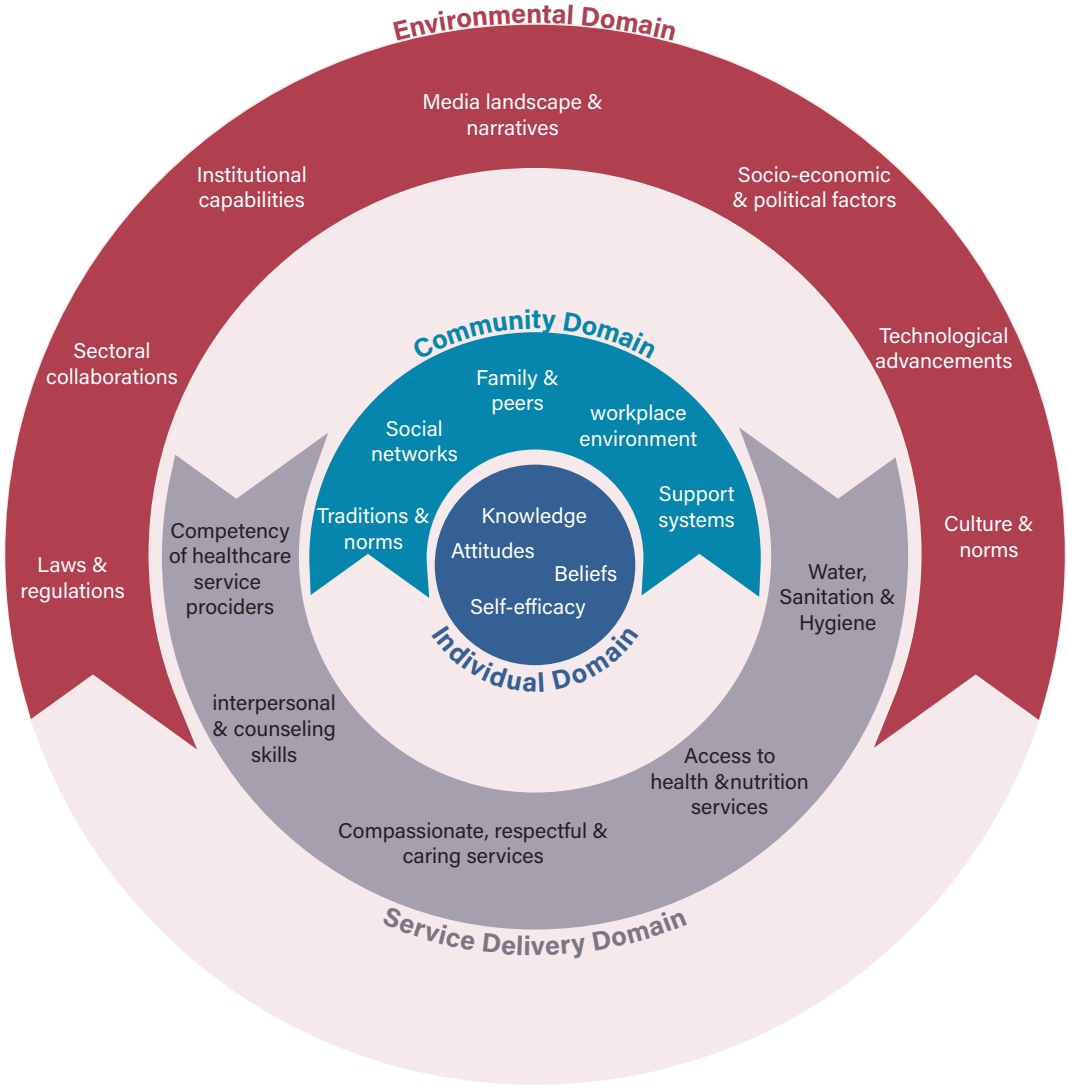
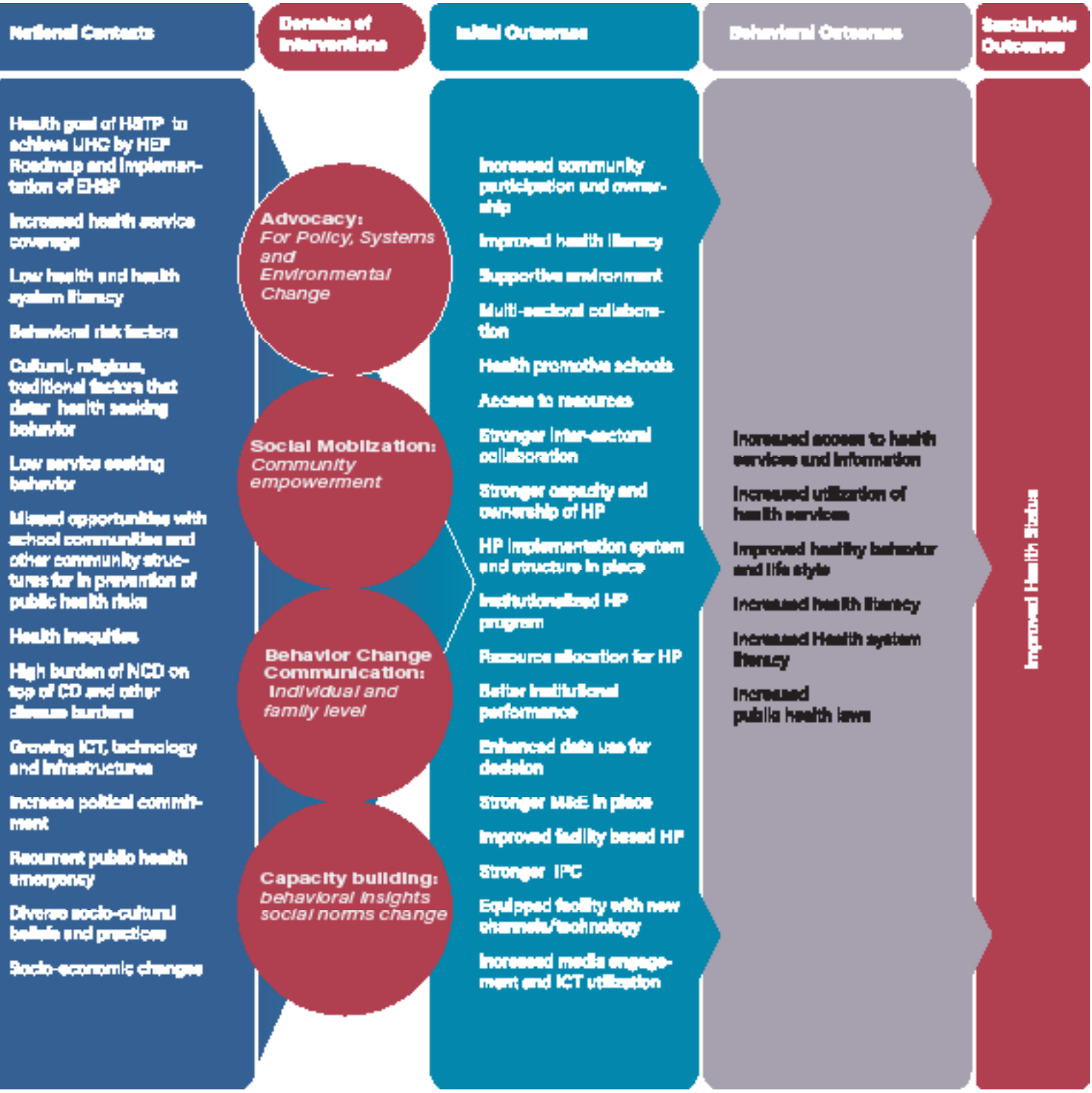


Figure 5: Strategic Framework



5.9. Strategic Directions, Objectives and Interventions

The broad strategic framework for the national Health promotion strategic plan (2021/22-2025/6) encompasses strategic directiones set out in the Ottawa Charter for health Promotion:

1. Capacity building
2. Health in all policies (HiAP)
3. Create supportive environments (Healthy settings: schools, cities, and health institutes)
4. Community Engagment
5. Develop personal skills (Targeted interventions for priority health concerns)
6. Coordination and Partnership
7. Strengthen M & E Systems

Figure 6: Strategic Directions

Strategic Direction (SD) 1: Capacity Building

This strategic Direction will focus on developing sustainable skills on health promotion planning, implementation and M&E, health infrastructure or service development, program maintenance and sustainability, building problem solving capability, organizational structures, resources and commitment to health improvement in health and other sectors. There is a need for capacitated and restructured Health Promotion program that can act as a nodal for facilitating and enabling the implementation of the National health promotion strategic plan.

Actions in this area shall address enhancement of health promotion structures, policy orientations, leadership, human resource development and capacity for resource mobilization.

Strategic Objective (SO) 1: Strengthen personnel and organizational capacity for health promotion program implementation

Priority Strategic Interventions:

1.1 Establish and strengthen the health communication structure from Federal to Woreda level

1.2 Conduct capacity gaps assessment under each level of the health system and other sectors

1.3 Providing adequate on-job trainings for Health Promotion practitioner, the front line community (e.g. HEWs) and facility level health workers

1.4 Put in place Health Promotion implementation system and structure at all level

1.5 Higher health promotion curricula revision to ensure it is able to address current needs.

1.6 Equip health facilities with furniture and equipment (chairs, shelves, and audio-visual materials) to ensure an enabling environment for patients/clients to access to health education.

1.7 Establish Resource center, Information desk(Health Literacy Center), directory at health facilities

1.8 Develop and implement health promotion guidelines(advocacy, social mobilization (SM), interpersonal communication(IPC) guidelines, school peer education manual and HEWs pocket guide)

1.9 Enhance capacity of media professionals, advertising companies and others sectors

1.10 Organize short and long term capacity building programs including experience sharing/study tours in order to gain insights into the international best practices.

SD2: Building Healthy Public Policy- Health in all policy(HiAP)

This direction of the strategic plan emphasizes Health in All Policies (HiAP) as a systematic approach for considering the health implications of public policies across all sectors. It anticipates the synergistic effects of public policies, and prevents and mitigates harmful health effects ensuing from policies. It contributes to the accountability of policymakers for health impacts through efficient, effective multi-sectoral actions; and emphasizes the need to be alert to prevent any unintended consequences of public policies on determinants of health, well-being, and the health system. By promoting healthy practices across all sectors, HiAP fosters inclusive, sustainable development and helps address the social determinants of health, reduce multi-sectoral risk factors, and promote health and well-being.

SO2. Promote health in all sectors polices and strategies and reduce their health consequences

Priority Strategic Interventions

2.1 Scan existing policies and strategies from all sectors and identify priority areas for multi-sectoral engagement

2.2 Support evidence generation on sectoral factors impacting health and advocacte for Health in All Policies

2.3 Develop and implement a legal framework and implementation arrangement for effective implementation of multi-sectoral actions

2.4 Advocate for the inclusion of health and health-related perspectives in all relevant sectorial policies and regulation

2.5 Advocate for allocation of sector-specific budget line for social determinants of health initiatives

2.6 Conduct joint planning, monitoring, and evaluation of multi-sectoral actions, including evidence generation

2.7 Formulate lessons from existing multi-sectoral initiatives such as the One WASH program, Seqota Declaration and multi-sectorial woreda transformation, and scale these up more broadly

2.8 Utilize Multi-sectoral Woreda Transformation platform to enhance planning, budgeting, execution, and monitoring and evaluation of multi-sectoral development interventions in pilot Woredas to bring about the four L's (Livelihood, Lifestyle, Literacy and Longevity)

2.9 Promote environmental impact assessment to mitigate health impacts of major projects

SD3: Create supportive environments (Healthy settings)

This strategic direction emphasizes initiation and implementation of health promotion standards to promote different healthy settings (school, health facilities and work places).

Healthy settings approach focus on settings based health promotion, with the intention of improving people's health where they spend most of their time. The approach acknowledges that behavioural changes are only possible and sustainable if they are integrated into everyday life and correspond with concurrent habits and existing cultures.

The healthy settings approach is a holistic way of improving the living, working, playing and learning environment of people to facilitate and enable them to make healthy choices.

SO 3: Initiate health promoting school initiative and integrate health promotion into all schools

This strategic objective refers to strengthening the capacity of schools to make them a safe and healthy setting for living, learning and working.

Schools play a vital role in the well-being of students, families and their communities, and in linking education and health. Health-promoting schools embodies a whole-school approach to promoting health and educational attainment in school communities by using the organizational potential of schools to foster the physical, social–emotional, and psychological conditions for health as well as for positive education outcomes

This initiative is necessary to ensure sustainability by institutionalizing health promotion in all functions of the education system, such as governance of the educational process and its content, resource allocation, educators' professional development, information systems and performance management.

Priority Strategic Interventions:

3.1 Collaboration among different organizations, sectors, schools and the local community in setting policies for HPS

3.2 Develop comprehensive health promoting school policies

3.3 Revise School health framework and packages and capacitate staffs at all level

3.4 Adapt/adopt national school health standard and indicators and implement in all schools

SO4: Reorient health facility towards health promoting hospital/health facilities

This strategic objective refers to promoting the health of patients, promoting the health of staff, changing the organization to a health promoting setting, and promoting the health of the community in the catchment area of the hospital/health facilities. The concept of Health Promoting Hospitals/Facility (HPH/F) is a paradigm shift from the conventional mandate of health service providers providing clinical and curative services to health promoting facilities. It is a move towards a holistic system to include mandates that are sensitive and respects cultural needs. HPH/Fs are among the major health promoters of the society. Appplying a settings based approach to health promotion, a HPH strives to create a supportive policy and physical environment, which promotes the health and wellbeing of all who access its services and work there.

Standards for health promotion in hospitals are necessary to ensure the quality of services provided in this area. For effective achievement of the HPH/F approach, the HPH needs to be implemented as a "comprehensive overall approach that is integrated within hospital/ health service (quality) management systems".[38]

Priority Strategic Interventions:

4.1 Adopt/adapt health promoting hospitals/facilities standards, develop implementation manuals, self-assessment form to support their implementation

4.2 Advance facility based health education program to health promoting hospitals/ facilities initiative and implement in all health facilities

4.3 Enhance the role of health facilities in the promotion of health and behaviour change of the community

38 WHO, 2007a, p.7

4.4 Integrate health promotion protocols in the existing curative guidelines at the private and public health care services

4.5 Integrate health promotion services within hospital and health service quality management systems

4.6 Build the capacity of health care providers

4.7 Establish/integrate monitoring and evaluation mechanisms

SO 5: Create an enabling environment and promote health in the workplace

To meet this strategic objective, a coordinated and comprehensive set of strategies and interventions, including programs, policies, benefits, environmental supports, and links to the surrounding community, designed to meet the health and safety needs of all employees.

The workplace is one of the most important settings affecting the physical, mental, economic and social well-being of workers, and in turn the health of their families, communities and society;

Priority Strategic Interventions:

5.1 Establish health promotion committee and develop a workplace health promotion standard and implementation guideline

5.2 Define and deepend understanding of health and health promotion needs in the workplace and develop a package of interventions.

5.3 Identify and enhance opportunities to support healthy setting in targeted workplaces

5.4 Put interventions in place that address multiple risk factors and health conditions concurrently and recognizes that the interventions and strategies chosen influence multiple levels of the organization

5.5 Strengthen and capacitate the structures within the workplace to meet occupational health and health and safety requirements

5.6 Advocate for workplace health promotion policy

5.7 Implement workplace standards in large organizations, small and medium sized enterprises and public administrations

5.8 Establish/integrate monitoring and evaluation mechanisms

SD 4: Community Engagement-Strengthening Community Actions and Ownership

This strategic direction focuses on the strengthening of Health promotion through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. The emphasis is on ensuring active participation and engagement of the community in planning, implementation, monitoring and evaluation of health and health related activities. It is about enabling communities to enchance control over their lives through creating health literacy and decision power. Re-designing, testing, and implementing a package of alternative approaches which take into account the emerging challenges to the existing community engagement strategies will be a key milestone in this strategic period. The expected result of this direction is to achieve a community with improved health behaviour, health outcomes, and improved accountability.

SO 6: Enable communities and their leaders to take the ownership and control of their population's health and wellbeing.

Priority Strategic Interventions:

6.1 Design, test, and scale up theory and context-based community engagement options and develop community engagement strategy

6.2 Strengthen participation of the community in health facility governing boards

6.3 Design and implement interventions to increase health literacy and health system literacy

6.4 Cultivate and incubate local community-led innovations for local health problems

6.5 Develop health promotion materials/job aids for community-level actors based on mapping/review.

6.6 Empower health professionals to support the self-care efforts of their clients.

6.7 Enhance mass media engagement to change community norms.

6.8 Provide mechanisms for increasing community participation in decision-making in local and regional health authorities.

6.9 Engagement of influential leaders and ambassadors in selected health areas.

SD5: Developing Personal knowledge & Skills-Improving health and health system literacy

This strategic direction covers the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. It is about expanding the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Actions in this area include the use of appropriate principles, approaches and methods to enable individuals take part in, control and enhance their health.

SO 7: Enable individuals and families to take ownership and control of their health.

Priority Strategic Interventions:

7.1 Generate evidence to determine KAP gaps of individuals and families to determine essential health promotion strategies

7.2 Employ traditional as well as innovative approaches to reach individuals and families with standardized health messages to improve the health and health system literacy of citizens

7.3 Determine audience groups, perform analysis of problem behaviors, set objectives, identify effective mix of communication channels, and develop culturally sensitive messages for identified health issues(refer Annex)

7.4 Develop or adopt guidelines, approaches and SOPs for comprehensive awareness raising and behavior change strategies

7.5 Train health and community workers to deliver services or empower target groups

7.6 Strengthen coordination mechanism within the Ministry, NGOs, Associations (different health and education based), Academia, CSOs, Faith Based Organizations (FBO/RBOs) and community based structures for the dissemination of information on selected health problems.

7.7 Develop and introduce discussions guide that helps HEWs to facilitate support group discussions on selected health areas

7.8 Standardize the health messages and materials to enable them to be delivered in a consistent and appropriate way to the target communities and households

7.9 Develop effective and innovative multi-media campaigns to promote behaviours to reduce preventable disease and promote early health seeking behaviours.

7.10 Identify existing national health laws issued to protect the health of the population and keep environments safe and healthy

7.11 Document societal values and practices that impact health

7.12 To address the needy people, Prepare , Print and distribute the Updated Family Health Guide in the form of Brail for Blind people.

7.13 Develop NCD Health messages for target peoples with disabilities (Blind people) audio spot

7.14 Develop NCD Health messages for target peoples with disabilities (Deaf/people with hearing difficulties) audio-Visual spot with sign language.

7.15 Organize and facilitate Air time radio/TV segments/spot with key messages

SO 8: Strengthen capacity of emergency health communication preparedness, response and resilience

8.1 Generate evidence on the outcome of risk communication and community engagement (RCCE) on Covid-19, Cholera and acute watery diarrhea (AWD) and document lesson lernt for future health emergencies and outbreaks.

8.2 Develop standardized/harmonized messages on emergencies which can be disseminated through different communication channels.

8.3 In consultation with EPHI, assess preparedness and response to ensure that rapid and transparent information related to diseases outbreaks are communicated to the public

8.4 In collaboration with EPHI, build capacity of experts at all levels on risk communication and community engagement as part of emergency preparedness and response.

SO 9: Identify existing national health laws issued to protect the health of the population and keep environments safe and healthy

9.1 Assess the status of implementation and constraints impeding full implementation of international health regulation (IHR), framework Convention on Tobacco Control (FCTC), national laws such as environmental health laws, road safety laws, family health laws, food product labeling, etc.

9.2 In coordination with relevant partners and stakeholders, sensitize and inform decision makers, health officials, health program experts and managers on the purpose of health laws and recommendations for improved implementation.

9.3 Advocate for ownership and establishment of coordinating mechanisms, and to provide guidance for their implementation, including throughcapacity building trainings and promotional materials.

SD6: Coordination and Partnership (Intra and inter organization)

Actions in this strategic direction address the modalities for initiating, establishing and managing partnerships, coalitions, and joint actions around Health Promotion.

SO 10 placed System to health promotion coordination within health sectors, universities, line ministers and implementing partner.

Priority Strategic Interventions:

10.1 Establish strategic partnership with key line ministries to enhance action,coordination and integration across all sectors.

10.2 Create coordination platform for priority health issues which needs multisectoral engagement.

10.3 Establish and maintain strong collaborative relationships with partner agencies and higher education institutions

10.4 Establish Health Promotion and Education (HPE) professional association

10.5 Capacity strengthening of media outlets to enhance their engagement on health media programming

10.6 Establish a mechanism for information sharing platform (create web based data sharing, face-to face community of practice)

SO 11: Advocate for greater mass media involvement and include different communication technologies to enhance health transformation initiatives

11.1 Build partnership with mass media and to put in place a forum to better coordinate support for health communication interventions and initiatives

11.2 Enhance the capacity of key personnel working in the media industry via updated health information, guidance materials and orientations/trainings to increase their understanding of priority health issues and approaches.

11.3 Advocate for institutionalizing a special platform and information sharing mechanism to rapidly respond to health threats and diseases outbreak.

11.4 Explore and adopt current and emerging technologies which are appropriate for the implementation of health education and communication interventions.

11.5 Support the scaling up of hotline telephone counseling services for different health services and train counselors on interpersonal communication skills.

11.6 Deploy community diary based radio programming within the MOH

SD7: Strengthen Systems to Monitor & Evaluate Health Promotion Interventions

A monitoring and evaluation (M&E) plan can help to guide health promotion interventions implementation. Indicators for monitoring progress, the mechanism and the process for collecting and publishing the M&E results, shall be agreed through an open forum.

SO 12: To develop a standard M&E framework for both the management and implementation of health promotion activities.

Priority Strategic Interventions:

12.1 Hold Stakeholder Meeting to agree on Health Promotion Monitoring Indicators and M&E Priorities for HP.

12.2 Incorporate evidence based research into health promotion programmes.

12.3 Collaborate with academic and research institutions to promote evidence-based health promotion interventions.

12.4 Establish a platform for knowledge management and transfer for health promotion

SECTION VI:
IMPLEMENTATION MODALITY

The implementation of this strategic plan requires coordination of stakeholders across all levels. As such, there is a need for an integrated Health Promotion Strategic plan under which all stakeholders work.

The stakeholders in the implementation of this strategic plan include government ministries, agencies, NGOs, and community structures. The MOH, RHB, ZHD, WoHO, PHC will lead, and capacity building for all activities in the country by coordinating other government agencies, UN Agencies, Development partners, International NGOs, CSOs, and community structures.

6.1 Role and Responsibilities

Each health sector division will play a leadership role in coordinating partners to strengthen capacity and to support a coordinated health education and promotion response.

H. Role and Responsibilities of MOH

- Create awareness and ensure proper utilization of the strategic plan by all stakeholders/partners who are engaged in health promotion and communication interventions.
- Employ the NHPSP to develop any materials such as print/electronic, tools, strategies, IEC, job aids, etc., that are meant for health education and communication
- Support RHBs and other Sector Offices who work on health education and communication to implement the strategic plan, among other things, by making resources, including human and financial resources, available.
- Coordinate monitoring and evaluation of the implementation of the strategic plan in collaboration with key stakeholders
- Provide special support for emerging regions and hard to reach areas within other regions to implement the strategic plan, in particular in pastoralist and agro-pastoralist contexts.

I. Role and Responsibilities of RHB

- RHBs under the leadership and coordination of the designated Department will have the following roles and responsibilities:
- Create awareness on how to utilize the strategic plan in collaboration with regional partners using available communication strategies
- Develop any materials such as print/electronic, tools, strategies, IEC, job aids, etc., that are meant for health education and communication in line with the Strategic Plan
- Ensure proper utilization of the strategic plan by all stakeholders who are engaged in health education and communication interventions in their respective regions
- Support ZHD/WoHO and other sector offices who work on health education and communication to adopt/adapt the strategy, among other things by making resources, including human and financial support, available.

J. Role and Responsibilities of ZHD/WoHO

- Familiarize the strategy with health programmers and other stakes
- Collaborate with local partners to develop culturally-relevant health communication and education
- Utilize the strategic plan to develop promotional materials such as print/electronic, tools, strategies, IEC, job aids, etc.
- Provide support to guide utilization of the strategy for those involved in health education and communication interventions
- Provide support to WoHOs, PHCUs and other sector offices to adopt the strategic plan and availing resources – human resource and financial

K. Role and Responsibilities of PHCU

- All actors in PHCUs, such as health centers, Health Posts (with HEWs), WDGs and kebele health committees are expected to use this strategic plan to conduct health promotion interventiones at community and household levels, according to the following description of roles and responsibilities:
- Develop culturally-relevant promotional materials in line with the Strategic Plan
- Provide support to strengthen the understanding and facilitate the implementation of the strategy
- Ensure that the strategic links to HEWs, support and guide their health education and promotion efforts

L. Role and Responsibilities of Partners

- In this context, partners refer to UN Agencies, Development Partners, NGOs and civil society organizations including faith based organizations and community based organizations. Their key roles and responsibilities of partners include:
- Support MOH and its structural offices at all levels on the familiarization, dissemination and implementation of the strategy.
- Collaborate with MOH in evaluating the effectiveness of the strategy.

M. Role and Responsibilities of Media Outlets

- Media outlets include both print and electronic media that works on health promotion. Key roles and responsibilities of media outlets are:
- Support MOH and RHBs in creating awareness and amplify community health concerns. Disseminate information free or with minimal costs. Support community dialogue forums and other communication strategies like advocacy, and social and/or community mobilization
- Support MOH and RHBs in developing good quality media materials to support targeted health promotion interventions

N. Roles and responsibilities of public and private Sector

- The sector ministries key roles and responsibilities include:
- Mainstream health promotion to mitigate health effects
- Develop health promotion materials in line with the strategic plan.
- Support implementation of the strategy at all levels
- Implement measures to ensure safe and healthy work place and environment
- Create strong linkages across all levels with FMOH, RHBs, ZHOs, WoHOs, etc. to promote health and address factors that threaten life and discourage demand for health services
- Enforce the implementation of guidelines, standards and protocols in food beverage, cosmetics drugs and health services

SECTION VII:
MONITORING AND EVALUATION

Timely monitoring is essential to adjust and inform future strategic directions and plans. Monitoring can also help ensure health promotion activities take into account changing epidemiological trends.

To monitor the implementation of each proposed intervention, a framework with a set of performance indicators are crucial. Evaluations, including surveys on the efficacy and effectiveness of health promotion actions in selected public health programmes, will be conducted regurarly in collaboration with national, regional and international stakeholder. Policies, legislative actions and use of financial resources will be monitored and evaluated as appropriate.

7.1. Health Promotion Outcome Measures

1. Health literacy measures, including health-related knowledge, attitudes, motivation, behavioural intentions, personal skills, and self-efficacy;
2. Social action and influence measures, including community participation, community empowerment, social norms, and public opinion;
3. Healthy public policy and organizational practice measures, including policy statements, legislation, regulation, resource allocation, organizational practices, culture and behaviour;
4. Healthy lifestyles and condition measures, including tobacco use, food choices and availability, physical activity, alcohol and illicit drug use and the ratio of protective vs. risk factors in the social and physical environment;
5. Effective health services measures, including provision of preventive services, access to health services and social and cultural appropriateness of health services;
6. Healthy environments measures, including restricted access to tobacco, alcohol and illicit drugs, positive environments for youth and the elderly, freedom from violence and abuse;
7. Social outcomes measures, including quality of life, functional independence, social support networks, positive discrimination and equity;
8. Health outcomes measures, including reduced morbidity, disability, avoidable mortality, psychosocial competencies and life skills;
9. Capacity building outcomes, including measures of sustainability, community participation and empowerment.

Table 5: Possible list of Indicators (most proxy indicators listed below are national indicators)

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
1) Strengthen personnel and organizational capacity for health promotion program implementation	% of Health Promotion Experts and health workers trained on health promotion strategies (SBCC, Social Mobilization, advocacy) manuals and guidelines approved by the ministry who can implement # of trainings across sectors for coordination and joint-actions for health promotion activities # of media professionals trained in health reporting and messaging, and priority health issues # of and type of materials distributed to media professionals with up-to-date health information and national health priorities # of HEWs who trained on interpersonal communication and facilitation skills	Increased skills for health promotion planning, implementing and M&E among health and staffs across sectors	Research/ evaluation findings
2) Health in all policies: Promote health in all sectors polices and strategies and reduce their health consequences	# of national policies reviewed # of advocacy workshops organized #/Proportion of line ministry allocate adequate budget to conduct health promotion activities	# and type of national policies revised by stakeholders # of government organizations integrated health in their policies Increased social protection and equity	Reports (National/ Regional)

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
3) Reorient health facility towards health promoting hospital/health facilities	% of health facilities designated/declared as health promoting facilities Proportion of facilities which have adequate budget to conduct health promotion activities percent of service providers reporting the use of communication/job aid materials	improved quality of care and promote healthy behaviour to patients and families increase patient and community satisfaction	Assessment report Regular report
4).Implement health promoting school initiative and integrate health promotion into all schools	# of manuals prepared # of trained school and health office staff # of health promoting schools Proportion of schools considered as health promoting facilities.	improved health status of students and supportive environment for early prevention of health risk factors among younger generation increased health literacy among school teachers, staffs, students, parents, and communities	Reports Research
5).Create an enabling environment and promote health in work place	# of workplaces dedicated to be healthy settings	Reduced numbers of workplace related major diseases incidences and risk factors	Assessment survey report

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
6). Enable communities and their leaders to take the ownership and control of their population's health and wellbeing	# of community members participating in community engagement activities/campaigns # of job aids and training	Increased community participation and ownership	Assessment report
7). Enable individuals and families to take ownership and control of their health	# of Generate evidence to determine KAP gaps # of innovative approaches to reach individuals and families #/ of households using family health guides # of individuals reached health messages through different channels	Reduced numbers of major diseases incidences and risk factors Reduced health care cost for treatment Improved health literacy	Survey report
8). Strengthen capacity of emergency health communication preparedness, response and resilience	Generated evidence on the outcome of risk communication and community engagement(RCCE) # of experts trained on RCCE Standardized/harmonized messages on emergencies developed	Resilient community during public health emergency	Assessment
9).Identify existing national health laws issued to protect the health of the population and keep environments safe and healthy	# of Advocacy sessions	Working Law enforcement system	Assessment

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
10). Established System to health promotion coordination within health sectors, universities, line ministers and implementing partner	Coordination platform for priority health issues created across stakeholders	Stronger inter-sectoral collaboration Stronger capacity and ownership of HP for decision makers	Assessment
11).Advocate for greater mass media involvement and include different communication technologies to enhance health transformation initiatives	# of media outlets capacitated # of media outlets engaged on health programming	Increased media engagement and ICT utilization	Assessment
12.) Develop a standard M&E framework for both the management and implementation of health promotion activities	Identified indicators and included in the system data capturing # of review meeting	Enhanced data use for decision and M&E in place	Assessment

SECTION VIII:
COSTING/BUDGETING

Estimating the costs of implementing the National Health Promotion Strategic Plan is important to policy-makers for a number of reasons including the fact that the results can be used as a component in the assessment and improvement of the performance of the health promotion strategy part of the health system. The approach used to estimate the costs is the use of program costing method. It primarily involves identification and quantification of the activities to be costed, determining and quantifying the type of specific inputs for implementing the activities and gathering unit costs from different sources. After gathering the necessary information, a costing tool was developed to produce estimates of the investment needed.

Alcohol Pads
SCREENING test
FULL

The total cost of implementing the health promotion strategy over the five years is estimated to be ETB 2.08 billion or about USD 43.4 million using the current period exchange rate. On average, this is equivalent to an average annual investment need of ETB 416 million. The total costs of for each year as well as the investment needs under each strategic direction are given in the table below.

Table 6: Total estimated cost under each strategic direction (,000)

SD	Strategic Direction	2021/22	2022/23	2023/24	2024/25	2025/26	Total Cost (ETB)	Total Cost (USD)	Percent
SD-1	Capacity Building	216.74	227.53	234.39	237.79	242.31	1,158.77	24.14	55.7%
SD-2	Building Healthy Public Policy/Health in All Policies(HiAP)	3.98	2.79	4.65	8.90	9.63	29.96	0.62	1.44%
SD-3	Create supportive environments (Healthy settings)	9.19	84.69	77.66	58.89	53.18	283.60	5.91	13.63%
SD-4	Community Engagement-Strengthening Community Actions and Ownership	90.11	87.15	89.76	93.60	96.41	457.02	9.52	22.0%
SD-5	Developing Personal Skills-Improving health literacy and health system literacy	10.10	13.48	16.52	18.76	17.01	75.88	1.58	3.65%
SD-6	Coordination and Partnership	3.16	6.84	8.71	10.23	8.30	37.23	0.78	1.79%
SD-7	Strengthen Systems to Monitor & Evaluate Health Promotion Interventions	7.54	7.13	7.35	9.08	7.80	38.90	0.81	1.87%
	Total	**340.83**	**429.61**	**439.04**	**437.25**	**434.64**	**2,081.36**	**43.36**	**100.0%**

8.1. Financing sources

The major sources for financing the national health promotion strategy are government Channel -2) and through programs and projects by implementing partners. It is planned to increase the involvement of partners over the five-year strategy implementation period. In addition, community engagement and sponsorship of some specific projects is supposed to increase significantly. The table below show the contribution of the three financing sources over the five-year period.

Table 7: Financing sources

Source of Finance	2022	2023	2024	2025	2026
		Share (%)			
Government	80	74	69	62	53
Partner	20	23	26	30	35
Other	-	3	5	8	12
		Expected fund to be mobilized			
Government	272.7	317.9	301.0	269.3	230.4
Partner	68.2	98.8	116.1	133.0	152.0
Other	-	12.9	22.0	35.0	52.2

ANNEX I:
IMPLEMENTATION ACTION PLAN

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
Initiation phase								
1. Launch the Health Promotion Strategy						# of workshops/ events conducted	1	MOH(Health promotion (HP) unit and other stakeholders
2. Orient Regional Teams on the Health Promotion Strategy						# of workshops/ events conducted	2	
3. Meet with Partners/ Donors to Secure Commitments to Support Activities						# of workshops/ events conducted	1	
Subtotal								
SD1: Capacity building								
SO 1.1: Strengthen personnel and organizational capacity for health promotion program implementation								
1. Review/assess current staffing structures in order to rollout capacity building at all level (National, regional, Zonal, Woreda, Hospital and PHCU).						# of as-sessments conducted	1	MOH (HP unit)
2. Review of higher education health promotion curricula						# of as-sessments conducted	1	MOH (HP unit)
3. Higher health education curricula revision and make it fitting with current need						# of workshops/ events conducted	5	MOH (HP unit)

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
4. Conduct advocacy with Ministry of Education						# of workshops/ events conducted	5	MOH (HP unit)
5. HP capacity assessment in other sectors						# of as-sessments conducted	1	MOH (HP unit)
6. Capacity building training for other sectors and stakeholders						# of trainings conducted		MOH (HP unit)
7. Conduct capacity gaps assessment under each level of the health system						# of as-sessments conducted	1	MOH (HP unit)
8. Conduct supportive supervision to strengthen capacity of HP experts at all level						# of as-sessments conducted	10	MOH (HP unit)
9. Advocate for recognition on importance of resource allocation for HP						# of workshops/ events conducted	3	MOH (HP unit)
10. Develop health promotion guidelines (Advocacy, SM, IPC guidelines and HEWs pocket guide)						# of manuals/ guidelines developed	4	MOH (HP unit)
11. Print of health promotion guidelines (Advocacy, SM, IPC guidelines and HEWs pocket guide)						# of copies	56,000	MOH (HP unit)

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
12. Distribution of health promotion guidelines(Advocacy, SM, IPC guidelines and HEWs pocket guide)						# of copies	56,000	MOH (HP unit)
13. Conduct Mapping of SBCC Materials/Job Aids at all levels						# of assessments conducted	1	MOH (HP unit)
14. Develop health promotion training materials (Health promoting schools, RCCE, Quality assurance, HLM, Advocacy, SM and IPC)						# of manuals/ guidelines developed	7	MOH (HP unit)
15. Print of health promotion training materials (Health promoting schools, RCCE, Quality assurance, HLM, Advocacy, SM and IPC)						# of copies	30,000	MOH (HP unit)
16. Organize health promotion trainings (Health promoting schools, RCCE, Quality assurance, HLM, Advocacy, SM and IPC) for health service providers, health promotion focal and health promotion at all levels						# of workshops/ events conducted	212	MOH (HP unit)

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
17. Lesson learnt and experience sharing between regions						# of workshops/ events conducted	5	MOH (HP unit)
18. International experience sharing visit						# of workshops/ events conducted	5	MOH (HP unit)
19. Capacitate/train media professionals and advertising companies for effective messaging						# of workshops/ events conducted	5	MOH (HP unit)
Subtotal								
SD2: Building healthy public policy/Health in All Policies(HiAP)								
SO 2.1. Promote health in all sectors polices and strategies and reduce their health consequences								
1. Establish National Health Promotion Steering Committee (NHPSC) with multidisciplinary and multisectoral members						# of groups established		
2. Review existing relevant laws, regulations and policies by sector, and recommend required adjustments to respond to the current needs						# of as-sessments conducted	1	
3. Share the assessment recommendations/ findings to concerned stakeholders in order to make required adjustments to respond to the current needs						# of workshops/ events conducted	1	

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
4. Conduct national and sub national advocacy activities to advocate HiAP						# of workshops/ events conducted	5	
5. Develop a framework on HiAP						# of manuals/ guidelines developed	1	
6. Organize buy- in meetings to advocate and sensitize all sectors to support the creation of supportive environments						# of workshops/ events conducted	1	
7. Support development and implementation of operational healthy policies in all sectors						# of sup- portive su- pervisions conducted	10	
8. Advocate for and work with law enforcement authorities to ensure the implementation of rules and regulations for promoting health						# of workshops/ events conducted	10	
9. Advocate with sectors and including Parliamentary representatives						# of workshops/ events conducted	1	
10. Generate evidence for the impact and effectiveness of HiAP						# of as- sessments conducted	1	

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
11. Build capacity for health promotion focal across sectors						# of workshops/ events conducted	1	
Subtotal								
SD3: Create supportive environments (healthy settings)								
SO3.1: Initiate health promoting school initiative and integrate health promotion into all schools								
1. Establish steering committee with MOE and stakeholders						# of workshops/ events conducted	1	
2. Assess current school health program implementation status						# of workshops/ events conducted	1	
3. Revise school health framework						# of workshops/ events conducted	5	
4. Develop comprehensive health promoting school policies						# of workshops/ events conducted	5	
5. Implement comprehensive health promoting school policies						# of supportive supervisions conducted	36	

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
6. Advocate comprehensive health promoting school policy at all level(National and regional)						# of workshops/ events conducted	13	
7. Revise school health packages						# of workshops/ events conducted	10	
8. Adapt/adopt national school health standard						# of workshops/ events conducted	10	
9. Develop digital health applications at schools						# SBC materials	4	
10. Enhancing school engagement (strengthening clubs, develop message guide for schools, peer education, mini-media, health bazar) in 1500 Schools						# of workshops/ events conducted	60	
11. Capacity building for education and health school health focal at all level						# of workshops/ events conducted	60	
12. Supportive supervision at all level						# of supportive supervisions conducted	20	

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
SO3.2: Reorient health facility towards health promoting hospital/health facilities								
1. Introduce health promoting hospitals / facilities approaches in all health facilities						# of workshops/ events conducted	18	
2. Develop health facility based Health Promotion manual						# of workshops/ events conducted	5	
3. Print of health facility based HP manual						# of copies	10,000	
4. Distribution health facility based HP manual						# of copies	10,000	
5. Review of existing curative guidelines at the public health care services						# of workshops/ events conducted	2	
6. Integrate health promotion protocols in the existing curative guidelines at the private and public health care services						# of workshops/ events conducted	1	
7. Print of health promotion protocol						# of copies	10,000	
8. Distribution of health promotion protocols						# of copies		

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
9. Advocate for the importance of structure with skilled workforce in the health system for health promotion (HP)								
10. Develop Health Promotion Materials/Job Aids for Interpersonal Communication Skills(IPC)for in-service Healthcare Workers						# of SBC materials	5	
11. Print of job aids						# of copies	50,000	
12. Distribution job aids						# of copies		
SO3.3: To create an enabling environment and promote health in work place								
1. Assess current work place health promotion implementation situation						# of as-sessments conducted	1	
2. Develop work place health promotion guideline						# of workshops/ events conducted	3	
3. Translation of work place health promotion guideline into four local languages						# of manuals/ guidelines developed	4	
4. Print of work place health promotion guideline						# of copies	2,000	
5. Distribution of work place health promotion guideline						# of copies		

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
SD4: Community engagement (Strengthening Community Actions and Ownership)								
SO 4.1: Enable communities and their leaders to take the ownership and control of their population's health and wellbeing								
1. Conduct Mapping of Materials/Job Aids for Community-level Actors						# of assessments conducted	1	
2. Develop Health Promotion Materials/ Job Aids for Community-level actors Based on Mapping/Review findings						# of SBC materials	3	
3. Print of Health Promotion Materials/Job Aids						# of copies	2,000,000	
4. Distribution of Health Promotion Materials/Job Aids						# of copies	2,000,000	
5. Provide TOT Training for HEWs to cascade at Community-level (WDGs, MDGs, PYDGs and VHL on priority health issues in all region) to Use Health Promotion Materials and Become Health Promotion Advocates						# of workshops/ events conducted	1,334	

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
6. Strengthen capacity of mass media engagement to change community norms						# of workshops/ events conducted	3	
7. Develop health message guide to strengthen capacity and engagement of religious & traditional leaders						# of workshops/ events conducted	3	
Subtotal								
SD5: Developing personal skills-Improving health literacy and health system literacy								
SO 5.1: Enable individuals and families to take ownership and control of their health								
1. Organize workshops/ Seminars to raise awareness during important World Health events/days						# of workshops/ events conducted	19	
2. Roll Out National Campaign (e.g., Broadcast, Print Distribution, SMS)						# of SBC materials	95	
3. Monitor and Evaluate National Campaign Outcomes						# of supportive supervisions conducted	2	
4. Air radio/TV segments with key messages						# of placements		
5. Disseminate key messages Via SMS to the general public						# of SMS	44.5 mil.	

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
6. Identify stakeholders to conduct research related to Health promotion issues						N/A	N/A	Research Agencies/ Universities/ professional associations
7. Periodically review research findings and translate them into popular versions						# of assessments conducted	4	
8. Share latest research with relevant policymakers						# of workshops/ events conducted	2	
9. Conduct research on health promotion						# of assessments conducted	1	
S.O 5.2 Strengthen capacity of emergency health communication preparedness, response and resilience								
1. Generate evidence on the outcome of risk communication and community engagement and learn the lesson for the next interventions						# of assessments conducted	2	Research Agencies/ Universities/ professional associations
2. Develop standardized/ harmonized messages on emergencies which can be disseminated through different innovative communication outlet						# of manuals/ guidelines developed	4	MOH, EPHI, partners & sub national
3. In consultation with EPHI, assess preparedness and response to ensure that rapid and transparent information related to diseases outbreaks are communicated to the public						# of SBC materials	5	MOH, EPHI, partners & sub national

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
4. Buuild capacity of experts at all levels with preparedness and response of risk communication and community engagement						# of workshops/ events conducted	5	MOH, EPHI, partners & sub national
S.O5.3 Identify existing national health laws issued to protect the health of the population and keep environments safe and healthy								
1. Assess the status of implementation and constraints impeding full implementation of international health regulation (IHR), framework Convention on Tobacco Control (FCTC), national laws						# of as-sessments conducted	1	MOH, EPHI, partners & sub national
2. Plan to sensitize and reorient the purpose of health laws to decision makers, health officials, health program experts and managers with recommendations for improved implementation						# of workshops/ events conducted		
3. Advocate for ownership and establishment of coordinating mechanisms, and set standards to provide guidance for their implementation with capacity building training and promotional materials						# of workshops/ events conducted		
Subtotal								

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
SD6: Coordination and partnership								
SO 6.1: placed System to health promotion coordination within health sectors, universities, line ministers and implementing partner								
1. Develop terms of reference (ToR) of various program directorates/ departments						# of workshops/ events conducted	1	
2. Develop integrated communication work plans on annual basis								
3. Work with line ministries in joint planning, implementation, and monitoring of communication plans and strategies						# of workshops/ events conducted	1	
4. Establish coordination platforms between MoH and Regional health bureaus with Universities						# of workshops/ events conducted		
5. Establish a platform for knowledge management and transfer in health promotion						# of workshops/ events conducted	1	
SO6.2: Advocate for greater massmedia involvement and include different communication technologies to enhance health transformation initiatives								
1. Build partnership with mass media to put in place a forum to better coordinate support for health communication interventions and initiatives						# of workshops/ events conducted		

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
2. Enhance the capacity of media personnel via updated health information, guidance materials and orientations						# of workshops/ events conducted		
3. Advocate for institutionalizing a special platform and information sharing mechanism						# of workshops/ events conducted		
4. Explore and adopt the current and upcoming technologies which are appropriate for the implementation of health education and communication interventions						# of SBC materials		
5. Support the scaling up of hotline telephone counseling services in to different health services and train counselors on interpersonal communication skills						# of workshops/ events conducted		
6. Deploy community diary based radio programming within the MOH						# of placements		
Subtotal								

Activity	Timeline (years)					Process Indicators	Target	Responsible Entity
	1	2	3	4	5			
SD7: Strengthen Systems to Monitor & Evaluate Health Promotion Interventions								
SO 7.1: To develop a standard M&E framework for both the management and implementation of health promotion activities								
1. Hold Stakeholder Meeting to agree on HP Monitoring Indicators and M&E Priorities for HP						# of workshops/ events conducted	3	
2. Incorporate evidence based research into health promotion programmers						# of workshops/ events conducted	2	
3. Collaborate with academic and research institutions to promote evidence-based health promotion interventions						# of workshops/ events conducted	5	
4. Establish a platform for knowledge management and transfer in health promotion						# of workshops/ events conducted		
Subtotal								
Grand total								

ANNEX II:
HEALTH PROGRAM ISSUES BY DOMAINS OF HEALTH PROMOTION

Health programs	Health Issues	Health Promotion Objectives			
		Individual(Knowledge, Attitude, Skill)	Community(community based platforms/social networks): cultural Values, norms)	Organization level(Health facility, School, workplace)	Macro level(societal level): Multi sectorial issues, policy and regulation
Maternal Health	1. Preconception care 2. Antenatal care 3. Skilled birth attendance 4. Postnatal care 5. Abortion care 6. Obstetric fistula 7. Reproductive organ cancers 8. Female genital mutilation 9. Pelvic organ prolapse	▪ Awareness creation on the importance of preconception care ▪ Raise awareness of pregnant women on benefits of early ANC, institutional delivery, PNC services ▪ Awareness creation on avoiding unsafe abortion ▪ Awareness creation on prevention of obstetric fistula by using existing community structures and mass media ▪ Awareness creation on reproductive organ cancer screening ▪ Awareness creation on the prevention of Harmful traditional practice	▪ Community mobilization to engage community members to utilize early ANC, institutional delivery, and PNC ▪ Awareness creation for community leaders and influential people on the prevention and consequences of Harmful traditional practice	▪ Enhance proper counseling during health facility visit for maternal health services utilization (ANC, delivery, NPC)	▪ Advocate issues hindering access to services, for example, addressing factors responsible for second delay ▪ Advocate for improved quality of care ▪ Empower women to seek for health services
Family Planning	1. Family Planning(FP) 2. Postpartum (FP) 3. Unmet need 4. Health seeking behavior	▪ Awareness creation on the importance of Family Planning	▪ Engage influencers to deliver inspirational messages and calls to actions to mobilize support and participation of community members ▪ Demand creation on family planning services through effective social and behavior change communication interventions and male involvement	▪ IPC/counseling capacity building training for HWs ▪ Promote quality family planning counseling and services at all level.	▪ Advocate FP to higher officials. ▪ Promotion of national family planning communication guideline at all levels.
PMTCT	1. Primary prevention of HIV, syphilis, and HBV infection 2. Preconception service provision for HIV, syphilis, and HBV prevention and detection	▪ Awareness creation on ABCD (Abstinence, Being faithful to one uninfected partner, correct and consistent use of Condom and Discussion on reproductive issues) ▪ Awareness creation on safer and responsible sexual practices among discordant couples ▪ Awareness creation on the importance of strict follow up for all infants exposed to HIV, syphilis, and HBV	▪ Create public awareness about the benefit of early diagnosis, and building trust on the possibility of EMTCT of HIV, syphilis, and HBV ▪ Promote engagement of the peer support group (Mother support group) to increase the therapeutic and prophylactic services uptake	▪ IPC/counseling capacity building training for HWs ▪ Promote quality and integrated services at institutional levels	▪ Advocate for strengthened and integrated services

EPI	1. Low knowledge on vaccination 2. Rumors and misinformation on vaccination 3. High rate of defaulters 4. Vaccine Hesitancy on new vaccines 5. IPC among the HCW 6. Poor follow up	▪ Awareness creation on vaccine preventable diseases ▪ Awareness creation on new vaccines like Covid 19, HPV ▪ Cholera vaccine	▪ Improve community awareness to remove rumors and misconceptions towards HPV and Covid 19 vaccines ▪ Promote community engagement on preventing and tracing vaccine defaulters. ▪ Engage influencers to deliver inspirational messages and calls to actions to mobilize support and participation of community members	▪ IPC/counseling capacity building training for HWs ▪ Create school community awareness on HPV vaccine.	▪ Advocate on the implementation of new vaccines like HPV, covid 19, Cholera vaccine…
Child Health	1. Common childhood illness 2. Early childhood development 3. child injury(road traffic accident, burn and drowning) 4. Harmful traditional practices 5. Breast feeding	▪ Awareness creation on prevention of common childhood illnesses ▪ Awareness creation on childhood development(ECD) ▪ Awareness creation on prevention of childhood injury ▪ Awareness creation on risks of harmful traditional practices ▪ Awareness creation on early initiation of breast feeding and exclusive breast feeding for 6 months.	▪ Community engagement on utilization of community based child health services ▪ Engagement of community leaders on prevention of harmful traditional practices ▪ Community awareness creation on early initiation and exclusive breast feeding	▪ IPC/counseling capacity building training for HWs ▪ Awareness creation for facility managers on strengthening of neonatal services ▪ Awareness creation for KG teachers on ECD and prevention of childhood injury	▪ Advocacy on early childhood development
Nutrition	1. Nutrition during adolescents, pre-pregnancy, pregnancy and lactation 2. Breast feeding 3. Complementary feeding 4. Sick child feeding 5. GMP	▪ Awareness creation on the importance of nutrition adolescents, pre-pregnancy, pregnancy and lactation ▪ Awareness creation on early initiation of breast feeding, exclusive breast feeding for 6 months, timely complementary feeding and sick child feeding	▪ Awareness creation for community leaders on the prevention of Harmful traditional practice like food tabo	▪ Promote comprehensive and integrated nutrition services in school	▪ Advocate multi-sectoral engagement on the implementation of nutrition

AYH	1. Teenage pregnancy 2. Unsafe Abortion 3. HTP (GBV and FGM/C) 4. Substance abuse 5. Injuries 6. STI-HIV/AIDS	▪ Improve adolescent health literacy ▪ Promote A&Y participation in decision-making related to A&Y health matters ▪ Promote Parental Involvement	▪ Mobilize the community and raise their awareness about AYH ▪ Promote peer education. ▪ Engaging and sensitizing influential persons, community leaders and religious leaders on A&Y health issues	▪ Promote motivated, caring and compassionate health professionals ▪ Promote / strengthen youth friendly health services ▪ Enhance Health promoting schools ▪ Promote the integrate AYH services in industrial parks and development corridors	▪ Advocate for the implementation of existing laws on tobacco, alcohol and RH such as family health law, abortion law, and laws related to harmful traditional practices ▪ Advocating digital technologies for better health
Tuberculosis (TB)	1. Promote care seeking and prevention in the community 2. Accelerate TBL screening and diagnosis including universal DST 3. Early treatment of all types of TBL with efficacious medicines 4. Multi-Drug Resistance (MDR)-TB	▪ Increase comprehensive awareness about TBL among at-risk population reducing TB stigma ▪ Awareness creation on systematic screening of population at risk of TB ▪ Provide information to all persons with TB/ DR-TB & leprosy about the need for contact Screening ▪ Increase awareness to seek and utilize TB treatment ▪ Create awareness on the importance of treatment adherence.	▪ Mobilize traditional, political and religious leaders for public education and speech about available TB services, and social mobilization against stigma in the community.	▪ School TB education message using existing school "mini-medias".	▪ Map out local social services; facilitate referral linkage with community support groups, resources and local organizations, including for legal and economic support as relevant. ▪ Advocate for increased and sustained supplies
HIV/AIDS	1. Gender Inequality 2. Combination HIV prevention interventions 3. Enhance HIV case finding to attain 95% of PLHIV knowing their HIV status and linked to care 4. Enroll 95% of PLHIV who know their status into HIV care and treatment 5. Attain viral suppression to at least 95% for those on	▪ Provide information to all persons on gender based violence and providing support to survivors of GBV support. ▪ Increase comprehensive knowledge about HIV and AIDS for key and priority populations ▪ Create awareness on benefits of testing for target population ▪ Create awareness on benefits of ART for target population ▪ Maintain adherence counseling targeted to HIV positive individuals	▪ Undertake community dialogue on promoting gender equality and avoiding GBV ▪ Promote on Condom use among key and priority populations engaged in risky sexual behavior ▪ Social mobilization activities for index case testing, partner notification and social network services. ▪ Social mobilization activities for ART uptake. ▪ Mass Education on benefits of ART	▪ Provide comprehensive services in health facilities for survivors of GBV ▪ Strengthen school health promotion and promote for increased parent-teachers association ▪ PITC using an HIV risk screening tool at both public and private health facilities. ▪ Promote client-centered services ▪ Health worker capacity building for care and treatment and addressing disclosure	▪ Promote and advocate for sustainable interventions to educate about STI-HIV/ AIDS, etc. ▪ Promote for friendly health services and support for young people

Environmental health / WASH	1. Accessibility of WASH facilities 2. Sustainability of WASH facilities 3. Community ownership 4. Environmental pollution prevention 5. water treatment and safe storage at Household level 6. Food hygiene practices and safety measures 7. Sectoral collaboration 8. WASH at Institutions	▪ Create awareness to individuals on household latrine construction, proper utilization, operation and maintenance ▪ Promote demand creation for sanitation ▪ Promote ODF ▪ Promote proper hand washing practice ▪ Create awareness to all individuals to use existing WASH facilities at institutions ▪ Raise community awareness on the preventable water borne diseases and treatment options from source to the point of consumption ▪ Food hygiene practices and safety measures ▪ Create awareness on food handling and hygiene ▪ Create awareness on environmental pollution	▪ Create community mobilization to make all communities to have improved household latrine ▪ Promote hygiene and environmental sanitation, household latrine ownership and utilization, ▪ Promote water quality through proper handling, and safe disposal of liquid and solid waste ▪ Celebrate world toilet day using community celebrities ▪ Celebrate global hand washing day and advocate it at all level via mass and social media	▪ Promote the integration of hygiene and sanitation in health promoting school package ▪ Facilitate stakeholders to full fill WASH facilities in institutions as per the mandates in MoU	▪ Advocate for access, supply chain, Sectoral support and engagement
Malaria	1. ITN management and Utilization 2. IRS Adherence 3. Early diagnosis and treatment 4. Quality of service delivery 5. Stock out of malaria supplies 6. Low level of Awareness, knowledge and practice	▪ Awareness creation on correct and consistent use of ITNs ▪ Awareness creation on seeking IRS and maintenance behaviour, ▪ Improve skills in identification of malaria sign and symptoms and taking actions ▪ Increase awareness creation on continuous access to early diagnosis and treatment, ▪ Awareness creation on drug adherence based on prescription	▪ Promote and encourage establishment of community norms to prevent misuse of ITNs, IRS adherence, etc. ▪ Engage communities to strengthen community actions for control of larva sources and manage environmental factors	▪ Strengthen Anti-Malaria Clubs in schools: School health education addressing malaria prevention and control	▪ Advocate for improved early diagnosis and prompt treatment of Malaria
Non-Communicable Diseases	1. Low awareness of risk factors of NCDs and adoption of lifestyle 2. Life style changes (physical inactivity, tobacco use, unhealthy diet, salt and sugar intake reduction, etc.) 3. Low practice of periodic screening for common NCDs. 4. Creation of enabling environment to promote life style practices (e.g. physical exercise space) 5. Setting smoke free public and work place	▪ Increase awareness of NCDs and their risk factors ▪ Promote life style changes including health seeking behavior for periodic screening ▪ Celebrate important global health days (eg. World No Tobacco Day, World Diabetes Day and World Mental Health) ▪ To create awareness on screening for NCD risk factors (raised serum cholesterol level, raised blood pressure, and raised blood glucose), cervical cancer, breast cancer, refractive errors, glaucoma, diabetic/hypertensive retinopathy	▪ Promote community participation in organizing healthy activities ▪ Community/social mobilization to increase the knowledge of the community on risk factors of NCD ▪ Community/social mobilization on benefits of screening and early detection ▪ Sensitize for increased Sectoral partnership and collaboration	▪ Integrate communication Packages on NCDs and their risk factors in School Health and Nutrition ▪ Integrate NCD risk factors messages into the routine health education program of health facilities ▪ Conduct awareness raising programs on the risk factors of NCDs in work places. ▪ Promote protection of work place exposure to hazards.	▪ Advocate for creation of enabling environment to promote physical activity (city planning to influence for pedestrian roads, playgrounds, etc.) ▪ Advocate for increased capacity of health facilities to manage NCDs ▪ Collaborate with the national/regional nutrition council and task forces to address the dietary risk factors for NCDs ▪ Enforcement and strengthen the legal framework to protect workers and general population from environmental carcinogens.

ANNEX III:
TARGETTED ACTIONS FOR PRIORITY HEALTH ISSUES

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
Targeted actions for priority health issues: Contributing to program efforts			
1. **Targeted actions for priority health issues:** Develop (or strengthen) comprehensive multisectoral health promotion action plans for major health programs/ problems(NCD and injuries)	# of educational/promotional campaigns implemented to each major health problems	Reduced numbers of major diseases incidences and risk factors Reduced health care cost for treatment Productivity increased	Reports
2. **Communicable Diseases:** Develop (or strengthen) comprehensive multisectoral action plans for major communicable diseases	# of educational/promotional campaigns implemented to each major communicable diseases # of Celebrated important Global Health Events # of communication materials developed for different health programs # of communication SBCC/communication materials disseminated	Reduced numbers of major communicable diseases incidences and risk factors Reduced health care cost for treatment Productivity increased	Reports
2.1. HIV/AIDS and other STIs	% of young people who both correctly identify ways of preventing the sexual transmission of HIV/STIs and who reject major misconceptions about sexual transmission of HIV/STIs % of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months % of the general population receiving HIV test, and post-test counseling in the last 12 months # of people with comprehensive knowledge about the benefit of early diagnosis and treatment for EMTCT of HIV, syphilis, and HBV has increased # of community mobilization to increasing the pregnant, laboring, and lactating women and their babies access to EMTCT of HIV, syphilis and HBV services utilization % of adolescents and youth will have comprehensive knowledge on HIV World AIDS day celebrated	Reduced numbers of HIV/AIDS incidences and risk factors Reduced health care cost for treatment Productivity increased	Assessment report

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
2.2 Tuberculosis (TB)	% of the general public know/aware on methods of prevention against TB Treatment success rate of all forms of TB- bacteriologically confirmed plus clinically diagnosed, new and relapse cases Treatment success rate of TB cases: Percentage of cases with RR and/or MDR-TB successfully treated World Anti-TB Day celebrated World No Tobacco Day	Reduced numbers of TB incidences and risk factors Reduced health care cost for treatment Reduced the risk of AMR Productivity increased	Assessment report
2.3. Acute Respiratory Infection(ARI)	% of mothers and care givers know danger signs of ARI in children Proportion (%) of mothers and care givers seek timely referral for ARI	Reduced numbers of morbidity/ mortality of under 5 years old children	Assessment report
2.4. COVID-19	% of the general public aware on method of prevention against Corona virus % of the general public wear facemask properly % of the general public practicing handwashing with soap or use alcohol base hand rap/ sanitizer properly	Reduced numbers of morbidity and mortality related to COVID-19 Reduced health care cost for treatment Reduced the risk of AMR Productivity increased	Assessment report
2.5 Antimicrobial Resistance(AMR)	% of the general public aware about the dangers of self-medication % of the public knows the correct use of antibiotics for bacterial diseases rather than viral diseases % of the public knows the risk of AMR from their incorrect use % of the public reports completing an antimicrobials treatment course World Antimicrobial Resistance Day celebrated Antibiotic awareness Week	Reduced incidences and risk factors for AMR development: Available antimicrobial agents protected. Reduced health care cost for treatment Productivity increased	Assessment report

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
2.6.WASH & NTDs: Develop (or strengthen) comprehensive multisectoral action plans for safe water, improved sanitation and handwashing with soap at critical times	% of population with access to clean and safe water % of population know the importance of using sanitary toilets Proportion (%) of population who perceive the risk of trachoma # of Kebeles in a given woreda declare open defecation free % of population with access to improved sanitation % of households use improved sanitation facilities % of population with access to places for hand washing with water and soap increased % of population know the importance of washing hands with soap at critical times/points % of individuals wash hands with soap at critical times/points % of mothers and care givers know danger signs of diarrhoea in children % of children receive continued breast-feeding and/or feeding during diarrheal episode % of children receive Oral Rehydration Salt (ORS) during diarrheal episode World Water Day celebrated Global Handwashing Day celebrated World Toilet Day celebrated	Increased access to improved sanitation facilities Sustained hygienic usage of toilet with hand washing practice Reduced numbers of morbidity and mortality Reduced health care cost for treatment Reduced the risk of AMR Productivity increased	Assessment report
2.7. Malaria	% of the general public know/aware on methods of prevention against malaria % of households in malarious area with at least one ITN % of population using an insecticide-treated net among those with access to an insecticide-treated net % of children under five who slept under an ITN the previous night in malarious area % of pregnant women who slept under an ITN the previous night in malarious area % of households sprayed by IRS within the last 12 months World Antimalarial Day celebrated	Reduced numbers of malaria incidences and risk factors Reduced health care cost for treatment Reduced the risk of AMR Productivity increased	Assessment report

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
3. **Non-Communicable Diseases:** Healthy lifestyle: Engage sectors to promote healthy living and multisectoral preventive measures to avert the four behavioural risk factors for NCDs: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.	Numbers of advocacy campaign, plans, and strategies Increase in awareness of NCD and risks factors Awareness creations on early diagnosis/screening practices/ check-up for ANC, Hypertension/ Cardiovascular disease, Diabetes Mellitus, Cancer etc. Proportion(%) of population know importance of doing regular physical exercise Individuals do regular physical exercise (%) No smoking law enforcement in place World Diabetes Day celebrated World Cancer Day celebrated World Health Day based on thematic area celebrated	Reduced numbers of major NCD and injuries incidences and risk factors Reduced health care cost for NCD treatment Productivity increased Percent of adolescents and youth have comprehensive AYH information	Assessment report

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
3.1. Reproductive, Maternal, Newborn and Child Health: Promote vaccination against TT and cervical Ca, Promote at least 4 ANC visit, Health facility delivery, family Planning use and prevent teenage pregnancy, Enhancing primary prevention among adolescents, women, and men; Preventing unintended pregnancy; Empowering the community and increase reproductive health seeking behaviors	% of pregnant women know the importance of antenatal care visits % of pregnant women receive at least 4 antenatal care visits % of pregnant women know the importance getting TT during pregnancy % of pregnant women get TT % of pregnant women know the importance of to have deliveries by skilled birth attendants in the health facility % of pregnant women use Skilled Birth Attendance % of pregnant women know the importance of postnatal care visits % of pregnant women receive at least 4 postnatal care visits % of married couples who know at least two modern FP methods % of couples use any family planning methods (%) % of women know the importance of pep test (pap smear) % of women get pep test (pap smear) % of parents/caretakers understand the importance of fully immunizing children and know which childhood diseases they prevent % of girls know the importance of Human papillomavirus (HPV) Vaccination % of girls get HPV Vaccination % of teenage know the risk of teenage pregnancy % of parents/caretakers fully immunize their children by routine vaccine schedule % of adolescents and youth have access to comprehensive AYH information % of vulnerable adolescents and youth reached with targeted interventions % of schools integrate school health program and provide correct AYSRH information and education on health and well being Women's Health Month celebrated Cervical Cancer Awareness Month celebrated World Mothers Health Day celebrated The World Immunization Week celebrated	Reduced numbers of major NCD and injuries incidences and risk factors Reduced health care cost for NCD treatment Productivity increased Percent of adolescents and youth have comprehensive AYH information	Assessment report

Strategic objectives	Process/Output indicators	Outcome indicators	Means of verification
3.2. Nutrition: *Involve all sectors in increasing food security and access to nutritious food to Promote appropriate food use and utilization including* *Feeding practice particularly for vulnerable groups*	Proportion (%) of pregnant women and mothers breastfeed their children know the importance of iron containing micronutrient supplies/ iron-folic acid (FeFol) Proportion (%) of pregnant women and mothers breastfeed their children receive iron-containing micronutrient supplies/FeFol. Proportion (%) of pregnant women and new mothers know the importance and benefits of exclusive breastfeeding their babies IMMEDIATELY after delivery to 6 months Mothers exclusively breastfeed their children 0-6 months (%) Proportion (%) of mothers and care givers know the importance of pro - viding nutritious complementary feeding to their children aged 6-24 months % appropriate complementary feeding Improved access of nutritious food to targeted population % of schools children and communities has access to nutritious food in proportion against unhealthy food % of healthy markets and food products Proportion (%) of households know the importance of iodized salt (%) households use iodized salt World Breastfeeding Week celebrated	Reduction of malnutrition particularly in children, pregnant and lactating women as well as in adolescent Increased healthy choices to the population	Assessment report

ANNEX IV:
TERMS OF REFERENCES

Terms of Reference for National Health Promotion Steering Committee (NHPSC)

1. Approve health promotion as a priority at the highest level and commit to support the National Health Promotion Strategy.
2. Advice the MOH/government on specific matters related to health promotion.
3. Review policy framework and approve monitoring and evaluation tools, guidelines, SoPs, work plans, etc., for health promotion.
4. Identify health issues and prioritize health promotion areas in the respective organization and allocate adequate resources.
5. Ensure all agencies have a relevant official nominated as a Task Force Member (Technical Working Member).
6. Ensure all sectors effectively implement policies and activities that fall within their responsibility through Monitoring and Evaluation tool.
7. Ensure allocation of adequate agency annual budget or as per the requirement of the work plan to implement sector specific health promotion plans.
8. Support Health Impact Assessment as a requirement for development projects.
9. Identify health promotion research priority and support research.
10. Strengthen inter-sectoral collaboration for health promotion through fostering strategic partnership with engagement of government agencies, academia, civil society, and private sectors.
11. All members shall elicit full commitment as a committee member for NHPSC

Terms of Reference for Technical Working Group

1. Prepare agency specific work plan in line with National Health Promotion Strategy and in consultation with Health Promotion team of MoH;
2. Implement health promotion policies and activities that fall within their responsibility;
3. Develop evaluation and monitoring tool, guidelines, SoPs, work plans, etc., in collaboration with Health Promotion team of MoH;
4. Participate for health impact assessment tool development and implementation;
5. Submit progress report on implementation of health promotion activities to NHPSC through Health Promotion team of MoH and
6. Carry out any other specific work assigned by the NHPSC.

ANNEX V:
KEY CONCEPTS AND OPERATIONAL DEFINITIONS

Advocacy: An organized effort to inform and motivate leadership and decision makers to create an enabling environment for achieving program objectives and development goals. This includes promotion of the development of new policies, changing existing governmental or organizational laws, policies or rules, and/or ensuring adequate implementation of existing policies, to influence funding decisions for specific initiatives.

Behavior Change Communication (BCC): It involves communication-related processes and strategies to change individuals' knowledge, attitudes and beliefs. It is a component of broader Social and Behavior Change (SBC) processes that seek to achieve change in communities or environments.

Behavior change: Any transformation or modification of human behavior

Burden of disease: A measurement of the gap between a population's current health and the optimal state where people attain full life expectancy without suffering major illness.

Collaboration: A recognized relationship among different sectors or groups, which has been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by one sector or group acting alone.

Community: A specific group of people, usually living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Community empowerment: The process of enabling communities to increase control over their lives.

Determinants of health: The range of personal, social, economic and environmental factors which determine the health status of individuals or populations. Health promotion usually focuses on addressing the full range of potentially modifiable determinants of health – such as health behaviors and lifestyles, as well as factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environments.

Health: Health is usually defined as a state of complete physical, spiritual mental and social wellbeing and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end. In this sense, health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. (Adapted from the Ottawa Charter for Health Promotion)

Health communication: Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of multimedia and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development.

Health education: Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health.

Health Extension Program (HEP): a defined package of basic and essential preventive and selected high impact curative health services targeting households and communities. It is designed based on the concept and principles of PHC in order to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom.

Health literacy: the skills and knowledge of a person to access, understand and use information to make decisions, and take action about health and healthcare. Adequate health literacy may include being able to read and comprehend essential health-related materials (e.g., prescription bottles, appointment slips, etc.). Adequate health literacy may increase a person's capacity to take responsibility for their health and their family's health.

Health promotion: Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. The goal of Health promotion practice is to provide and maintain conditions that make it possible for people to make healthy choices and facilitate environmental conditions that support healthy behaviors. Health promotion represents a comprehensive social and political process, which embraces actions directed at strengthening the skills and capabilities of individuals, and action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion action- Describes programs, policies and other organized Health promotion interventions that are empowering, participatory, holistic, intersectional, equitable, sustainable and multi-strategy in nature which aim to improve health and reduce health inequities.

Health Promotion Approaches: Approaches in health promotion can be viewed in two broad ways- the type of interventions undertaken or the location, problem and beneficiaries relating to an intervention. From the type of interventions perspective, there are five commonly used approaches: Medical/disease prevention, behavior change, educational, empowerment and social change. From the location of interventions, problem addressed and population targeted, there are three main approaches: The settings approaches, the issues approach and the population approach. Social determinants of Health- The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

Health promotion outcomes: Health promotion outcomes are changes to personal characteristics and skills, and/ or social norms and actions, and/or organizational practices and public policies which are attributable to a health promotion activity.

Health system literacy: the ability of people and care providers to navigate the health system for effective utilization and improvement of health care services

Methods used in Health promotion: Health promotion focuses on outcomes-empowerment for health action, creation of environments that are conducive to health and increased social support for health and not on the methods per se which are viewed as inputs that lead to these outcomes. Being a process, its implementation depends on the combining various methods as determined by the issue being addressed, the physical location, the players and the resources available, among other considerations. The methods used in Health promotion are also used in other public health programs. For example, population health programs employ health communication, social marketing and social mobilization, methods which are also used in Health promotion.

Public health: The policies, strategies, legislation, standards and actions aimed at promoting health, preventing disease, and prolonging life through the organized efforts of society.

Social and Behavior Change: a strategic and interactive process that aims to change not only individual behaviors but also social conditions.

Social and Behavioral Change Communication (SBCC): the systematic application of interactive, theory-based, and research-driven communication processes and strategies to address tipping points for change at the individual, community, and social levels. A tipping point refers to the dynamics of social change, where trends rapidly evolve into permanent changes. It can be driven by a naturally occurring event or a strong determinant for change such as political will that provides the final push to tip over barriers to change. Tipping points describe how momentum builds up to a point where change gains strength and becomes unstoppable

Social mobilization: a continuous process that engages and motivates various intersectoral partners at national and local levels to raise awareness of, and demand for, a particular development objective. These partners may include government policy makers and decision makers, community opinion leaders, bureaucrats and technocrats, professional groups, religious associations, non-governmental organizations, private sector entities, communities, and individuals. This communication approach focuses on people and communities as agents of their own change, emphasizes community empowerment, and creates an enabling environment for change and helps build the capacity of the groups in the process, so that they are able to mobilize resources and plan, implement, and monitor activities with the community.

Socio-ecological model: a theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors, and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations.

Strategy: In Health promotion, a strategy refers to the broad lines of action to be taken to achieve set goals and objectives, incorporating the identification of suitable points of intervention, the ways of ensuring the involvement of other sectors, the range of political, social, economic, managerial and technical factors, as well as constraints and ways of dealing with them.

Women/Men/Youth Development Groups: Community members which are organized around settlement with an emphasis on participating, teaching, and learning from others as well as taking practical actions for the betterment of health on individual, family, and community levels.

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