National Health Promotion and Communication Strategy 2016 - 2020

Federal Ministry of Health

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Acknowledgement

The development of this strategy has been made possible through the relentless efforts of the partners. The Federal Ministry of Health acknowledges the following organizations and the designated experts for their contribution in planning, gathering, analysis, condensation and finalization.

Jhpiego
Save the Children
BBC Media Action
The Last Ten Kilometers (L10K)
World Health Organization (WHO)
United Nations Children's Fund (UNICEF)
Integrated Family Health Program (IFHP)
John Hopkins University Center for Communication Programs (CCP)

Foreword

Over the past two decades, Ethiopia has made impressive progress in the expansion of primary health services coverage reaching most communities and households. This is in large part due to a well-coordinated, extensive effort and intensive investment of the government, partners and the community at large in Primary Health Care (PHC) through the Health Extension Program and expansion of PHC units.

Through the implementation of the Health Extension Program (HEP) and the abolishment of user fees for key health programs such as maternal health services, tuberculosis (TB), family planning, among others, the Federal Ministry of Health (FMOH) has made services more accessible to the population. Ethiopia has achieved most of the health related Millennium Development Goals (MDGs), namely MDG 4 (reduction of child mortality), MDG 5 (reduction of maternal mortality), and MDG 6 (combating HIV/AIDS, TB and Malaria). Moreover, the country is in good position to register exemplary results in achieving the new Sustainable Development Goals (SDGs).

The 20 years health sector visioning document (2015-2035) and the Health Sector Transformation Plan (HSTP) for the period 2015/16 to 2019/20 have been used to guide our collective and coordinated efforts towards meeting the goal of improved health status of the population, as well as the SDGs.

While such significant progress is encouraging, communicable diseases and non-communicable diseases still remain major health problems. Despite high health services coverage low health service utilization has been identified as a challenge that needs to be addressed by assessing cultural issues, providers' attitudes and competencies, patient/client preferences and health seeking behaviors at the household and community levels. All health programs need to be guided with comprehensive and holistic health promotion and communication interventions.

The National Health Promotion and Communication Strategy (NHPCS, 2016-2020) has been designed to account for the current status of health and health service uptake in Ethiopia and is based on a conceptual framework that considers FMOH's pathways to improve health status as instrumental for the success of program goals.

As the momentum to bring health services closer to the community coupled with engagement of communities through the Health Development Army increases, it will be important to understand barriers that impede communities from utilizing health services and to implement strategies to increase demand for health services. The NHPCS will facilitate the development and effectiveness of context-specific health promotion and communication interventions to improve health behaviors, health and health system literacy, and the uptake of different health services.

FMOH believes that this strategy will provide a framework that can guide the designing and planning of health communication and education interventions. FMOH is committed to implement this strategy, build national and regional capacity for sustaining health promotion, and create an enabling environment for people to have access to and adopt healthy behavior and see a vibrant community that produces its own health in the long run.

I therefore, would like to seize this opportunity to call up on all our partners in the field of health to support the dissemination of this strategy in order to align their activities and harmonize implementation accordingly.

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State Minister of Health
Addis Ababa, Ethiopia

Acronyms

ARH	Adolescent Reproductive Health
BCC	Behavior Change Communication
BEmNOC	Basic Emergency Obstetric & Newborn care
BMI	Body Mass Index
CEmNOC	Comprehensive Emergency Obstetric & Newborn care
CRC	Caring, Respectful & Compassionate
CRGE	Ethiopia's Climate-Resilient Green Economy
EBC	Ethiopian Broadcasting Corporation
EBS	Ethiopian/Radio Broadcasting Service
EDHS	Ethiopian Demographic Health Survey
EPHI	Ethiopian Public Health Institution
EPI	Expanded Program on Immunization
FCTC	Framework Convention on Tobacco Control
FDRE	Federal Democratic Republic of Ethiopia
FGM	Female Genital Mutilation
FMHACA	Ethiopian Food, Medicine, and Healthcare Administration
FMoH	Federal Ministry of Health
FP	Family Planning
GoE	Government of Ethiopia
GTP	Growth and Transformation Plan
HDA	Health Development Army
HEC	Health Education & Communication
HEEC	Health Extension & Education Center
HEP	Health Extension Program
HEPHS	Health Extension & Primary Health Services
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSDP	Health Sector Development Plan
HSTP	Health Sector Transformation Plan
ICT	Information Communication Technology
IEC	Information, Education & Communication
IHR	International Health Regulation
INGOs	International Non-Governmental Organizations

IPC	Interpersonal Communication
KAP	Knowledge, Attitude & Practices
LLITN	Long Lasting Impregnated Treated Net
MERS	Middle East Respiratory Syndrome
MDGs	Millennium Development Goals
MOA/BOA	Ministry/Bureau of Agriculture
MOLSA/BOLSA	Ministry/Bureau of Labor & Social Affairs
MOU	Memorandum of Understanding
MOUDW	Ministry of Urban Development
NCDs	Non-Communicable Diseases
NGO	Non-governmental Organization
NHEC	National Health Education & Communication
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
RBS	Regional Broadcasting Service
RH	Reproductive health
RHB	Regional Health Bureau
SBCC	Social and Behavior Change Communication
SDGs	Sustainable Development Goals
SNNPR	Southern Nations, Nationalities, and Peoples' Region
SM	Social Mobilization
SWOT	Strength, Weakness, Opportunity & Threat
TB	Tuberculosis
ToT	Training of Trainers
TWG	Technical Working Group
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WoHO	Woreda Health Office
WOM	Word of Mouth
ZHD	Zonal Health Department

Definitions of Terms

Advocacy: an organized effort to inform and motivate leadership to create an enabling environment for achieving program objectives and development goals (to promote the development of new policies, change existing governmental or organizational laws, policies or rules, and/or ensure the adequate implementation of existing policies, to influence funding decisions for specific initiatives)

Behavior change: any transformation or modification of human behavior

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

Health communication: the study and practice of communicating promotional health information, such as in public health campaigns, health education, and communication between doctor and patient to influence personal health choices by improving health literacy

Health Development Army: 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

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 degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions

Health system literacy: the ability of people and care providers to navigate the health system for effective utilization and improvement of health care services
Health promotion: the process of enabling people to increase control over their health and its determinants, and thereby improving their health

Health promotion: the process of enabling people to increase control over their health and its determinants, and thereby improving their health

Public health emergency: an occurrence or imminent threat of an illness or health condition caused by bioterrorism, epidemic or pandemic disease, or a novel and highly fatal infectious agent or biological toxin that poses a substantial risk of a significant number of human facilities or incidents or permanent or long-term disability

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

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

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Executive Summary

The rapid developments that evolved in the health sector over the last two decades brought immense opportunities to engage communities and assist them to produce their own health. The health extension program (HEP) which deployed over 38, 000 Health Extension Workers (HEW)[1] both in rural and urban vicinities (Kebeles) and the creation of the Health Development Army (HDA) provided unprecedented commitment to ensure that health needs of communities are met. The expansion of Primary Health Care (PHC) services made basic health services available and easily accessible. As a result of the health delivery system strengthening process, progress has been made in the improvement of the health status of the population.

Despite achievements in the health system, low utilization of health services is observed due to barriers such as cultural and traditional factors compounded with unfriendly atmosphere and poor communication between providers and clients which has negatively affected the adoption of health seeking behaviors and health service uptake.

This revision of the National Health Promotion and Communication Strategy (NHPCS), 2005 - 2014 is therefore necessitated to suit to recent changes such as 2nd generation HEP, an increasing triple burden from communicable and non-communicable diseases and injuries/accident that demand behavioral interventions. Hence, a shift in focus from individual behavior change to addressing socio-economic and cultural factors discouraging behavior change at the community and household levels has been considered.

The strategy has identified 14 gap areas at individual, community and macro level:

1. Knowledge, attitude and behavior change
2. Promotion and sustaining of linkages among HEW/ HDA, community & local leadership
3. Community empowerment
4. Enhancing HEWs' capacity
5. Gaps from inadequate availability of standardized, community-focused guidelines
6. Setting friendly, welcoming health facility environment
7. Identifying, documenting & sharing societal values and practices for health
8. Promotion of healthy work & environment places
9. Greater mass media involvement
10. Multi-sector involvement for the promotion of health addressing social determinants of health and factors that limit demand for health services
11. Identification, sensitization and advocacy for implementation of existing public health laws and legal frameworks
12. Preparedness to respond to health threats of international concern
13. Climate and Health
14. National and regional capacity to sustain health communication works in the country at grassroots level mechanisms to measure progress and change over time

[1] FMOH, HSTP 2015/16-2019/20, pp. 12

Upon reviewing of the possible interactions of factors of each gap area using the socio-ecological model at individual, community and at macro level and their impact on health, the strategy has adopted a NHPC conceptual framework. Hence, it can serve to identify domains of health communication interventions and broad strategies.

This strategy is organized in the following 6 chapters:

Chapter 1 provides detail analysis of the country context (socio - economic progress with detailed analysis of health programs) presenting challenges that can be dealt with health promotion and health communication.

Chapter 2 highlights analysis of the communication context and opportunities for strengthening health promotion and health communication.

Chapter 3 presents, the basis of stock taking of lessons from past health communication interventions through expert consultations, as well as the review of recommendations in the series of HSDP, midterm reports, specific health programs, and documentation of the most important health promotion gaps.

Chapter 4 provides strategies at individual, community, macro level (societal, environmental, work place, public health laws and global). Special emphasis has been given on community empowerment through strengthening of HEP/HDA. A matrix of health programs showing key issues and domains of communication is presented as an annex to guide the utilization of the strategies and their adaptation to specific cultures.

Chapter 5 details the modality of strategy implementation and presents the need for strengthening partnership, identification of institutional arrangement and defining of roles and responsibilities.

Chapter 6 outlines monitoring and evaluation for each strategy, including when and how to gather indicators for measuring implementation and outcome.

Regarding implementation of the strategy, the FMOH respective directorates and Regional Health Bureaus (RHBs) will lead, coordinate, and monitor with technical and financial support from UN agencies, international non-governmental organizations (NGOs), and other stakeholders. Mapping of partners to build strong partnership is crucial. Modality of implementation for each specific strategy is defined, and the role of the partners outlined.

Effectiveness of the strategy will be measured with proper monitoring and evaluation. Indicators to measure progress, outputs, outcomes and impact have been developed and tools for collection and reporting are presented.

Key issues for each health program and respective communication objectives have been identified. The health programs include: Maternal, Neonatal, Child Health, Adolescent Reproductive Health including Family Planning, Adolescent Health, Expanded Program on Immunization (EPI), Nutrition, Communicable Diseases (TB, Malaria, HIV/AIDS and others), Neglected Tropical Diseases (NTD), Non-Communicable diseases (NCD) including mental health and road safety, Water, Sanitation & Hygiene (WASH), Public Health Emergencies, accident/ injuries and Climate and health.

Introduction and Rationale

In the last two decades, the Federal Ministry of Health (FMOH) has remarkably increased primary health services coverage, and as a result PHC services are now available and more accessible to both urban and rural population than ever before. The HEP and the associated expansion of health centers and primary hospitals contribute to achieving universal access to health care. Moreover, the number of health professionals has increased significantly by type and quantity.

The NHPCS (2005-2014), which was put in place to improve and guide efforts of social and behavioral change communication, could be seen as milestone. Tremendous work has been carried out to develop specific health program communication strategies to help increase the reach of national targets. The HEP and the recently introduced HDA initiative signifies the commitment of the Government of Ethiopia (GoE) to reach out to families, encourage community empowerment and sustain the uptake of health services. As a result, significant achievements have been observed such as improved health awareness, increased adoption of positive health behaviors, as well as utilization of health services. Despite these achievements, there are still significant gaps in the health status of the population partly because of lack of coordinated, comprehensive, and timely identification and resolution of health communication and promotion problems. It is crucial that the strategy focuses on three essential areas: (1) determinants of health at the individual level, (2) community empowerment, and (3) creating an enabling environment in order to sustain positive health outcomes.

The rationale for revising the National Health Communication Strategy (2005-2014); the health sector has grown dramatically as a result of continuous and robust policy and strategic measures with a shift in emphasized approaches, the introduction of new programs and frameworks for meeting national and regional targets. Furthermore, with the increased number of players in the health sector, the interest for different types of health program communication strategies continue to unfold. In line with these factors, the HSTP emphasizes health literacy and health system literacy of citizens. There have also been tremendous changes in the health system infrastructure as well as in the electronic and print media.

The revision of the strategy, therefore, is based on the situational analysis of the increasingly dynamic nature of the health system, the disease pattern change of both communicable and non-communicable diseases, the development of HEP and HDA initiatives, and the emerging of communication platforms including social media, and national and local electronic and print media outlets. Moreover, in line with the HSTP, there has been a shift in emphasis from individual behavior changes to social changes that can affect health at household, community, and environment levels.

The strategy is expected to provide a framework to support specific health programs. These programs are expected to develop their own respective health promotion implementation manuals that are congruent with this strategy outlining the specific communication objectives, audience profiles, media plan and other essential information for their respective health promotion and communication interventions. These health promotion and communication implementation manuals may address behavior change, create demand, nurture enabling environments for sustained change, increase access and universal coverage, or any combinations of these depending on their objectives.

Chapter 1

Country Context

Chapter 1: Country Context

1.1. Geography, Climate, Demographics, Political and Socio-economic Context

This chapter provides contextual information such as the geographic, demographic, political and socioeconomic profiles that needs to be considered when assessing the prospective contribution or the potential effectiveness of a health promotion and communication strategy. The information will provide insights necessary to determine relevant domains of health promotion and communication interventions.

1.1.1 Geography and Climate

Ethiopia is located in the Horn of Africa, with a total surface area of 1.1 million square kilometers, bordering Djibouti, Somalia, Kenya, The Republic of South Sudan, The Republic of the Sudan, and Eritrea. The country has diversified topography features, ranging from the highest peak, Ras Dashen, 4,500 meters above sea level, down to the lowest Afar depression, 110 meters, below sea level.[2] The lowlands make up nearly 61-65% of the land-mass, and are the major nomadic pastoralist and agro-pastoralist areas.[3]

The climate also varies with the topography, from as high as 47 degrees Celsius in the Afar Depression to as low as 10 degrees Celsius in the highlands. Ethiopia has three principal climates: tropical rainy, dry, and, warm temperate. Maximum and minimum average temperatures vary across regions of the country and seasons of the year. Generally, the mean maximum temperature is highest from March to May, and the mean minimum temperature is lowest from November to December.[4]

1.1.2 Demographics

Age structure and population size of a country has significant implications for health interventions. Ethiopia is the second most populous country in Sub-Saharan Africa (SSA) with a population of about 94.35 million (CSA EFY 2009 projected). The population is predominantly young with 53.3% younger than 20 years of age (0-14 is 42.8% and 15-19 is 10.5%). With the population growing at an annual rate of 2.6 %, the average size of a household is currently 4.8.[5]

About 83.5% of the population lives in rural areas, whereas the remaining 16.5% live in urban areas.4 The national average population density is 66.5 persons per sq.km although the situation varies from region to region. The highest population density is found in Southern Nation Nationalities and Peoples' Region (SNNPR) and can reach more than 1000 per sq. km.[6]

The country has rich diversity of cultures, religions, and languages. More than 80 different languages are spoken, and hence, one could clearly understand the complexities in health services delivery in such diverse population. Religious practices in the country are predominantly Christian and Muslim.

1.1.3 Political Environment

The Federal Democratic Republic of Ethiopia (FDRE) is established by the 1995 constitution. The FDRE is structured as a federal state with a bicameral parliament, with the House of Peoples' Representatives having the highest authority of the federal government and the

[2] CSA 2011
[3] Alemayehu Mengistu (FAO)
[4] Ethiopian Government Portal, http://www.ethiopia.gov.et/state-structure)
[5] Ibid.
[6] Aynalem Adugna (2014) EthioDemographyandHealth.org

House of Federation representing the common interests of the nations, nationalities, and peoples of the state. The head of state is a president elected by a joint session of both houses. A prime minister who is accountable to the council of Peoples' Representative heads the government.

The country has nine regional states, namely Tigray, Afar, Amhara, Oromia, Somali, SNNPR, Benishangul-Gumuz, Gambella, and Harari; and 2 chartered cities, namely Addis Ababa and Dire Dawa. Each regional state is autonomous and is headed by a state president elected by the respective regional council. The judiciary is constitutionally independent.

The regional states and city administrations are further subdivided into more than 800 districts (Woredas or sub cities), with political power decentralized to these districts to exercise full authority through councils of elected members.

1.1.4 Socio-economic Situation

Driven by robust economic policy and economic measures over the past two decades, the GoE has been implementing a market–based and agricultural-led industrialization economic program. Ethiopia is now one of the fastest growing economies with a Gross Domestic Product (GDP) estimated at around 55.61 billion US dollars.[7] Based on purchasing power parity, Ethiopia's economy is the fourth largest in SSA, 25% to 35% larger than the economies of Ghana and Kenya, respectively. Per capita income has increased from 558 US dollars to 632 US dollars in 2005 Ethiopian fiscal year.[8]

The remarkable economic growth has translated to a decline in poverty. Ethiopia has experienced a dramatic reduction in its poverty rate.[9] However, the economic progress has not been free of challenges. Agriculture, which is the main economic sector accounting for 83.4% of the labor force, about 43.2% of the GDP, and 80% of exports, is constrained by recurrent droughts and poor cultivation making the economy very vulnerable to climatic changes.[10]

An important feature of the Ethiopian economic reform, which is enshrined in its constitution, is the principle of equality of access to economic opportunities, employment, and property ownership for women. The overall economic dependency ratio for the country estimated at 81.5 dependents per 100 persons in the working age group of 15-64 years is yet another indicator for the economy to grow faster and produce job opportunities.[11]

Education has significantly improved in recent years with the proportion of females with no education among those between ages 10-14 at 19% as compared to those aged 65 and above at 98%. Similarly among males, 89 % of 65 and older men had no education compared with 15-20 % of the 10-24 years old.[12]

Moreover, the government is taking steps to address skill deficits among the youth. Progress in the education sector has shown that primary school gross enrolment reached 100% in 2014. The ratio of girls to boys in primary education has also reached 1.0 in the same fiscal

[7] World Bank, World Development Index 2014
[8] http://www.mfa.gov.et/news/more.php?newsid=3627, FDRE, Ministry of Foreign Affairs
[9] National Planning commission, GTP II, 2015/16-2016
[10] 2008 Macro Economic Development Report MoFED
[11] Ethiopian Government Portal, http://www.ethiopia.gov.et/state-structure)
[12] Mini DHS 2014

year, and a total of more than 19 million children have attended primary school education.[13,14] The enrolment of children to primary schools, particularly girls, has also played a key role in the improvement of health seeking behaviors.

1.1.5 Transport and Telecommunications

Transport and communication infrastructure in general is among the priority sectors given the utmost political attention by the GoE. The Federal and regional road network is reported to have increased from 48,800 km in 2009/10 to 63,604 km in 2015. In addition to this, 46,810 km all-weather woreda roads have been constructed from 2010 to 2015. As a result, the proportion of rural kebeles connected to all-weather roads has increased from 39% in 2009/10 to 76% by 2014/15, and the average time required to reach the nearest all-weather roads has declined from 3.7 hours to 1.7 hours.[15]

Huge investment has been made so as to acquire the latest technology and expand the services in the telecom sector. Between the periods of 2009/10 to 2014/15, the number of mobile subscribers increased from 6.7 million in 2009/10 to 38.8 million by 2014/15. The share of rural kebeles with access to telecom services (within 5km radius) increased from 62.1% in 2009/10 to 97% by 2014/15. The other significant achievement in the telecom sector during the GTPI period is the introduction of 3.75G and 4G internet networks with the capacity to provide services to 60 million customers.[16]

1.2 Health Status, Issues and Challenges

The health problems of the populations are largely caused by preventable communicable disease and nutritional disorders. Despite progresses made to date, there is still a high rate of morbidity and mortality as a result of these conditions.[17]

Ethiopia has enjoyed peace, stability and an all rounded steady growth and development. Economic growth and achievements in the health sector have brought positive impact on the population's health status. For instance, the average life expectancy has increased from 44 to 64 years.[18] Other factors improving key health indicators have also been observed in the last decade.

1.2.1 Maternal, Neonatal and Child Health

Maternal Health

Ethiopia has made a significant progress in reducing maternal mortality. Maternal mortality ratio has declined from 1250 per 100,000 live births in 1990 to 353 per 100,000 live births in 2015.[19] Due to an increased political commitment and strong leadership at all levels, there has been a tremendous increase in antenatal care coverage and percentage of deliveries assisted by skilled health personnel. In spite of these achievements, much has to be done to further reduce the maternal mortality, especially in making services equitably accessible to all

[13] World Band Report 2014
[14] CSA .statistical Abstract, 2006 EFY
[15] National Planning commission. GTP II, 2015/16-2016
[16] Ibid.
[17] FMOH. HSTP, 2015/16-2019/2020
[18] Ibid.
[19] UN report. Trends in Maternal Mortality: 1990-2015

segments of population. Improving early postnatal care also needs attention given that it is critical for maternal and newborn survival.

Lack of quality of BEmONC and CEmONC services at health facilities, availability of necessary equipment, and strong referral system are commonly identified constraints that hinder progress and highlighted in the HSTP for further improvements.

On the demand side, delays in seeking skilled care, delays in reaching the health facility, cultural norms and societal emotional support bestowed to mothers, distance to functioning health centers and financial barriers remain as challenges in accessing maternal health services.[20]

Family Planning

There is fairly good knowledge of contraceptive methods in Ethiopia, which is evident in the contraceptive prevalence rate among currently married women increasing from 8.1% in 2000 to 41.8% in 2014. Among other reasons, this increase is due to the contribution of HEWs in promoting behavioral change and implementation of FP services. Modern methods comprise about 40% of the contraceptives used. The increase in the use of injectables to 31% is a major contributor to the sharp rise of contraceptive use in the country. In the HSTP 2015/16 - 2019/20, emphasis to expand family planning through scaling up of long term family planning methods such as Intrauterine contraception device and implants has been given due attention.[21]

Despite improvements observed, there is a need to further improve counseling services to alleviate fears of side effects and provide tailored contraceptive advice to address real needs of clients. There are also different cultural barriers related to family planning including beliefs that outcome of pregnancy is predetermined by God/Allah. Additionally, the involvement of men in support of their partners to utilize family planning services needs to be encouraged.

Neonatal, Infant, and Under 5 Child Health

According to the UN Inter-agency Group's mortality estimates, Ethiopia's under-five, infant, and neonatal mortality rates were reported to have reduced to 59, 41 and 28 per 1000 live births in 2015, from 205, 122 and 61 per 1000 live births in 1990, respectively.[22] Ethiopia also successfully reduced under-five mortality by two thirds between 1990 and 2012, successfully meeting the MDG 4 target.

Health seeking behavior is given due emphasis because of its contribution to children's health. Immunization, which is one of the cost effective measures, is reported to achieve 94% coverage of Pentavalent III and 90% coverage of measles immunization. The percentage of fully immunized children is 86%. Dropout tracing and identification of ways to reach out to pastoralist children are necessary to further improve coverage.[23]

[20] HSDP IV, 2010/11 – 2014/15
[21] FMOH. HSTP , 2015
[22] UN interagency group report, 2015
[23] FMOH. HSTP, 2015

1.2.2 Nutrition

According to the 2011 EDHS, 17% of women between 15-49 years of age are anemic, 13% are mildly anemic, 3% are moderately anemic, and less than 1% are severely anemic. Moreover, 27% of women between 15- 49 years of age are thin, that is, they fall below the cut-off of 18.5 for the body mass index (BMI). Nine percent are moderately or severely thin, while only six percent of women are overweight or obese (BMI >25 kg/m2).

From 2000–2011, based on the new WHO Child Growth Standards, child nutrition status has shown improvement from the perspectives of stunting (too short for age), wasting (too thin for height) and underweight (too thin for age). As per the 2000 and 2011 EDHS reports, child nutrition status has shown improvement in reduction of stunting from 58% to 44%, in wasting from 12% to 10%, and in underweight from 41% to 29%. In 2014, 40% of children under age five were stunted, 9% were wasted, and 25% were underweight. Furthermore, three percent of children in Ethiopia are classified as overweight or obese.[24]

Breastfeeding is nearly universal in Ethiopia, and half of children below three are breastfed for about 25 months. More than half (52%) of children less than 6 months old are exclusively breastfed.[25]

Lack of adequate knowledge about proper nutrition, access to food, and unhealthy diet through the life course of an individual are a few of the major contributors to nutrition-related problems in the country.

1.2.3 Adolescent and Youth Health

The fact that prevalence of teenage pregnancy is 17% and unsafe abortion is about 500,000 estimated pregnancies end in abortion.[26] This signifies the importance of information, education and communication, counseling and support from families, school and community environment.

1.2.4 Communicable diseases

TB/HIV/Malaria

According to the HIV related estimates and projections for Ethiopia (FMOH/EPHI, 2012), Significant progress has been made in the prevention and control of HIV/AIDS and it is estimated that prevalence amongst the adult (15 till 49 years) population has dropped to 1.2% (0.8% in males and 1.6% in females) the adult HIV incidence stood at 0.03% in 2014.

The HIV epidemic in Ethiopia is becoming more concentrated with higher prevalence in major towns. The epidemic can be described as both generalized and heterogeneous with focus now on most at risk populations.[27,28] Although general knowledge about HIV is generally high (97% of women and 99% of men), comprehensive knowledge is surprisingly low (19% of women and 32% of men).[29]

Concerted efforts in malaria control and prevention have also had significant impact. Percentage of children under the age of five who sleep under insecticide treated nets increased from 3% in 2005 to 65% in 2010/11.[30]

[24] ibid.
[25] Socio-Economic, Behavioral and Health Services: Determinants Of Immunization Service Utilization: A Community And Facility-Based Study In Ethiopia, May 2012
[26] FMOH. HSDP IV
[27] FMOH. ARM report 2012/2013
[28] Mini EDHS 2014
[29] CSA. EDHS 2011
[30] Ibid.
[31] Ibid.
[32] FMOH. HSTP, 2015

Use and distribution of insecticide treated bed-nets is a major factor for the reduction of malaria related deaths. Proportion of household in malaria prone areas who own at least one Long Lasting Impregnated and Treated Net (LLITN) is 54.8%. Proportion of pregnant women in malaria endemic areas who slept under LLITN is only 35.3% while for children under five, the figure was 38.2%.[31]

Regarding to TB, Ethiopia is among the highest in high burden countries with estimated incidence, prevalence, mortality of 224/100,000, 211/100,000, and 32/100,000 respectively in 2014.[32] According to the HSDP IV report, the national tuberculosis detection and treatment success rates is 67% and 92% in 2014/15, respectively.

Neglected Tropical Diseases (NTDs)

NTDs have received increasing global and regional attention. Efforts are getting momentum to reduce morbidity and mortality due to these diseases. Globally, there are around 17 diseases identified as NTDs. The FMOH launched a master plan in June, 2013 targeting 8 priority diseases: Podoconiosis, non-lymphatic Filariasis, Schistosomiasis, Leishmaniasis, Guinea Worm, Soil transmitted helminthes, and Trachoma. These diseases disfigure, blind, kill, and debilitate sizeable proportions of the population. The health and socioeconomic impact of these is immense.

Public Health Emergencies

Considering diseases and health threats of international concern resulting from natural and manmade calamities with serious social and economic consequences, the FMOH has put a structure in place to coordinate preparedness and response.

Natural calamities such as drought, flooding, and global warming remain significant threats along with public health threats such as cholera, dengue fever, yellow fever, avian flu, Pandemic flu, Ebola, and Middle East Respiratory Syndrome (MERS).

Hygiene and Sanitation

Unsafe drinking water, poor hygiene and sanitation, and unsafe environment that provide favorable breeding areas for vectors remain factors contributing to many communicable diseases. According to the 2014 mini DHS, only 55% of the Ethiopian households have access to an improved source of drinking water. Furthermore, 88% of households use non-improved toilet facilities.[33]

Furthermore, poor hygiene practices such as open defecation, improper food and water handling, and lack of hand washing during critical times exacerbate the situation.

[33] FMOH. HSDP IV

[34] FDRE, Prevention and Control of Chronic Non-Communicable Diseases Strategic Framework, 2014

1.2.5 Non–Communicable Diseases

The growing burden of chronic non-communicable diseases in low and middle-income countries is gaining attention worldwide, including in the African continent. Chronic diseases, such as heart disease, stroke, cancers, chronic respiratory diseases diabetes, and high blood pressure are by far the leading causes of mortality in the world, representing 60% of all deaths. Eighty percent of chronic disease deaths occur in low and middle-income countries, where chronic diseases affect younger populations and lead to premature mortality due to lack of prevention or effective management of the diseases or their risk factors. It is well known that most of these diseases are attributed to common preventable risk factors such as smoking, alcohol and drug abuse, unhealthy diet, and physical inactivity. The trend in Africa causes extra burden on top of existing problems of communicable diseases, maternal and prenatal conditions and nutritional problems.

The situation in Ethiopia is similar to the rest of the African region. Injuries related to road traffic and homicidal incidents significantly contribute to the rise of non-communicable disease burden. Considering the trend of chronic diseases, FMoH has developed a NCD strategy and identified the following as major challenges regarding NCDs.

- Poor awareness and misconceptions about the burden and consequences of chronic diseases,
- Unfavorable environmental conditions restricting physical activity (walking, cycling, sports, etc.),
- Proliferation of industrial/commercial food processing and brewery
- Lifestyle behaviors (smoking, alcohol, physical inactivity, refined foods with added salt, sugar and saturated fat, etc.)
- Inadequate physical activity (walking, cycling, sports, etc.)

Chapter 2

Situational Analysis of Health Promotion and Communication Context

Chapter 2: Situational Analysis of Health Promotion and Communication Context

The political and policy environment in the last two decades particularly has created a favorable environment for the health sector to make use of a wider array of communication channels and for the general public to have more options for accessing health information. The increase of private and public media outlets, establishment of public communication structure, expansion of ICT and transportation network, increasing use of mobile as well as the increasing engagement of partners and stakeholders with the capacity to enhance communication networking and capabilities are among a few examples of an evolving media sector worth mentioning.

2.1. Macro Policy Environment for Health Promotion and Communication

2.1.1 Massmedia Context

Quite a number of policies and strategies have been put in place since 1991 after the fall of the previous military regime. Mass media remains a key element and receives serious attention for analyzing the communication context of a country. The fact that mass media has the potential capacity to reach a large proportion of the population in very short period of time makes it an undisputable ally. Expansion of mass media services with varying degrees of capacity and languages has been observed. The Commercial Radio Broadcasting Service directive - 01/2008 and Community Radio Broadcasting services directive -02/2008 were issued to encourage alternative broadcasting services to provide education, entertainment, and information to the public. Currently, there are more than 30 national, community, and educational radio stations, and more than 10 national and regional TV channels operating in the country.

The Press freedom bill of 1992 enabled hundreds of private newspapers and magazines to seek registration. Currently, at any one time every week, one can find about 20 different newspapers for sale in the streets of Addis Ababa and regional cities.

Mass media remains one of the major sources of health information. According to EDHS (2011), the proportion of women between 15 and 49 years of age who listen to the radio has increased from 16% in 2005 to 22% in 2011, while the proportion among men 15-59 has increased from 31% to 38%.

Regarding communication device ownership, the EPI Determinant Behavioral Survey result (May 2012, FMOH) shows that from the total respondents, 57.2% had owned mobile phones, 55% owned a radio, and 31.1% owned

a television. Another study was conducted in 2012 by the United Kingdom Department for International Development (DIFID) on Media Exposure IRIS. Results showed that radio constituted 80%, TV 61.6%, word of mouth/interpersonal communication (WOM/IPC) 49.5% as a whole (specific WOM 96% and 90% for Somali and Afar, respectively), community meeting 35.5%, Church/ Mosque 16.9%, mobile 16.3%, newspaper 13.3%, and others (such as billboard and satellite TV) ranging from 4% to 2.1%. Again, most reliable and most important sources of information among the community were radio (53.1% and 52.2%), TV (20.5% and 21.5%), and WOM (11.1% and 9.7%), respectively.

Pertaining to program preference by gender on radio, news and current event is the first by 52.6 % (male) and 41.6 % (female), second is music by 5.9% (male) and 14.3% (female), third is drama by 6.6% (male) and 10% (female), fourth is entertainment by 5.7% (male) and 5.3% (female) fifth is sport by 6.1% (male) and 1.9 % (female), while the preference for health by female is found to be 2.5%.

Judging by the amount of current mobile phone coverage in the country, mobile phone can be used as one way of disseminating health communication messages with due care to technological barriers such as the receiver's capability to access different languages. Currently, mass media health education and communication intervention formats are mainly on health-related questions and answers, round table discussions, documentary films, dramas, feature stories, spots, and news stories.

2.1.2. The Information Communication Technology (ICT) Policy

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

Mobile SMS messaging and Health Internet are increasingly being used to disseminate and exchange health information for the general public. In addition, these infrastructures 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 quality health services delivery.

[35] The national Information and Communication Technology policy and strategy,2009

2.2 The Health Policy and program strategies

2.2.1 The Health Policy

The 1993 Health Policy boldly indicated priority health issues and the significance of Information, Education, and Communication (IEC), as well as health education and community mobilization as priority interventions to address most health problems in the country and to encourage participation of communities in efforts to take control over their own health. To operationalize the policy, Ethiopia has implemented successive Health Sector Development Plans (HSDPs) since 1997 in four phases.

In its general strategies, the policy recommended strengthening of health education by targeting specific populations through the mass media, health facilities, community leaders, religious and cultural leaders, professional associations, schools and others. It identified priority health issues for:

- Inculcating attitudes of responsibility for self-care in health and assurance of safe environment.
- Encouraging the awareness and development of health promotive life-styles and attention to personal hygiene and healthy environment.
- Enhancing awareness of common communicable and nutritional diseases and the means for their prevention.
- Inculcating attitudes of participation in community health development.
- Identifying and discouraging harmful traditional practices while encouraging their beneficial aspects.
- Discouraging the acquisition of harmful habits such as cigarette smoking, alcohol consumption, drug abuse and irresponsible sexual behavior.
- Creating awareness in the population about the rational use of drugs.

2.2.2. Health Sector Development Plan, Health Program Strategies

The health sector transformation plan, in line with our country's second growth and transformation plan (GTPII), has set ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels of the system.

The importance of health promotion, disease prevention, and behavioral change communication, are highlighted and will remain in the HSTP as key components of the HEP to help achieve increased demand of health services and community empowerment for the sustainability of health outcomes. In addition, the HSTP gives emphasis for health literacy and health system literacy in order to enhance the skills and knowledge of individuals and communities to take control over their own health, as well as the skill and knowledge of health care providers and health communication professionals to provide quality health services and information.

Specific health program strategies prepared by FMOH in collaboration with partners, such as the list of examples in Table 1 below, have provided due emphasis on health promotion, health education and communication as a means to achieve health program targets.

Therefore, the NHPCS is aligned with the HSTP specific program priorities and reassessed strategies in order to contribute to the achievement of program objectives and to harmonization of efforts. Table 1 Examples of health program strategies that emphasize the use of SBCC.

Strategies	Emphasis on Health Promotion and Communicaton
National Health Communication Strategy (2005-2014)	Strategic Direction
National Plan For Malaria Prevention and Control	IEC and community mobilization
Public Health Emergency Management Guideline 2012	Heath education and communication to increase community participation
National Measles Surveillance and Outbreak Management Guideline (2012)	Communication outbreak findings to health professionals, communities and individuals
National Guideline For Family Planning Services (2011)	Advocacy, social mobilization and communication, segmenting its primary audiences
Child Survival Policy Strategy (2005)	Emphasis on promotion of antenatal care through community information and Newborn temperature management, to educate community, families on HIV/PMTCT, promote exclusive breastfeeding, Epi plus, use of bed nets, etc.
Health Extension Program Manual	Health extension packages, community mobilization approaches and IEC/BCC

2.2.3 *Institutional Arrangement for Coordination at National and Regional Levels*

In a bid to better coordinate, guide, and sustain the effectiveness of health promotion and health communication, as well as ensure that health programs receive support, the FMOH and RHBs used different structural arrangements and staffing patterns. The Health Extension and Education Center (HEEC) served as center for training in health education and communication and played a significant role in designing, producing, and disseminating health education materials. Currently, the Health Extension and Primary Health Services (HEPHS) Directorate is mandated to coordinate the HEP including primary health services, Hygiene and Environmental Health and the Health Education and Promotion activities.

The directorate established National Health Education and Communication Technical Working Group (NHEC-TWG) to provide advisory role for the Ministry and coordinate with partners in the planning and implementation of health promotion and health communication. This is to ensure harmonization, alignment, and capacity building for sustained health promotion in the country.

The Health Education and Promotion Case Team, organized under the HEPHS Directorate, is bestowed with, among other things, the coordination of the planning, implementation, monitoring, and evaluation of the National Health Promotion and Communication Strategy with the NHEC-TWG. The Health Education and Promotion Case Team has vertical and horizontal relationships with all relevant Health Directorates.

[33] FMOH. HSDP IV

[34] FDRE, Prevention and Control of Chronic Non-Communicable Diseases Strategic Framework, 2014

2.2.4 The Health System Network

The health system has a three-tier system that involves a primary health care unit (PHCU) comprised of five health posts and one health center. This level is linked to community through the HEWs/HDA. General hospitals at secondary level provide secondary level of care and specialized hospitals at tertiary level provide tertiary level of care. In the tier system, there are 16,447 health posts, 3,586 health centers, 311 hospitals both public and private.[36] It is estimated that more than 7000 private health facilities function currently across the nation.[37] The facilities provide immense opportunities to serve as source of health information and education reaching millions of people with awareness raising and behavior change communication interventions.

2.3 Health Promotion and Communication SWOT Analysis

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

Strengths:

- Supportive policy environment with strong leadership and commitment for integration of health communication and opportunities to make use of resources
- A functional HEC-TWG (Health Education and Communication Technical Working Group) that serves as a platform to coordinate and foster partnership as well as harmonize and align health promotion and communication interventions
- Strong commitment and leadership in engaging and encouraging communities to participate in the health promotion and diseases prevention at household level
- 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 enable the attainment of the nationally and globally set targets to promote health, to reduce morbidity and mortality
- Existence of Health Education and Promotion Officer at different levels
- Well established and sustained health extension program with skilled workers to reach, educate, mobilize, and provide health services in all villages and households across the nation
- Increased dissemination of health information on a continuous basis to enhance awareness of the public
- Increased trend in documentation and dissemination of best practices in health promotion and diseases prevention
- Increased trend in using ICT and the Internet for information sharing

[36] FMOH, HSDP IV and HSTP
[37] FMOH, Health and Health related indicator, 2015

Weaknesses:

- Inadequate number of health education experts and structure at each level
- Limited understanding of the need and importance for specific planning of health promotion and communication by different stakeholders at each level
- Inadequate strategic guidance and follow up of health promotion and communication interventions
- Fragmented initiatives in health messaging that are often inconsistent in terms of contents, resulting in duplication of efforts and wastage of resources
- Insufficient use of evidence-based and formative assessments in the development and production of IEC/SBCC materials
- Insufficient national/regional guidelines on health communications (Interpersonal Communication and Counseling, advocacy, community empowerment)
- Limited initiatives to mainstream curricula of health promotion/education courses in medical degree programs to produce health professionals with a very strong background in health education and promotion
- Insufficient experts in behavior change communication and failure to place them at appropriate positions
- Absence of staff and structure at zonal and woreda level for the management of health promotion and communication interventions
- Poor empowerment of communities to take health promotion and disease prevention in to their hand
- Poor knowledge and skill of HEWs, HDAs and primary health care staffs on health promotion and communication
- Inadequate implementation, identification, sensitization and advocacy of existing public health laws and legal frameworks
- Inadequate preparedness to respond to health threats of international concern
- Inadequate integration of climate and health interventions
- Low engagement of media in health promotion and diseases prevention interventions
- Inadequate availability of harmonized and community-focused guidelines
- Lack of health education and communication skills of health professionals and health care providers
- Limited activities in identifying, documenting, and sharing societal values and practices for health
- Limited adaptation and use of technologies for health promotion and communication
- Inadequate resources allocation for health promotion and communication interventions
- Lack of harmonization and alignment of health communication and promotion interventions with law enforcement measures (tobacco control, environmental sanitation, food safety, and standardization of salt and sugar contents)

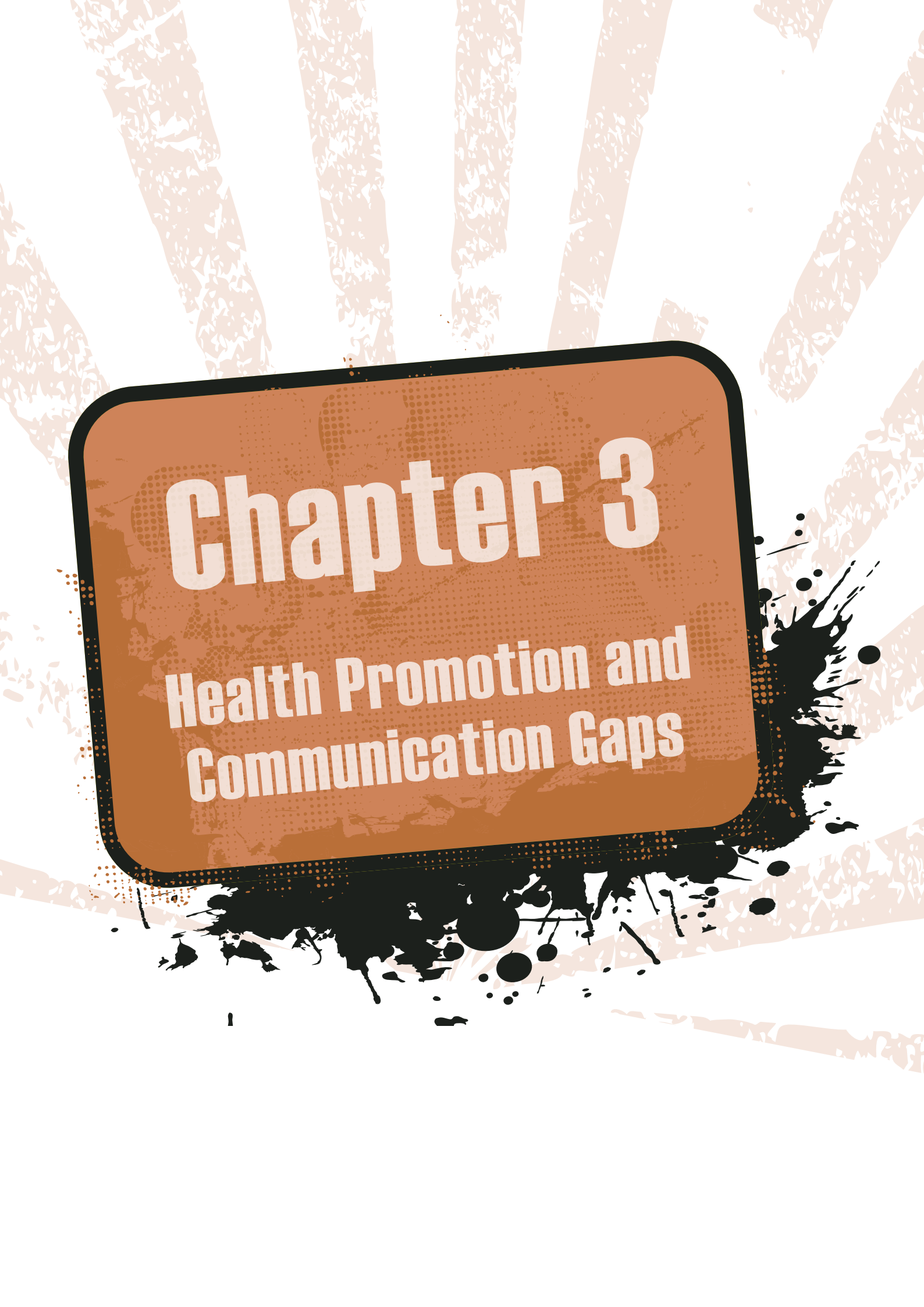
- Inadequate emergency communication practice and system to address public health emergencies
- Inadequate monitoring and evaluation mechanisms in place to follow up and assess the effectiveness of health communications and their impacts

Opportunities:

- Increasing opportunities for public-private partnerships to promote healthy lifestyles
- Increasing number of community radio/ TV outlets and print media with capacity to accommodate multiple languages with a positive sense of social responsibility
- Increasing intersectoral collaboration and availability of grass root level structures (HEWs, HDAs, etc.)
- Increasing community participation in health activities and organized health infrastructures that are capable in managing public health interventions
- Steady increase in forming partnership, sharing, and use of expertise and resources with partners
- Growing ICT infrastructures, including the mobile and electronic media that have improved capacity to reach wider audiences
- Urbanization and/or industrialization
- Expansion of educational institutions (e.g. schools and universities) and increment in literacy rate

Threats:

- Inadequate multi-sectoral collaboration
- Emerging public health problems such as high road traffic accidents, noise pollution, water and sanitation, NCDs.
- Limited access to TV media constrained by unaffordable price for broadcasting fees.
- Low level of adult literacy rate.
- Emergency situations such as outbreaks and natural disasters that may distract regular health development activities.
- Epidemiologic shift in disease etiology
- Climate changes and its effect on health
- Urbanization and/or industrialization
- Audience diversity while using mass media
- Behavioral change needs long time (KAP-Gap)


Chapter 3
Health Promotion and Communication Gaps

Chapter 3: Health Promotion and Communication Gaps

Stocktaking of health communication interventions to find out what has best worked and what has not (gaps) is necessary for a thorough understanding of health education and communication gaps in order to inform and develop an effective, impactful health communication strategy.

The health education and communication can be assessed in line with HSTP initiatives under the community participation and ownership pillar that emphasizes enhanced evidence based health education and communication initiative.

The three methods used to make critical analysis and identify gaps include:

- Analysis of FMOH's series of HSDP performance reports,
- Analysis of the socio-ecological model to assess components that health communication interventions have failed to address,
- Results of consultative assessment done with experts in the Ministry.

3.1. Analysis of Health Promotion and Communication Gaps Based on the HSDP Implementation

In all the series of HSDPs including the HSTP for the period 2015/16 -2019/20, health education and health promotion are clearly featured as an integral part in the health sector program planning and implementation.

With the advent of the HEP introduced towards the end of HSDP II that increasingly expanded in the subsequent periods deployed more than 38,000 HEWs and expansion of health posts, the health education and health promotion activities took advantage the existence of the HEP to increase awareness, knowledge, behavior change, community mobilization and participation. The HEWs have become instrumental for the remarkable achievements made in the key health programs.

The HSDP III main report on IEC has acknowledged the intensity of the design, production and dissemination of promotional materials including mass media messages. The role of HEP in serving as a vehicle to reach households with community conversation and house to house education is also cited as encouraging contribution.

The National Communication Strategy which was developed for 2007-2014 before the full conceptualization of the HEP, however, is indicated that it did not embrace HEP fully and thus a clear disconnect to integrate IEC/BCC with the HEP, improve capacity of HEW skills and missed opportunities for budget allocation observed.

In addition, IEC/BCC activities have focused much more on dissemination of information, increase of knowledge and behavior change and did not identify upstream factors responsible for hampering behavior change under certain conditions or among certain groups. Poor linkages between federal, regional and woreda offices for the purpose of a coordinated response affected the

quality of the interventions in terms of standardization, harmonization and alignment.

Little attention had been given to build federal and regional capacity to provide and support technical assistance for the development of region-focused, culturally sensitive to the specific needs of the local communities. Due to limited resources, impact assessment of the IEC/BCC activities has not been made possible.

From the analysis of the strategic objectives indicated in the "heath sector map" named in periods preceding to the HSDP IV and the components of the "pathway to improved health status" in the HSTP, increased access to health services and community enhancement has not been well exploited to align and make health communication activities focused and strategic.

Understanding of the pathways provide clues to identify particular areas to design effective health communication interventions and remain focused on demand creation of health services, supporting HEWs, HDAs and health professionals at health center level, and providing participatory skills to strengthen community empowerment.

3.2 Determinants of Health

Sustained national economic development, improving road and communication infrastructures, improved literacy rate, particularly female education, industrialization (increase in local production of drugs and equipment, local manufacturers of food, etc.), and urbanization among others, are recognized as opportunities in the analysis of the national context used for the planning process of the HSDP V.

Evidence shows that improvements in health status of population follow with progress in socioeconomic developments, which in turn contribute to empowering citizens to sustain gains. This implies that health is much more than mitigating illnesses as it is frequently referred to.

The WHO defined health as "...a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity". In 1986, this definition was expanded to better define health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. The fundamental prerequisites for health or social well-being include housing (shelter), education, food, and income to mention few.

The health of individuals and communities are greatly influenced by many determinants (Figure 1). Many factors including biological, social, cultural, economic, and environmental factors influence the status of health. The reality is that health cannot be achieved by individuals adopting desired behaviors and practices alone. Their ability to pursue good health is limited by varying degrees of knowledge, information, behavior, community support, economic means, and access to services. It is of utmost importance to understand how these determinants of health interact to design effective health communication strategies.

For example, access to roads and transportation services for hard to reach areas with no access to health facilities can determine survival of mothers in need of skilled birth attendants. Unless this issue is solved by responsible sector offices, the promotion of giving birth at a health facility alone does not help ensure healthy practices at birth and reduction of maternal morbidity and mortality.

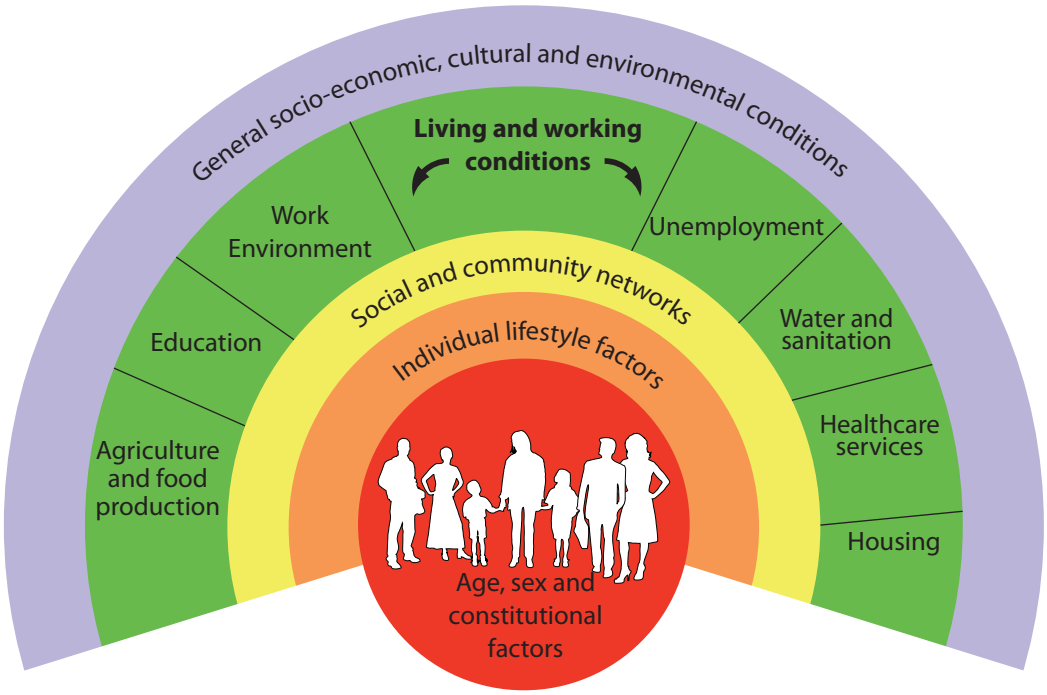


Figure 1: Determinants of health – Socio- Ecological Model
Source: Dahlgren & Whitehead, 1991

Social, Economic and Environmental Factors

A range of health issues have come about as a result of social, economic, and environmental factors on individuals and communities coupled with issues of equity on the physical, mental, and social wellbeing of significant size of the population. In spite of impressive socioeconomic developments (job opportunities, increasing health services, education, housing, water and sanitation, road and telecommunication infrastructural development, etc.), poverty, unemployment and inadequate income, high illiteracy level, inadequate access to health services, poor housing and water quality, gender inequality, religion, and other social factors affect the health of the Ethiopian population.

Economic Factors

Generally, insufficient income and household resources preclude people from having basic necessities of life. This situation excludes and marginalizes people from participating in activities and accessing health services. Furthermore, poverty also drives people to engage in risky health behaviors that adversely affect their health. On the other hand, with growing income and consequent lifestyle changes such as unhealthy diet, physical inactivity, and alcohol consumption, NCDs increase in major cities. In addition to this, urbanization in most parts of the country has been drastically increasing the tendency to use factory processed foods and beverages. Inadequate

labeling of the products with health information is leading the population to use those products without appropriate knowledge.

Education

Education plays a significant role in acquiring the analytical skills needed to deal with different encounters in life. Research shows that there is a big gap between those who have education and those who have little or no education in seeking of healthcare and similar divides along the lines of earning power.

Low level of education coverage is a barrier to health communication since it limits access to health information and health services that can improve their health literacy and health system literacy. It is estimated that 52% of the adult population in Ethiopia has difficulties with reading and writing (Mini EDHS 2014). Health literacy affects people's ability to search for and use health information, adopt healthy behaviors, and act on important public health alerts. Limited health literacy is also associated with poor health outcomes and higher costs.

Access to health services

In spite of the remarkable expansion of health services, access and utilization of these services are widely hampered as a result of poor knowledge, cultural and gender influence, and geographic inaccessibility. Whilst developing regional states that require special support are mainly affected because of population movement and geographic barriers, pockets of populations in other regions also remain disadvantaged that require special intervention.

Environmental Factors

As natural as it is expected from economic and development progresses, industrial by-products such as environmental pollution, road traffic accidents, the availability of recreation centers, transport facilities, water supply and sanitation, natural or man-made disasters are causing significant impact on health.

Road traffic accidents are increasingly observed with inappropriate behavior of drivers and pedestrians. Adopting innovative approaches to advocate for the implementation of national regulation framework for road safety rules is crucial for behavior change.

The 2014 ratification of the Framework Convention on Tobacco Control by the house of people's representatives is to reduce demand and supply of tobacco use as well as to help protect people from the harmful effects of second hand smoking. Regulations to prohibit and restrict smoking in public and work places needs to be promoted and get attention by the decision/ law makers and judiciaries.

3.3 Health Communication Gaps

Based on desktop review of health promotion and behavior change models, socio-ecological model (Please see Figure 1) was adopted. Based on this model, an assessment tool was designed focusing on factors that affect behavior change across all programs. Based on the analysis of the socio-ecological model and rapid assessment conducted at FMOH level, basic health promotion and communication gaps have been identified at individual, community, socioeconomic, and environment levels.

3.3.1 Gaps at the Individual Level

1. Gaps in knowledge, attitude and behavior change

Results of existing surveys and national level studies show some improvements on major factors affecting behavior change and demand for health services, including progress made on status of key health behaviors and health service utilization (DHS 2011, miniDHS2014, EPI survey 2012, etc.). Considering the general literacy status especially, in rural areas, poor access to health information leads to low level of health literacy that adversely affects the health of the population. This indicates that there are still significant gaps in knowledge, attitude, and healthy practices (KAP) in most health programs that continue to impact progress towards meeting national targets. (See Annex 1)

Understanding KAP benchmarks used in specific programs and in various studies is of utmost importance to determine targets of health communication and design effective strategies using effective channels of communication and messages.

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 strategies. There is also a need to reduce myths and misconceptions around competent health practices and create an enabling environment.

3.3.2 Gaps at the Community Level

2. Gaps in interactions among PHCU and communities

Observations on the HEP show that increased effectiveness in the delivery of services and achievement of targets can be best achieved with increased levels of support, commitment, leadership, and stronger linkages among community leaders. The cooperation of local leadership in community mobilization forms a strong foundation for the successful implementation of HEPs.

The HDA is one of the platforms established to enhance full participation of communities to help to take practical actions of new healthy behaviors and practices to improve the health of individuals, families, and communities. Ongoing capacity strengthening of the HDA members to improve their knowledge and communication skills to promote, mobilize, and encourage adoption of healthy practices needs closer attention. There is also a need to build capacity of the HC staff on HEP packages in order to facilitate coordination and networking of the health facilities. Even though there are maturity differences in terms of implementing HEP among regions, administrative reports show that there are no adequate functional systems of interaction among PHCUs and households. The level of commitment, support, leadership, and engagement needs to be strengthened continuously.

3. Gaps in Enhancing Community Empowerment and Ownership

Community-based development programs such as the rural HEP have resulted in increased community capacity. To expedite the implementation of the HEP packages, the HDAs initiative was introduced. It is therefore critical to build the capacities of HEWs, HDA members, and health center staff to communicate, influence, and engage the community to control factors and improve health. In addition, continuous assessment of health promotion interventions among communities needs to be undertaken to identify gaps and take corrective response. Moreover, health literacy and health system literacy are not well addressed in the health extension package to create demanding community that results improved quality of care. While various community-level approaches have enhanced community participation in socioeconomic development, more has to be done to improve the capacity of community leaders and other influential members (clan leaders, traditional birth attendants, religious leaders, traditional healers, etc.) and empower the community to take decisions affecting their own health. Community leaders also must be informed of the interplay of factors affecting the communities' health and new approaches in mobilizing community members.

4. Gaps in enhancing health extension workers' capacity in interpersonal communication and community empowerment skills

The role of HEWs in driving the success of programs largely depends on their capacity to mobilize the community and their interpersonal communication skills to inform families to adopt new behaviors, as well as motivate community members to produce their own health through performing healthy actions.

Intervention is needed to improve HEWs' interpersonal communication and facilitation skills in order to lead family level conversations and various other community dialogues (pregnant mother conference, community conversations, community-based nutrition programs, etc.). In addition, the integration of communication and facilitation skills in the different guidelines produced at program level is critical to address these gaps related to interpersonal communication skills.

5. Lack of harmonized messages and community-focused guidelines

Although HEP guidelines have been made available nationwide, more efforts have to be made to raise knowledge and encourage adoption of high impact

behaviors such as hand washing, prevention of communicable infections and risk factors for NCDs, as well as promotion of mental health and road safety among others.

Harmonization and development of messages and guidelines is important to improve the quality of message and materials targeting the different segments of the audience and maintain message production standards.

6. Gaps in creating friendly, and welcoming health facility environment

One of the HSTP transformational agenda is creating caring respectful and compassionate health professions. A lot has to be done to make health facilities client-centered through the enhancement of health professionals' communication skills and approaches to motivate clients. Friendly health facilities will not only increase demand for health services but encourage information sharing mechanisms and continuously improve quality of services. There is a gap in client-professional interaction at the health facility level. Standard guidelines focusing on interpersonal communication for health professionals achievable by health facilities are indispensable and need to be widely available.

3.3.3 Gaps at Socio-economic and Environmental Levels

7. Gaps in identifying, documenting, and sharing societal values and best practices for health

There are societal values, best practices and experiences among Ethiopian communities such as values related to HIV testing in Guraghe society, prevention of Female Genital Mutilation in different parts of the country and others that need to be documented and shared. However, some of these values, practices and experiences such as Dagu practiced in the Afar Community, and cultural gatherings (Coffee Ceremony, Edir, Ekub, Mahebre) are not documented and shared among policy makers and practitioners for health communication interventions.

8. Gaps in promoting healthy work and environment places

With the rapid economic advancement of the country and mega projects providing job opportunities for thousands of young people, there are also growing health risks associated with unsafe handling of machineries, exposure to hazardous chemicals, and environmental pollution. In light of this, it is important to mainstream health promotion in business environments and advocate for updated/improved investment policies to ensure workers' safety and access to health information and healthcare services.

9. Gaps in greater mass media involvement and use of technologies

Although mass media has been instrumental in health communication, its use can be strengthened through innovative approaches that keep the general public and targeted audiences well informed about health issues. Despite the contribution by the mass media in keeping the general public at large informed on health information, it lacks the capacity to develop evidence-based high impact programs. Health education and communication is multidimensional, requiring the use of different channels and technologies like mobile health, satellite-based services, social media, etc., that can create synergetic effect to improve behaviors of the community towards to health.

10. Gaps in multi-sectoral involvement in health promotion in addressing social determinants of health and factors that discourage demand for health services

Beyond acknowledging the importance of multi-sectoral involvement in health promotion, little has been done with health education and communication interventions to get different sectors engaged. Much of the focus has been on increasing awareness and behavior change. However, there is now a growing consensus that improved health status cannot be achieved only by the health sector but with the involvement of other sector offices and other stakeholders. For example, health concerns that arise out of road safety issues, tobacco smoking, alcohol and substance abuse, inaccessibility of health services, nutrition, hygiene and sanitation, etc., can only be overcome through the coordinated efforts of different sectors. Therefore, health education and communication needs to promote and advocate the involvement of the different sectors in health.

11. Gaps in identification, sensitization and advocacy for implementation of existing public health laws and legal frameworks

In order to bring about sustainable health outcomes, existing public health laws must be effectively enforced. Since health can be affected by external factors as well, individual behavior change alone cannot lead to improved health status unless supported by law enforcements. There are numerous national public health legal frameworks as well as International Health Regulations, such as 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.

In addition, inappropriate labeling of food products by various factories and distribution to the communities have become barriers to understanding the contents of the products and their composition. Much is needed to inform the public and advocate law enforcement for such kind of problems.

12. Gaps in preparedness to respond to health threats of international concern

There is inadequate preparedness capacity to effectively respond to disease outbreaks of international concern. The risks and threats posed by diseases such as cholera, yellow fever, meningitis, avian flu, Middle East Respiratory Syndrome (MERS), Ebola, etc., are immense. Given the role that the health communication plays in mitigating the risks and consequences of such disease outbreaks, the level of preparedness in terms of putting a strategy to quickly alert the public needs attention in order to build local capacity in terms of guidelines, training and readiness.

13. Gaps in Climate and Health

Local and international experiences inform the need to develop a climate resilient health system. Climate change affects the dynamics of disease transmissions. The location, intensity, and frequency of occurrence of vector borne diseases such as malaria, Leishmaniasis, dengue fever, and yellow fever have increased in different parts of the country as a result of increased temperature, weather and climate variations. Their consequent impacts on productivity of crops and livestock, as well as water and sanitation have serious direct or indirect influences on the health status of the population.

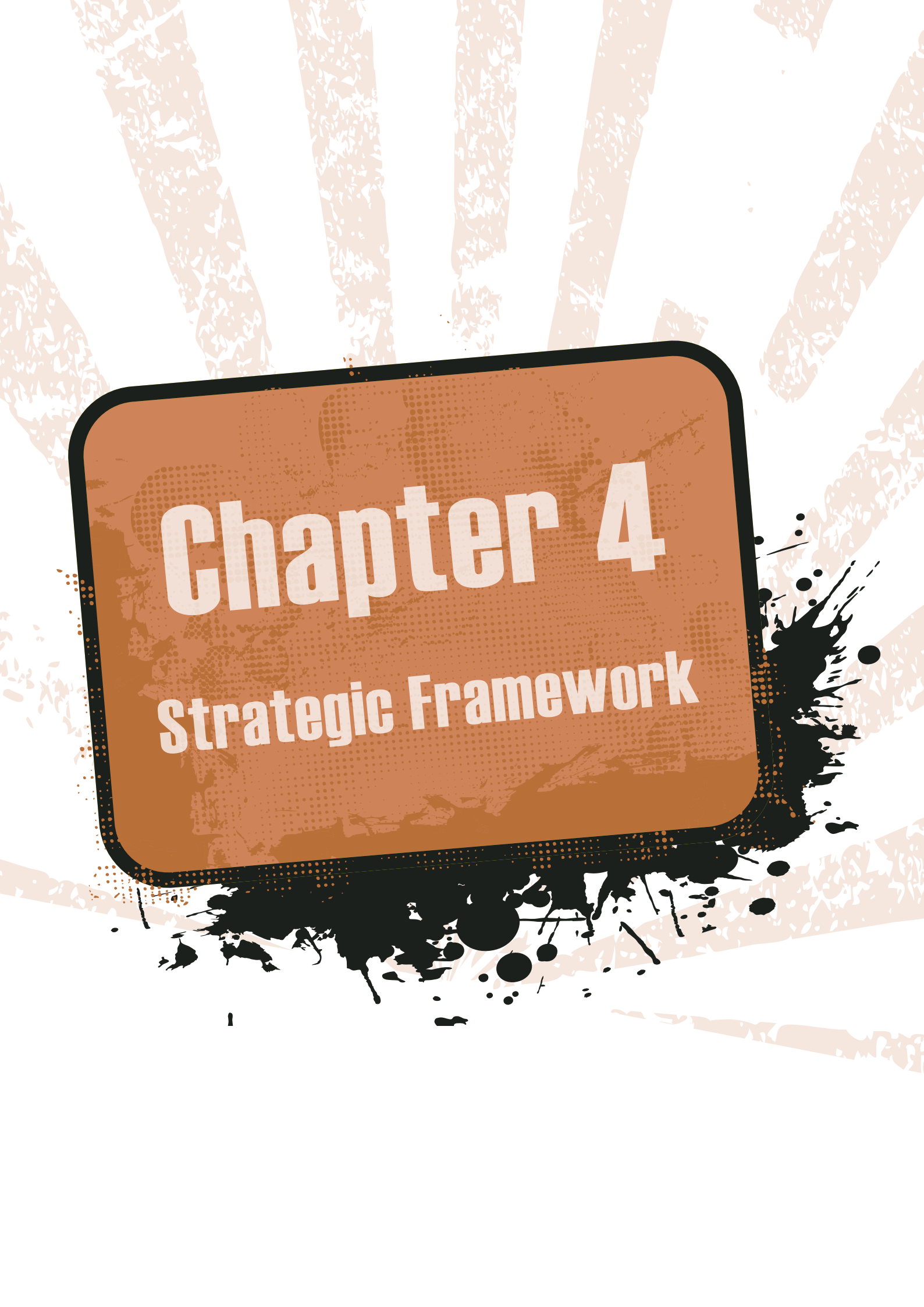
Ethiopia's Climate-Resilient Green Economy Strategy (CRGE) is an indication of the Government's commitment to protect the country from the adverse effects of climate change and build a green economy. Health sector is one of the six sectors identified under climate adaptation and therefore serves as good opportunity for health communication interventions to align and harmonize with the initiative. Health communication can empower vulnerable societies with knowledge and skills concerning climate change and health, and can support capacity strengthening for climate resilient preparedness and other approaches to improve the health status of local populations.

14. Gaps in Sustaining Health Communication

Health improvements of the country would not be possible without the improved awareness and behavior change among the people as a result of information, communication, social mobilization, and advocacy work. Immense progress has been observed by the Ministry of Health, RHBs, civil societies, community-based organizations, partners, and the media.

Yet, the capacity to lead, coordinate, harmonize, develop, and guide implementation, as well as monitor and evaluate health communication at all levels (FMOH, RHBs, Districts, Community) need to be enhanced. There is currently no health education and promotion structure at regional, zonal, and Woreda levels. Producing highly qualified professionals in health promotion and health education requires collaborations with universities and colleges.

Despite regular review meetings, supportive supervision, and reporting systems that are in place at all levels of the health system, gaps are still observed in the generation of data for decision-making purposes related to SBCC interventions. Indicators and monitoring systems for data around SBCC interventions need to be developed and continuously tracked for stronger communication program impact.


Chapter 4
Strategic Framework

Chapter 4: Strategic Framework

4.1 Conceptual Framework for National Health Promotion and Communication Pathway

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

The purpose of the health communication pathway is to simplify the understanding of the general context and the interplay of determinants impacting health. The context analysis helps to identify opportunities and challenges related to specific health issues and devise effective interventions for each of the domain of communication: at individual/families, community, health facilities, and at societal levels. The framework further illustrates how expected outcomes corresponding to each domain of communication contribute to health status improvement when the right mix of audiences, channels of communication, and messages are applied. Moreover, the pathway clearly delineates areas for designing behavior change communication, social mobilization, and advocacy strategies with envisaged outcomes at initial stages of strategy implementation and in the long run.

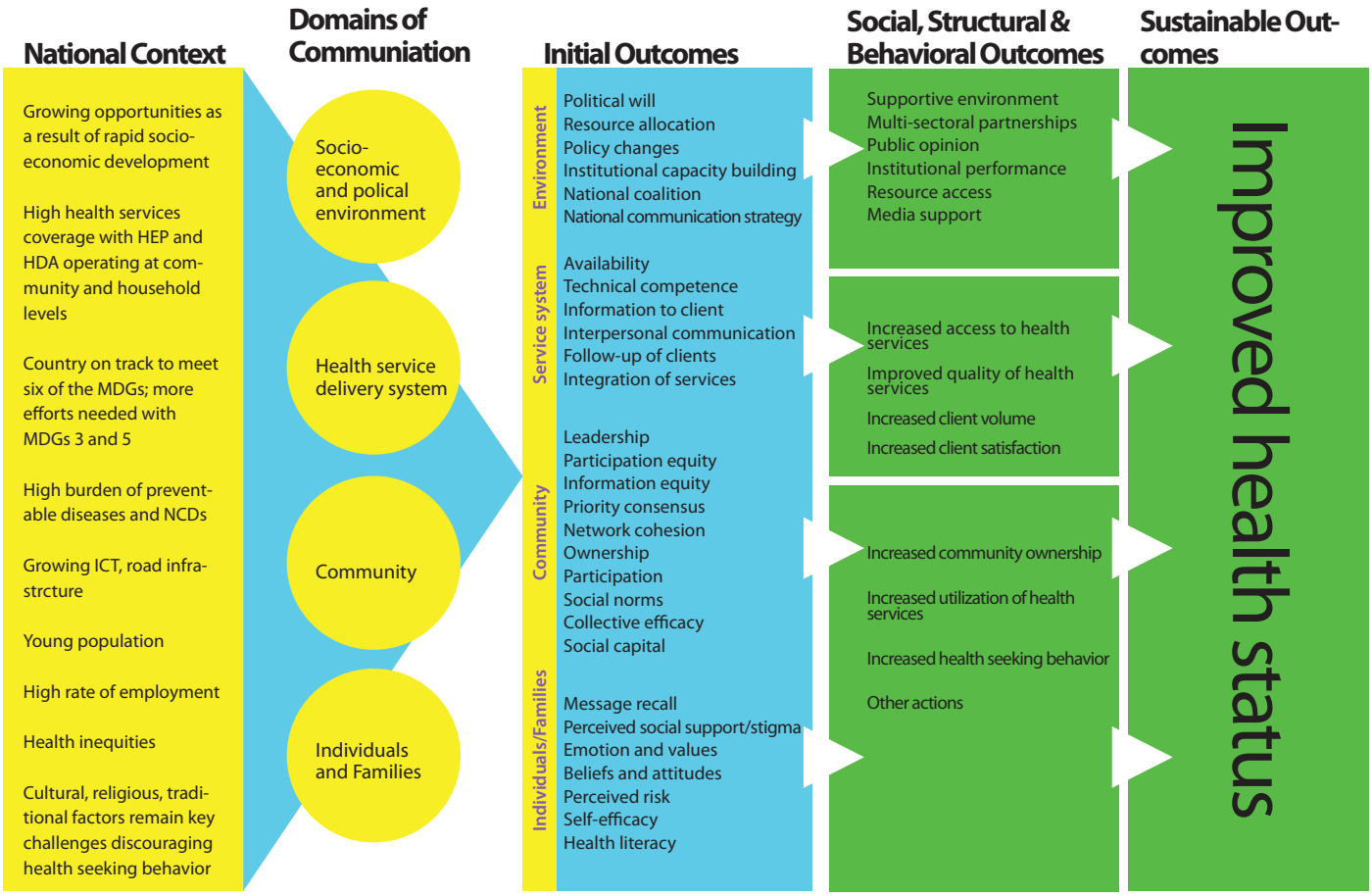


Figure 2: Conceptual Framework for National Health Promotion and Communication Pathway

4.2 Principles of the National Health Promotion and Communication Strategy

This strategy will be guided by the following principles.

Ownership: It is vital to align health education and communication interventions with national and regional priorities. Gains achieved through health education and communications need to be sustained through community engagement including but not limited to, generating local resources. Therefore, it is indispensable to promote ownership of health education and communication interventions at all levels. Clear accountability is also important for effective and efficient implementation of the strategy.

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 communication 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 communication 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 education and communication 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 education and communication demand active engagement of various sectors. Therefore, it is crucial to make sure that effective integration is in place.

Evidence-Based: Health education and communication interventions and strategies must be based on research and lessons learned under previous and ongoing programs. It is essential to work with higher education institutions and research centers in conducting health communication related studies and thereby inform on the impact and progresses made in health communication efforts. It is mandatory to make necessary changes in health communication strategies and interventions based on evidence generated through different studies.

Multiple means of communication: Health education and communication interventions should effectively make use of a mix of reinforcing and complementary media channels, communication tools, and approaches to develop holistic and positive behavioral and social change.

Cost effectiveness: Health education and communication interventions must be cognizant of the ratio and amount of resources spent on the intervention in light of the impact achieved.

4.3 Strategic Framework Goal and Objectives

Goal:

The goal of the strategy is to guide and harmonize health communication interventions and drive improvements in implementation to increase knowledge, realize positive behavior change and, healthy practices, increase demand of health services, and facilitate a supportive, enabling environment for sustained health outcomes, and ultimately improved health status of the population.

Objectives:

1. Guide and harmonize health education and communication interventions
2. Improve knowledge, attitudes, and practices including addressing barriers for behavior change and community empowerment
3. Enhance community empowerment through capacity building of frontline workers/HEW, HDA/ and community leaders by promoting the use of standardized community guidelines and manuals
4. Promote and advocate for multi-sectoral involvement in addressing social determinants that affect health and for mainstream health promotion in sectors including influencing policy and legal support. Advocate for supportive enabling environments
5. Enhance effective engagement and wide use of public, institutional, social, and community media and other new technologies for health communication programming in order to strengthen audience specific and need-based SBCC programs.
6. Ensure effective implementation of the strategy through continuous monitoring, evaluation, and dissemination of best practices at different levels.

4.4 Strategies at Individual, Community, Health Service Delivery, and Sociocultural, Economic & Environmental Levels

The following broad strategies presented at the individual, community, and macro levels aim to address health issues and socioeconomic determinants of health identified for each health program. It is therefore essential to make use of the Annex 1 to understand specific health issues and to update strategies depending on the specific cultural dynamic or local situation, carry out audience analysis or segmentation, set communication objectives, and make use of the right mix of communication channels ranging from the traditional media to ICT and social media.

4.4.1 Individual Level Strategies

1. Develop/standardize health education and promotion messages

- Analyze existing studies and/or conduct new studies on knowledge, attitude, practices, and behaviors of specific health programs including barriers to health service utilization
- Determine audience groups, perform analysis of problem behaviors, set objectives, identify effective mix of communication channels, and develop culturally sensitive messages

- 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. Involve the use of different print and broadcast media, games, mobile, IPC or other traditional ways of communication (For example, "Dagu" communication system in Afar Region)

2. Develop guidelines and manuals for behavior change communication (BCC), social mobilization and advocacy

- Review, update and standardize training manuals and guides
- Conduct Training of Trainers (ToTs)
- Coach and monitor utilization and implementation of BCC, social mobilization and advocacy activities

4.4.2 Community Level Strategies

3. Form/strengthen the existing community networking/organizations to be inclusive and collaborative for health and health system literacy interventions

- Use available, existing organized platforms
- Increase community capacity through skills training and participatory approaches including dialogues
- Ensure inclusiveness by gender, age, occupational status, etc.
- Build on the existing community system to enhance collaboration

4. Strengthen interaction among PHCUs and Communities

- Ensure different community representatives such as women and youth are members of health facility community management or board
- Conduct regular meetings whereby representatives of community members, leaders, and HEWs hold dialogues and work to improve health and health system literacy level of the community by introducing the primary health care service standards.
- Instill sense of ownership through strengthening local capacity and coordination systems (i.e., capacity of kebele command posts, kebele administrations, HEWS and HDAs) to improve active engagement

5. Provide opportunities for communities to shape and influence the development and delivery of quality services and policies that reflect local needs and priorities

- Strengthen capacity of local actors including HEWs in identification of local health needs
- Advocate with policy and decision makers as well as law enforcement bodies at all levels to set policies and priorities that are consistent with community needs
- Promote engagement and equal opportunities for family and community decision makers through community dialogue

6. Enhance communication and facilitation skills and knowledge of HEWs and HDAs

- Update HEWs with current information about different health issues using different channels
- Include different health communication approaches and techniques in Integrated Refresher Training (IRT) and other guidelines developed to train HEWs
- Support HEWs through appropriate community friendly communication tools and materials such as community conversation tools and facilitators' guides, speaking books (that serve illiterates as well), flipcharts, brochures, and leaflets that can be used in groups and handed out to individual clients
- Enhance the capacity of religious, clan, and community leaders to deliver health promotional messages and advice on adopting safe practices and behaviors to stay healthy

4.4.3 Health Service Delivery Strategies

7. Create friendly and inviting health facility environment through improved relationships between health service providers and their clients through CRC

- Enhance the capacity of health service providers in interpersonal communication and counseling skills
- Provide opportunities for model health service providers to share experiences and best practices
- Support health service providers with appropriate and standardized communication materials and job aids
- Recognize health service providers who have demonstrated exceptional performance and design incentivize mechanisms

8. Strengthen health facility-based education

- Plan and implement health education at health facilities
- Equip health facilities with print and audio-visual communication materials
- Strengthen linkages between health facilities and communities on health system literacy
- Enhance client provider counseling

4.4.4 Socio-cultural, Economic and Environment Level Strategies

9. Document societal values and practices that impact health

- Document and scale up positive traditional practices and values as necessary
- Explore context-specific traditional attitudes and practices that may impair health
- Seek participatory, local and culturally appropriate ways to address traditional attitudes and practices that impair health
- Enhances social norm changes such as Open Defecation Free, Home Delivery Free, et

10. Promote healthy workplaces and environment

- Identify and document workplace and environment health risks (such as tobacco, physical inactivity, unhealthy diet, road traffic accidents, machinery and chemical accidents, sexual violence, environmental pollutions, etc.) in coordination with relevant stakeholders
- Develop health communication guide and toolkit for promotion of healthy workplaces and safer environments
- Build capacity of health communication and promotion officers in health and other sectors to address workplace and environmental health and safety issues

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

- Build partnership with mass media to put in place a forum to better coordinate support for health communication interventions and initiatives
- Enhance the capacity of media personnel via updated health information, guidance materials and orientations/trainings to increase their understanding of priority health issues and approaches in order to strengthen advocacy and public awareness raising activities
- Advocate for institutionalizing a special platform and information sharing mechanism to rapidly respond to health threats and outbreak diseases to minimize consequent risks to the public
- Explore and adopt the current and upcoming technologies which are appropriate for the implementation of health education and communication interventions.
- Support the scaling up of hotline telephone counseling services in to different health services and train counselors on interpersonal communication skills.
- Deploy community diary based radio programming within the FMOH

12. Advocate for mainstreaming of health and multi-sector response to social determinants of health

- Conduct and document analysis of relevant policies, their impact on health and identify health issues that are rooted in different policies
- Identify issues and factors that affect demand for health services requiring a multi- sectoral response
- Build partnership and networks of stakeholders related to identified health issues and appropriate development of multi-sectoral response(s)
- Assess existing sector resources and capacities to strengthen setting based health promotion and expand health message delivery channels to reach employees, students, families and communities
- Strengthen school health promotion through setting of guidelines and standards to make school environment free of substance abuse and conducive to the initiation of health communication projects, as well as to build internal capacity for health promotion
- Plan, coordinate and support observance of special annual days to raise awareness and advocate on specific health issues

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

- Assess the status of implementation and constraints impeding full implementation of IHR, FCTC, national laws such as Environmental Health laws, Road safety laws, Family Health Laws, Food Product Labeling, etc.
- In coordination with relevant partners and stakeholders, 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
- Advocate for ownership and establishment of coordinating mechanisms, and set standards to provide guidance for their implementation with capacity building training and promotional materials

14. Support sensitization and communication activities of climate and health

- In consultation with the relevant team and with relevant stakeholders, work jointly on issues identified and plan climate resilience communication and promotion activities
- Develop promotional materials
- Promote the implementation of the national health adaptation plan
- Organize sensitization and advocacy meetings involving mass media

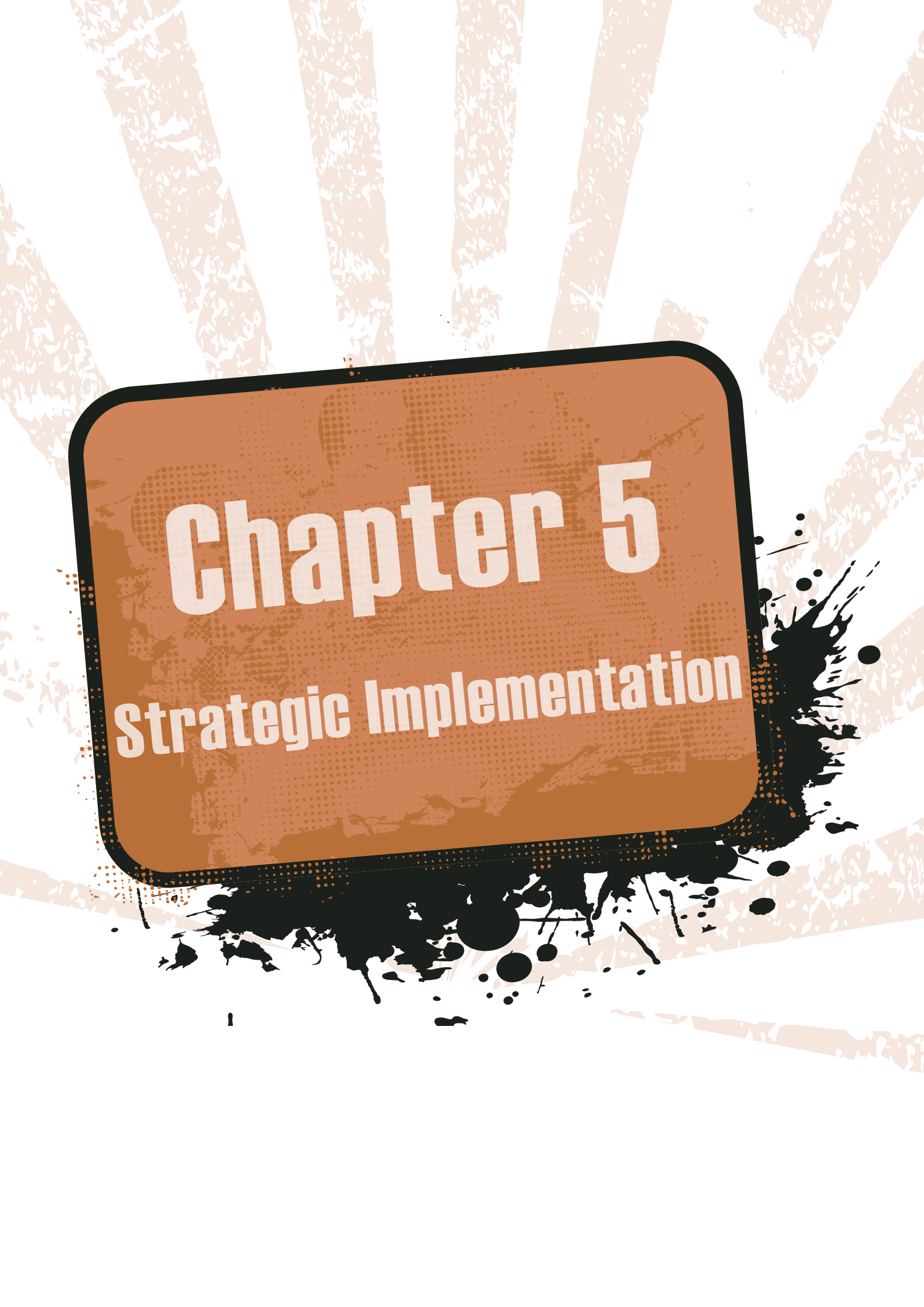
15. Strengthen capacity of emergency health communication preparedness, response and resilience

Given the emergence and reemergence of borderless diseases and health threats of international concern, their risks and consequent human loss, national and regional capacity building with emergency health communication preparedness and response continues to save time and energy. It also helps to avoid confusion and weak coordination in times of unpredictable events.

- Develop emergency preparedness and response communication guidelines and training manuals
- Develop messages on emergencies which can be disseminated through different communication outlets
- In consultation with EPHI, assess preparedness and response to ensure that rapid and transparent information related to diseases outbreaks are communicated to the public
- In collaboration with EPHI build capacity of experts at all levels with preparedness and response of risk communication

16. Enhance national and regional capacity to deliver health communication work in the country

- Establish and strengthen the health communication structure from Federal to Woreda level
- Assess current capacity in designing, planning, implementing, monitoring and evaluating health communication and health promotion
- Train, monitor and support actors in the health sector who are strategically positioned to design, implement, monitor and evaluate health communication
- Work with higher learning institutions with the aim of producing adequate health professionals in health promotion
- Set standards and develop guidelines to support the harmonization of communication interventions at the community level and to institutionalize the design, production, testing and dissemination of communication and promotional tools, materials and documents
- Establish a computerized repository for soft copy communication tools, job-aids, mhealth and other SBCC materials to facilitate system reviews, as well as update and enhance utilization
- Encourage and support higher institutions and research centers to conduct research on health communication efforts
- Set quality assurance standards and mechanism for health communication
- Enhance national and regional capacity to lead, coordinate, implement, monitor and evaluate health communications activities at all levels
- Support the development of grassroots-level mechanisms to measure progress and change of health communication interventions over time including guidelines and skills training
- Special focus for gender sensitivity and adolescent needs


Chapter 5
Strategic Implementation

Chapter 5: Strategy Implementation

5.1 Institutional Arrangement Modality

FMOH, as decreed by law, has the authority to ensure and protect the country's public health. To this effect, based on the country's objective reality as seen through development achievements and assessments and analyses of challenges, successful health policies and strategies have been developed. Accordingly, the country primarily has aimed to reach to the appropriate levels of effort to satisfy the population's demand for its health development and disease prevention.

5.2 Strategy Implementation Modality

The implementation of each strategy requires specific implementation modality as presented in the table below. In addition, depending on the specific context of the implementation, further breakdown of the strategy with detailed plans of activities was deemed essential.

Table 2: Strategy implementation modality

Strategy	Mechanism of Implementation	Responsibility
Individual level strategies		
1. Use standardized health education and promotion messages	• Review existing and new evidence • Harmonize messages • Develop Standardized SBCC materials etc. • Make use of woreda based plan for message designing • Set quality assurance standard • Revise and update the existing family health guide	• FMOH • RHBs • Zone Health Departments
2. Use guidelines and manuals for BCC, social mobilization and advocacy	• Develop IE/BCC material development guide line and tool kits • Develop health literacy and health system literacy implementation guide line • Develop SBCC quality assurance guide line • Develop emergency preparedness and response communication guideline and tool kits. • Develop and produce promotional materials • Make use of woreda based plan for message designing	• FMOH • RHBs

Community level strategies		
3. Use existing community networks/platforms for organizations to be inclusive and collaborative for the improvement of health literacy and health system literacy interventions	• Map existing community level networks/ platforms (folk media like Dagu, coffee ceremonies, HDAs, parent-teacher associations, youth associations, women groups, and other traditional groups…) • WoHO initiates mapping of existing community level networks through HEWs and HDAs. • Organize and conduct capacity building activities on how to use the community networking.	• FMOH/RHBs • WoHO/PHCU • HEW /HDA
4. Use all opportunities for communities to shape and influence the development and delivery of quality services and policies that reflect local needs and priorities.	• Use need assessment tools • Use existing health system • Strengthen linkage among HEWS, HDAs, and community leadership to enhance health promotion activities • Work with other directorates and partners • Advocate policy makers, decision makers and law enforcement bodies on quality service provision • Use social marketing approach as appropriate	• Woreda Health Office • Kebele Administration • ZHD • RHB • FMOH
5. Enhance communication and facilitation skills and knowledge of HEWs and HDAs	• Update IRT handbook and guides and rollout the training • Update HEWs with current health information using different channels • Support HEWs through appropriate and friendly communication tools such as community conversation (CC), CLTSH, speaking book, etc. • Encourage and make use of community discussions and radio listening groups • Integrate communication and facilitation skill in all guidelines.	• FMOH • RHBs • ZHDs • WoHO • Media partners • INGOs/NGOs

Health Service level strategies		
6. Strengthen the relationships between health service providers and their clients to improve friendliness and welcoming health facility environment through caring, respectful and compassionate (CRC) health professionals	• Review and update IPC training materials to demonstrate CRC • Train health care providers on IPC • Document and encourage best experience sharing and practices • Develop and provide standardized IPC job aids	• FMOH • RHBs • ZHDs • WoHO • Media partners • INGOs/NGOs
7. Strengthen facility based health education	• Assess facility based health education status • Equip health facilities with job aids and audio visual materials (audio-video materials, TV, DVD players, batteries) • Conduct continuous monitoring and improve quality of facility based health education programs	• FMOH • RHBs • ZHDs • WoHOs • PHCUs • Media networks • INGOs/NGOs Donors, UN agencies
Socio-cultural and economic environment level strategies		
8. Explore and use societal values and practices that impact health	• Collaborate with higher education institutions, partners, and research centers to assess the values and practices • Scale up positive traditional practices and values to inform health promotion and communication intervention	• FMOH • RHBs • Academic institutions • Research institutes • INGOs/NGOs • MOE
9. Promote healthy work place and environment	• Identify work place and environment health risks and develop appropriate communication tools to promote healthy work place and safe environment • Build partnership forum (MOU, Plan) • Conduct policy advocacy for healthy work place and environment • Strengthen partners and stakeholder capacity to exercise healthy work place and safer environment	• FMOH • RHBs • MOLSA/BOLSA • MOA/BOA • MOUDW • Government Communication Affairs office • EBC/RBC

10. Enhance use of multiple media outlets to promote health transformation initiatives	• Advocate and use mass media, social media, school media outlet including plasma TV • Networking and partnership • Advocacy meetings • Mechanism of sharing timely information and updates • Capacity strengthening • Explore and adopt new technologies	• FMOH • RHBs • EBC • Media network • MOE
11. Advocate for mainstreaming of health and multi sector response to social determinants of health	• Jointly initiate with relevant directorate and coordinate with sector ministries • MOU • Joint plan and mechanism of coordination for implementation • Proposal for resource mobilization • Advocacy meeting and tools • Advocate for inclusion of school health education in primary school curriculum	• FMOH • RHBs • All sector ministries • WOHO • Donor groups • INGOs/NGOs
12. Identify existing IHR and national health laws issued to protect the health of the population and keep environment safe and healthy	• Jointly initiate with relevant directorate and coordinate with relevant partners and media • Coordination for planning and implementation of risk communication • Sensitization and advocacy meetings • Media advocacy	• FMOH • RHBs/ZHDs/WoHOs • EFMHACA • EPHI • WOHO • Municipalities/sub cities • Media
13. Enhance capacity at all levels to deliver health communication activities including the support of grassroots level mechanism to measure progress	• National and regional health education and communication capacity assessment • Health education and communication structure at all level • Establish national TWGs • Local and abroad training • Collaboration with universities and higher institutions and partners • Encourage the establishment of national and regional health promotion and communication platforms to share ideas, experiences, knowledge and new evidences…	• FMOH • RHBs • Donors • Universities • INGOs/NGOs

14. Strengthen capacity of emergency health communication preparedness and response	• Jointly initiate with EPHI and relevant partners • Collaborate with UN agencies and relevant stakeholders (to share timely information of international concern and national warning systems) • Training and communication tools • Experience sharing within the country and abroad	• FMOH • RHBs • EPHI • UN agencies • MOA • Media • Donors and partners
15. Support sensitization and communication activities of climate and health	• Jointly initiate with UN agencies and collaborate with relevant sector ministries • Partnership, frame work, joint planning, strategies • Media communication • Sensitization • Climate change risk mitigation and adaptation communication tools	• FMOH • RHB • Relevant Ministries • Media • UN agencies • INGOs/NGOs

5.3 Partnership & Stakeholders' Role

5.3.1 Partnership

Fostering partnership is crucial for effective implementation of the strategy. Building partnership will help mobilize resources, expertise and capacity to solve problems. At all levels of the health system down to community level, health communication and health education can be successfully implemented with the organized efforts of actors.

The FMOH, RHB, ZHO, WoHO, KHC will lead the mapping and identification of partners. The first step in the preparation of building partnership is to do mapping of partners at each level. The following questions need to be considered for mapping exercises: Who are our allies to address health issues? Who has the capacity and expertise, when mobilized, to support efforts? Who may not be interested with the specific health issues that we need to persuade and bring to our side?

Following meetings with the identified partners, roles and responsibilities can be developed for the lead health sector (as indicated below) and for stakeholders depending on the health issue.

5.3.2. Roles and Responsibilities of Different Stakeholders

5.3.2.1. Role of the Health Sector

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

A. Role and Responsibilities of FMOH

- Create awareness and ensure proper utilization of the strategy by all stakeholders/partners who have engaged in health promotion and communication interventions
- Employ the NHPCS 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 strategy through availing resources including human and financial resources
- Coordinate monitoring and evaluation of the strategy in collaboration with key stakeholders
- Provide special support for emerging regions and pocket/hard to reach areas within other regions to implement the strategy in the context of pastoralist and agro-pastoralist context.

B. Role and Responsibilities of RHB

RHBs with leadership and coordination of respective Department will have the following roles and responsibilities:

- Create awareness on how to utilize the strategy in collaboration with regional partners using available communication strategies
- Employ the strategy to develop any materials such as print/electronic, tools, strategies, IEC, job aids, etc., that are meant for health education and communication
- Ensure proper utilization of the strategies by all stakeholders who are engaged in health education and communication interventions in their respective regions
- Support ZAD/WoHO and other sector offices who work on health education and communication to adopt/adapt the strategy in availing resources including manpower and financial support

C. Role and Responsibilities of ZAD/WoHO

- Familiarize the strategy with health programmers and health communicators
- Collaborate with local partners to develop culturally-relevant health communication and education
- Utilize the strategy 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 strategy and availing resources – human resource and financial

D. Role and Responsibilities of PHCU

All actors in PHCUs, such as health centers, Health Posts (with HEWs), HDAs and kebele health committees would use this strategy to conduct health education and communication at community and household levels, along with the following roles and responsibilities:

- Make use of the strategy to follow and develop culturally-relevant promotional materials
- Provide support in the understanding and implementation of the strategy
- Ensure that the strategy links and guides HEWs in their health education and communication efforts

5.3.2.2. Role and Responsibilities of Partners

- In this context, partners refer to UN Agencies, civil society organizations including faith based organizations, community based organizations, and NGOs. The key roles and responsibilities of partners include:
- Support FMOH and its structural offices at all levels to implement the strategy to the optimal level
- Provide support for FMOH in familiarization, dissemination and implementation of the strategy
- Collaborate with FMOH in evaluating the effectiveness of the strategy

5.3.2.3. Role and Responsibilities of Media Outlets

Media outlets include both print and electronic media that work on health education and communication. Key roles and responsibilities of media outlets are:

- Support FMOH and RHBs in creating awareness for the public and amplify community health concerns identified through community dialogue forums and other communication strategies like advocacy, and social and/or community mobilization

5.3.2.4. Roles and responsibilities of public and private Sector

Sector offices refer to line offices including the MoE at all levels such as schools, school clubs, higher education institutions, Ministry of Agriculture (MoA) at all levels, Ministry of Water Irrigation and Energy, Ministry of Information and Communication, and others in their respective sector networks that can contribute to the improvement of health status of the community. Since these sector offices engage directly or indirectly in health education and communication, they are key stakeholders in implementing this strategy. The sector ministries key roles and responsibilities include:

- Mainstream health promotion in addressing factors to mitigate health effects
- Employ the strategy to develop promotional materials
- Support implementation process 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 threatening life and discouraging demand for health services
- Enforce the implementation of guide lines, standards and protocols in food beverage, cosmetics drugs and health services.

Chapter 6

Monitoring & Evaluation Plan

Chapter 6: Monitoring and Evaluation

6.1 Overview of Monitoring and Evaluation

Greater attention will be paid to monitoring and evaluation (M&E) to understand how effectively and efficiently this strategy is contributing to the success of health programs. There is little documentation to learn from past health communication interventions. The objectives of this monitoring and evaluation plan are to provide guidance for health programmers and health communication professionals to measure the progress of strategy implementation and evaluate its successes, but also to help track the effectiveness of targeted strategies and messages. It is also to monitor that messages are conveyed through appropriate channels to the right audiences for sustainable health outcomes.

Building capacity of health professionals at all levels including HEW supervisors and HEWs helps to guide undertake M&E activities remain imperative to continuously and consistently improve the effectiveness of health communication projects. Indicators related to health promotion and communication should be identified in line with HMIS, as well as different sources of data including reports and surveys.

Such capacity in formative and summative evaluation needs to be well built at various levels to determine the effectiveness of strategies, and how objectives and outcomes are achieved. These capacities also will inform future strategies, save costs through opportunities for reassessment of objectives and reaffirm that ongoing strategies are effective enough to achieve objectives.

6.1.1 Benchmarks of Success

The success of the strategy will be measured by how well the following sets of indicators have been achieved:

- Gaps in health knowledge, attitude and behavior improved at individual/participant level
- Community capacity enhanced to prevent injuries, risks, and diseases
- Societal values and practices impacting health outcomes explored and used
- Safe environment that supports healthy life strengthened and sustained
- Increased healthy communication relationships between clients and health workers.
- Health promotion and communication capacity enhanced at all level levels
- Health literacy skills of households and communities increased to produce their own health

6.2 Monitoring and evaluation plan

Table 3 Monitoring and evaluation plan

Gaps in Health Communications	Strategies	M&E Indicators	Frequency of data collection	Means of verification
Gaps at the individual level • Gaps in knowledge, attitude and behavior change	• Analyze existing studies and/or conduct formative researches to identify KAP gaps • Develop/standardize health education and promotion messages • Develop quality assurance standards • Develop guidelines and manuals for Behavior Change Communication, Social mobilization, Advocacy, Health and Health System Literacy, Emergency Preparedness	• Number of formative research studies conducted /reviewed	Yearly, mid-term and final	Research proposals/ reports
		• Number of thematic guidelines and tools developed and disseminated • IEC materials developed • Availability of quality assurance guidelines	Yearly Quarterly	Guidelines /IEC materials developed
Gaps at the community level • Gaps in promoting and sustaining strong linkage of HEW/HDA, community, and local leadership	• Strengthen linkages of the among the HEW/HDA, the community, and leadership	• Mechanism of coordination and platforms put in place • Number of capacity building trainings, review meetings conducted at PHCUs and kebele level • Number of community level coordination mechanisms and health posts that received support • Number of catchment area of population that received support from health center staff	Quarterly	Reports, field visits

Gaps in Health Communications	Strategies	M&E Indicators	Frequency of data collection	Means of verification
• Gaps in enhancing community empowerment over factors affecting community health	• Provide opportunities for communities to shape and influence the development and delivery of quality services and policies that reflect local needs and priorities	• Number of community leaders who received capacity building • Number of meetings conducted with involvement of community members, HDAs and HEWs • Number of advocacy meetings conducted	Quarterly	Reports, field visits
• Gaps in enhancing the capacity of HEWs	• Enhance interpersonal communication and facilitation skills and knowledge of HEWs and HDAs	• Number of HEWs who received updates about different health issues through different channels (mobile, newsletter, etc.) • Number and type of health education/ communication materials and job aids distributed to HEWs to support their work • Number of HEWs who trained on interpersonal communication and facilitation skills	Quarterly	Reports, field visits

Gaps in Health Communications	Strategies	M&E Indicators	Frequency of data collection	Means of verification
• Gaps in creating friendly, welcoming health facility environment	• Create friendly, inviting health facility environment through improving relationships between health service providers and their clients • Strengthen Health Facility Based Education	• Availability of interpersonal communication and counseling Guide line • Number of health care providers trained in interpersonal communication and counseling skills • Number and type of platforms for health service providers to share experiences and best practices • Number of job aids distributed to health service providers	Yearly Quarterly	Reports, field visits
Gaps at socio-economic and environmental levels • Gaps in identifying, documenting & sharing societal values and best practices for health	• Document Societal values and best practices that impact health	• Number of initiatives undertaken to identify societal values • Number of best practices identified, documented and shared	Yearly	Reports, field visits, experience sharing and review meetings

Gaps in Health Communications	Strategies	M&E Indicators	Frequency of data collection	Means of verification
• Gaps in promoting healthy work & environment places	• Promote healthy work place and environment	• Number of workplace and environment health risks identified and documented • Number of tool kits developed on workplace and environmental health risks	Quarterly	Reports, advocacy meetings/visits
• Gaps in greater mass media involvement and appropriate technology utilization	• Advocate for greater mass media involvement to enhance health transformation initiatives • Identify exiting technologies and adopt for different health education and communication intervention	• Number of consultations with media houses • Number of media professionals trained in health reporting and messaging, and priority health issues • Amount of media space made available for free for health • Number and type of materials distributed to media professionals with up-to-date health information and national health priorities • Existence of institutionalized platform for media professionals to share information on health • Number of new and existing technologies utilized	Quarterly	Reports, review meetings

Gaps in Health Communications	Strategies	M&E Indicators	Frequency of data collection	Means of verification
• Gaps in multi-sectoral involvement for health promotion in addressing social determinants of health including factors that discourage demand for health services	• Advocate for mainstreaming of health and multi-sectoral response to social determinants of health, address and advocate for removal of factors discouraging behavior change	• Number of consultative meeting held with stakeholders to mainstream health and design health promotion interventions • Increased amount of resources allocated for health education and communication • Number of manuals developed focusing on school health • Number of international days observed	Yearly Quarterly	Reports, advocacy meetings
• Gaps in identification, sensitizing and advocating for implementation of existing public health laws and legal frameworks	• Identify existing national health laws issued to protect the health of the population and keep environment safe and healthy •	• Number of national laws/regulations reviewed for their status of implementation • Number of sensitization meetings on reviewed laws and regulations on their status of implementation	Yearly Quarterly	Reports, advocacy meetings

Gaps in Health Communications	Strategies	M&E Indicators	Frequency of data collection	Means of verification
• Gaps in preparedness to respond to health threats of international concern	• Strengthen capacity of emergency health communication preparedness and response	• Number of guidelines and standardized training tools developed on emergency health communications • Number of IEC/BCC materials developed by risk • Number of stakeholders trained on emergency health communication preparedness and response	Yearly Quarterly	Reports, review meetings
• Gaps in climate and health	• Support sensitization and communication activities of climate and health	• Number of sensitization meetings • Number of promotional materials developed and distributed	Yearly	Reports, field visits
• Gaps in sustaining health communication work in the country, community focused guidelines and in promoting appropriate grassroots-level mechanisms to measure progress and change over time	• Strengthen health education structure at all levels Enhance national and regional capacity to deliver health communication work in the country	• Availability of health education and promotion structure at all levels • Number of formative researches/ assessments initiated and supported • Number of people at national, regional, and local levels trained in the design, implementation, monitoring and evaluation of health promotion and communication • Number of health promotion and communication guidelines, training manuals, and toolkits developed • Number of health promotion and communication materials developed • Establishment of computerized repository of soft copy IEC/BCC materials	Yearly Quarterly	Reports, review meetings

Annexes

Annex 1: Health program issues by domains of communication

Individual health areas are analyzed and communication objectives are identified for each health issue identified in the following health program areas:

1. Maternal, Neonatal, Child Health
2. Reproductive health/family planning
3. Safe motherhood
4. Child and adolescent health/ Expanded Program on Immunization (EPI)
5. Nutrition
6. Communicable Diseases (TB, Malaria, HIV/AIDS and others)
7. Neglected Tropical Diseases
8. Non-Communicable diseases including mental health and road safety,
9. Environmental health and personal hygiene (WASH)
10. Public health emergencies
11. Climate and health
12. Health Extension Program/ Health Development Army

Table 4: Health program issues by domains of communication

Health program	Issue	Communication and advocacy objectives		
		Individuals	**Community**	**Macro level (societal level)**
Maternal, Neonatal, Child Health	1. Skilled birth attendance 2. Abortion care 3. Quality of care 4. Health seeking behavior 5. Unmet need 6. Accessibility 7. Supplies and equipment 8. Skilled health professionals 9. Breast feeding, complementary feeding	• Raise awareness of pregnant women on benefits of MNCH in general services; ANC, Postnatal Care (PNC), PMTCT, Nutrition, danger signs; etc. • Promote birth preparedness plan • Involve men in supporting women to have access to MNCH, RH/FP, SMH services • Empower women to seek for health services	• Raise awareness of the benefits of attending MNCH, RH/FP, and SMH, and the consequences of lack thereof	• Advocate issues hindering access to services, for example, addressing factors responsible for second delay
Reproductive health/ family planning Safe motherhood			• Promote for support mothers and children to access to services • Advocate for the establishment of community capacity to assess health issues and address self sufficiently • Involve religious and clan leaders in encouraging and support women to use family planning and other services • Empower communities to get involved in problem solving endeavours to improve health	• Advocate for improved quality of care, the availability of supplies, basic emergency obstetric care, and skilled health professionals

Health program	Issue	Communication and advocacy objectives		
		Individuals	**Community**	**Macro level (societal level)**
Child and adolescent health/EPI	1. Health seeking behavior 2. Dropout rates 3. Supplies 4. Vaccine stocks 5. Poor follow up 6. Utilization of facilities	• Raise awareness • Encourage and motivate behavior change, health seeking behavior	• Promote routine immunizations • Initiate community dialogue to question and modify contribution of community values, practices and norms to improved health	• Engage influencers to deliver inspirational messages and calls to actions to mobilize support and participation of community members
Nutrition	1. Birth interval 2. Level of education 3. Household wealth 4. Foods for weaning 5. Feeding practices 6. Harmful traditions	• Raise awareness on breastfeeding	• Promote early and exclusive breastfeeding	• Advocate for strengthened promotion of community-based nutrition
Non Communicable Diseases	1. Awareness 2. Environmental conditions 3. Lifestyle 4. Physical activity	• Raise awareness	• Improve access to promotion, prevention and control of major NCDs risk factors	• Advocate for improved protection of communities from NCD risk factors through enabling policy • Advocate for increased commitment and action • Develop technical guidance and training materials • Advocate for enhanced health and other systems • Advocate for strengthened networks and partnerships

Health program	Issue	Communication and advocacy objectives		
		Individuals	Community	Macro level (societal level)
Environmental health / WASH	1. Accessibility of WASH facilities 2. Awareness 3. Sustainability of WASH facilities 4. Community ownership 5. Sectoral collaboration	• Raise awareness • Promote demand creation	• Promoting hygiene and environmental sanitation, household latrine preparation and utilization, improving water quality through proper handling, and safe disposal of liquid and solid waste • Community mobilization	• Advocate for access, supply chain, Sectoral support and engagement
PMTCT	1. Utilization of services 2. HIV test kits and supplies 3. Accessibility 4. Integration of ANC with PMTCT 5. Awareness	• Raise awareness • Utilize services	• Promote active support of communities	• Advocate for strengthened and integrated services
Neglected Tropical Diseases	1. Poverty 2. Access to clean water 3. Sanitation 4. Inadequate attention 5. Environment 6. Awareness 7. Health seeking behavior 8. Inadequate attention	• Raise awareness • Utilize services	• Community involvement in controlling factors responsible for the spread of NTDs • Community participation in mass treatment • Improved practice of WASH • Setting of hygienic practices (hand washing, environmental sanitation and wearing shoes)	• Advocate for social mobilization and sensitization • Enhance partnership and collaboration for integrated NTDs control

Health program	Issue	Communication and advocacy objectives		
		Individuals	**Community**	**Macro level (societal level)**
HIV/AIDS	1. High risk populations and behaviors 2. Knowledge & awareness of STIs 3. Unsustainable interventions 4. Resources required to manage the epidemic amongst them 5. Shortage of supplies Rapid Test kits 6. Inadequate care 7. Health facility accessibility 8. Low retention of ART patients at health facility	• Continue promoting awareness raising and safe sex practices, ART treatment and Sexually Transmitted Infection(STI) screening and treatment • Promote contact tracing • Promote adolescent reproductive health	• Strengthen school health promotion to increase awareness of safe sex practices, reduce substance abuse (tobacco, chat, etc.) • Engage community leaders, civil societies and religious leaders to promote safer sex, provide psychosocial support for the affected and tackle stigma and discrimination	• Promote and advocate for sustainable interventions to educate about HIV/AIDS, STI, etc. • Promote for sustained supplies and creation of friendly health services and support for young people • Strengthen school health promotion and promote for increased parent-teachers association
Malaria	1. Early diagnosis and treatment 2. Quality of service delivery 3. Stock out of malaria supplies, 4. Awareness	• Increase awareness • Promote for consistent use of LLTINs • Practice vector control	• Engagement in vector control and full support for improved quality of indoor residual spraying	• Advocate for improved early diagnosis and prompt treatment of Malaria
Tuberculosis	1. DOTS (Directly Observed Treatment Short Course) coverage 2. Multi-Drug Resistance (MDR)-TB 3. CBTC –community based therapeutic center 4. Drugs and supplies	• Increase awareness to seek and utilize TB treatment	• Provide support for the community level treatment • Encourage individuals with the disease to comply treatment	• Advocate for increased and sustained supplies

Health program	Issue	Communication and advocacy objectives		
		Individuals	**Community**	**Macro level (societal level)**
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, etc.) 3. Low practice of periodic screening 4. Low capacity of health facilities in the management of NCDs 5. Sectoral collaboration 6. Creation of enabling environment to promote life style practices (physical exercise, standardize salt and sugar intake, etc.) 7. 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	• Promote community participation in organizing healthy activities • Engagement of communities in creating enabling environment • Setting community norms to tackle factors exacerbating impacts of risk factors	• Sensitize for increased Sectoral partnership and collaboration • Strengthen platforms for increased engagement of sectoral offices • Adoption of laws and support for their implementation • 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
Health Extension Program/Health Development Army	1. Capacity building 2. Enabling environment 3. Motivation 4. linkages and networking	• Provide information and support • Seek and utilize services • Comply with the education and advice provided	• Create enabling environment • Comply with information, education to meet targets • Put in place stronger networking and platforms to facilitate HEP implementation	• -Sensitize and advocate for increased capacity building support

Health program	Issue	Communication and advocacy objectives		
		Individuals	**Community**	**Macro level (societal level)**
Maternal, Neonatal, Child Health	1. Skilled birth attendance 2. Abortion care 3. Quality of care 4. health seeking behavior 5. Unmet need 6. Accessibility 7. Supplies and equipment 8. Skilled health professionals 9. Breast feeding, complementary feeding	• Raise awareness of pregnant women on benefits of MNCH in general services; ANC, Post Natal Care (PNC), PMTCT, Nutrition, danger signs; etc. • Promote birth preparedness plan • Involve men in supporting women to have access to MNCH, RH/FP, SMH services • Empower women to seek for health services	• Raise awareness of the benefits of attending MNCH, RH/FP, and SMH; and consequences	• Advocate issues hindering access to services for example addressing factors responsible for second delay
Reproductive health/ family planning Safe motherhood			• Promote for support mothers and children to access to services • Advocate for establishment of community capacity to assess health issues and address self sufficiently • Involve religious and clan leaders in encouraging and support women to use family planning and other services • Empower communities to get involved in problem solving endeavours to improve health	• Advocate for improved quality of care, availability of supplies, basic emergency obstetric care and skilled health professionals
Child and adolescent health/EPI	1. Health seeking behavior 2. Dropout rates 3. Supplies 4. Vaccine stocks 5. Poor follow up 6. Utilization of facilities	• Raise awareness • Encourage and motivate behavior change, health seeking behavior	• Promote routine immunizations • Initiate community dialogue to question and modify contribution of community values, practices and norms to improved health	• Engage influencers to deliver inspirational messages and calls to actions to mobilize support and participation of community members

Health program	Issue	Communication and advocacy objectives		
		Individuals	**Community**	**Macro level (societal level)**
Nutrition	1. Birth interval 2. Level of education 3. Household wealth 4. Foods for weaning 5. Feeding practices 6. Harmful traditions	• Raise awareness on breastfeeding •	• Promote early and exclusive breast feeding	• Advocate for strengthened promotion of • community-based nutrition
Non communicable diseases	1. Awareness 2. Environmental conditions 3. Lifestyle 4. Physical activity	• Raise awareness	• Improve access to promotion, prevention and control of major NCDs risk factors	• Advocate for improved communities protection from NCD risk factors through enabling policy • Advocate for increased commitment and action; • Develop technical guidance and training materials; • Advocate for enhanced health and other systems • Advocate for strengthened networks and partnerships
Environmental health / WASH	5. Accessibility of WASH facilities 6. Awareness 7. Sustainability of WASH facilities 8. Community ownership 9. Sectoral collaboration	• Raise awareness • Promote demand creation	• Promoting hygiene and environmental sanitation, household latrine preparation and utilization, improving water quality through proper handling, and safe disposal of liquid and solid waste • Community mobilization	• Advocate for access, supply chain, Sectoral support and engagement

Health program	Issue	Communication and advocacy objectives		
		Individuals	Community	Macro level (societal level)
PMTCT	1. Utilization of services 2. HIV test kits and supplies 3. Accessibility 4. Integration of ANC with PMTCT 5. Awareness	• Raise awareness • Utilize services	• Promote active support of communities	• Advocate for strengthened and integrated services
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Health program	Issue	Communication and advocacy objectives		
		Individuals	**Community**	**Macro level (societal level)**
HIV/AIDS	1. High risk populations and behaviors 2. Knowledge & awareness of STI 3. Unsustainable interventions 4. Resources required to manage the epidemic amongst them 5. Shortage of supplies Rapid Test kits; 6. Inadequate care 7. Health facility accessibility 8. Low retention of ART patients at health facility	• Continue promoting awareness raising and safe sex practices, ART treatment and Sexually Transmitted Infection(STI) screening and treatment • Promote contact tracing • Promote adolescent reproductive health	• Strengthen school health promotion to increase awareness of safe sex practices, reduce substance abuse (tobacco, chat, etc.) • Engage community leaders, civil societies and religious leaders to promote safer sex, provide psychosocial support for affected and tackle stigma and discrimination	• Promote and advocate for sustainable interventions to educate about HIV/AIDS, STI, etc. • Promote for sustained supplies and creation of friendly health services and support for young people • Strengthen school health promotion and promote for increased parent-teachers association
Malaria	1. Early diagnosis and treatment 2. Quality of service delivery 3. Stock out of malaria supplies, 4. Awareness	• Increase awareness • Promote for consistent use of LLTINs • Practice vector control	• Engagement in vector control and full support for improved quality of indoor residual spraying	• Advocate for improved early diagnosis and prompt treatment of Malaria
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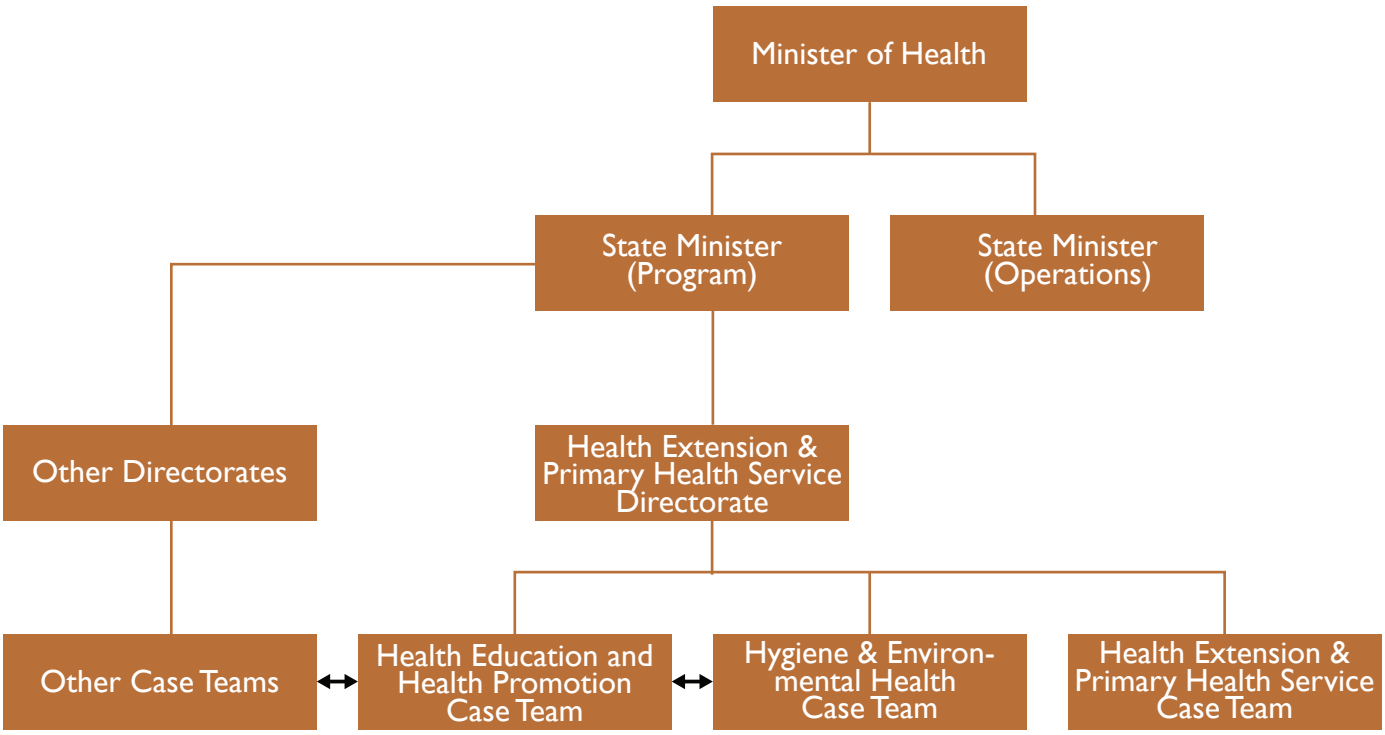
Health program	Issue	Communication and advocacy objectives		
		Individuals	**Community**	**Macro level (societal level)**
Non Communicable Diseases (NCDs)	1. Low awareness of risk factors of NCDs and adoption of life style 2. Life style changes (physical inactivity, tobacco use, unhealthy diet, etc.) 3. Low practice of periodic screening 4. Low capacity of health facilities in the management of NCDs 5. Sectoral collaboration 6. Creation of enabling environment to promote life style practices (physical exercise, standardize salt and sugar intake, etc.) 7. 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	• Promote communities participation in an organize healthy activities • Engagement of communities in creating enabling environment • Setting community norms to tackle factors exacerbating impacts of risk factors	• Sensitize for increased Sectoral partnership and collaboration • Strengthen platforms for increased engagement of sectoral offices • Adoption of laws and support for their implementation • Advocate for creation of enabling environment to promote physical activity (city planning to influence for pedestrian roads, Ground plays, etc.) • Advocate for increased capacitate of health facilities to manage NCDs
Health Extension Program/health Development Army	1. Capacity building 2. Enabling environment 3. Motivation 4. linkages and networking	• Provide information and support • Seek and utilize services • Comply with the education and advice provided	• Create enabling environment • Comply with information, education to meet targets • Put in place stronger networking and platforms to facilitate HEP implementation	• Sensitize and advocate for increased capacity building support

Annex 2: Organizational Structure



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