

# National Health Promotion Strategic Plan 2015-2019

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*Health promotion is the process of enabling people to increase control  
over their health and its determinants, and thereby improve their  
health*

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Ghana Health Service, Accra

May, 2016





# Forward

According to the World Health organization (WHO), 75% of illnesses in the world could be prevented through health promotion linked to inputs of better nutrition, clean water supply, sanitation, immunization and population management, among others. The need to harness the different and varied resources of various stakeholders, individually and collectively, is therefore crucial and vital to improve health. Effective communication, advocacy and social mobilization (key components of health promotion) are essential tools for achieving all of these inputs to address the broad social determinants of health. The Ottawa Charter therefore defined Health Promotion (HP) as the process of enabling people to increase control over and improve their health. The Charter called for advocacy for health actions for bringing about favorable political, economic, social, cultural, environmental, behavioral and biological factors for health, enabling people to take control of the factors influencing their health and mediation for multi sectoral action.

The 2005 Health Promotion Policy was consequently revised starting from 2013 to 2015 taking due cognizance of current strategic documents and frameworks of the Ministry of Health /Ghana Health Service, the Communicate for Health Project, the World Health Assembly resolutions, the Ottawa Charter, the Regional Strategy for Health Promotion, and other international frameworks and best practices. A detailed National Strategy with action plan and an M&E framework to measure performance has been prepared through a multi-stakeholder process with support of our development partners.

This Strategic Plan (2015-2019) describes opportunities and strategies to further improve upon Health Promotion in the country through a collective approach involving all stakeholders. We take this opportunity to invite and encourage all stakeholders: government institutions, donors, non-governmental organisations, development partners and the health sector, to be part of this collective effort to improve upon the quality of life of Ghanaians as envisaged in this Strategic Plan.

I take this opportunity to thank all partners who have supported the cause of improving Health Promotion in the country in the past and hope that they will redouble their efforts through effective partnership to achieve the goal and objectives of this Strategic Plan.

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Hon. Alex Segbefia  
*Honourable Minister of Health*

# Table of Contents

Forward	3
List of Acronyms	7
Chapter One:	
<b>Introduction</b>	<b>9</b>
1.1 Rationale	9
1.2 Methodology	11
Structure of Document	12
Chapter Two:	
<b>Current Situation of Health Promotion</b>	<b>13</b>
2.1 Context and Concepts Globally	13
2.2 Current Situation and Bottleneck Analysis of Health Promotion in Ghana	15
2.3 Studies on Knowledge, Attitudes, Beliefs, Perceptions and Practices (KABPP) in relation to Health Promotion	19
Chapter Three:	
<b>Proposed National Health Promotion Strategies and Action Plan</b>	<b>22</b>
3.1 Conceptual Framework of Proposed Strategy	22
3.2 Goal, Strategic Objectives, Intermediate Results and Indicators	24
The Goal	24
Strategic Objective (SO) 1: Improving quality of health promotion services	24
SO2: Improved Healthier Communities	25
SO3: Increased collaboration and partnerships for health promotion	25

Chapter Four:	
<b>Strategies and Key Activities</b>	<b>27</b>
4.1 Proposed Strategies	27
4.2 Implementation Arrangement, Management Approaches, Gender Integration	39
Chapter Five:	
<b>Estimated Cost of the Plan</b>	<b>41</b>
References	43
Annexes	45

# List of Acronyms

BGMSL	Better Ghana Management Services
CAD	Change Agent Programme
C4H	Communicate for Change
CHOS	Community Health Officers
CHPS	Community Health Planning Services
CPD	Continuing Professional Development
DA	District Assembly
DHIMS2	District Health Information Management System2
DHS	Demographic and Health Survey
EWP	Employee Wellbeing Programme
FP	Family Planning
GoG	Government of Ghana
HP	Health Promotion
HPC	Health Promotion Champions
HPD	Health Promotion Department
ICC-HP	Inter-agency Coordinating Committee for Health Promotion
IR	Intermediate Result
KABPP Practices	Knowledge, Attitudes, Beliefs, Perceptions and Practices
KNUST Technology	Kwame Nkrumah University of Science and Technology
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation

NGOS	Non-Governmental Organisations
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
OPD	Out-Patient Department
SBCC	Social Behavioural Change Communication
SfC	Set for Change
SO	Strategic Objective
UCC	University of Cape Coast
UHAS	University of Health and Allied Sciences
UNICEF	United Nations Children Fund
USAID	United States Aid for International Development
WASH	Water Sanitation and Hygiene



# Chapter One: Introduction

## 1.1 Rationale

The discipline of “Health promotion” has struggled over the years in Ghana and elsewhere to gain due recognition as a technical health discipline. This under-recognition has been influenced largely by the pervasive traditional medical model of health which is based on provision of clinical treatment services in fixed facilities to already self-motivated patients. Health promotion received a major boost in 1978 when the Alma Ata declaration acknowledged that the promotion and protection of the health of the people was essential to sustained economic and social development and contributed to a better quality of life and to world peace [WHO 1978]. Primary Health Care (PHC) was identified as the main strategy to achieve Health For All (HFA), which is a vision that recognizes that health is determined not only by the provision of medical care or health services but also by economic, social, political and environmental variables in the communities in which people live.

According to World Health organization (WHO), 75% of illnesses in the world could be prevented through health promotion linked to inputs of better nutrition, clean water supply, sanitation, immunization and population management, among others. The need to harness the different and varied resources of various stakeholders, individually and collectively, is therefore crucial and vital to improve health. Effective communication, advocacy and social mobilization (key components of health promotion) are essential tools for achieving all of these inputs to address the broad social determinants of health [MOH 2005].

The plight of “health promotion” in the country was not helped by the absence of any clearly articulated policy on health promotion even after Alma Ata till about 2005. The first major attempt to provide guidance and policy direction for health promotion in Ghana was in 2005 when the first Health Promotion (HP) Policy was drafted and revised in 2013 due to

emergence of a number of new issues. These issues included the Ottawa declaration on HP, new WHO recommendation to member countries, especially Africa, on the need for the development of formal policies on Health Promotion in the continent.

Furthermore, in revising the 2005 Health Promotion Policy in 2013, and further revised in 2015, careful consideration was made to place it within the context of current strategic documents and frameworks of the Ministry of Health /Ghana Health Service, the World Health assembly resolutions, the Regional Strategy for Health Promotion, the Sustainable Development Goals and other international frameworks and best practices [MOH 2015].

The major deficiency of the 2005 Policy was that no Strategic Plan was developed to operationalize it. Furthermore, an M&E framework was not developed with indicators for measuring progress with implementation. The new policy provides an overall framework for Health Promotion development and practice in the country. It also sets out health promotion policy measures which were expected to lead to effective Health Promotion response to the needs of the health and health related sectors in the country [MOH 2015].

Taking due cognizance of the shortcomings of the first draft Policy in 2005, a detailed National Strategy with action plan and an M&E framework to measure performance was added to the process, hence the development of this National Strategy and Action Plan to operationalize the new 2015 policy. The process for the development of the National Strategic Plan started in 2014 and has been influenced greatly by the initiation of a joint USAID sponsored project between C4H and Health Promotion Department (HPD) in 2014.

### **The C4H project description**

The USAID Communicate for Health (C4H) program in Ghana is working with the Government of Ghana (GOG), Ghana Health Service's Health Promotion Department (GHS/HPD), local Ghanaian partners, and international development partners to improve behavior change in family planning (FP), water, sanitation, and hygiene (WASH), nutrition, maternal and child health (MCH), malaria prevention and treatment, and HIV/AIDS; strengthen capacity of GHS/HPD to effectively design, coordinate and deliver social and behavior change communication (SBCC) and health

promotion (HP) campaigns; and develop and strengthen capacity of two local organizations to receive direct USAID funding.

The C4H Project objectives are:

1. Strengthen the capacity of GHS/HPD and other SBCC and social marketing organizations to design and execute evidence-based, coordinated social and behavioral change communication initiatives and health promotion activities at scale in various areas of health including MNCH; FP; nutrition; WASH; malaria prevention, control and case management, and the prevention and management of HIV.
2. Strengthen the GHS/HPD systems for effectively coordinating the development and delivery of social and behavioral change communications and health promotion activities.
3. Develop and strengthen capacity of up to two local organizations to receive direct USAID funding to (a) design, execute, and disseminate evidence-based SBCC materials interventions and (b) implement social marketing program for contraceptives and other health commodities.

## 1.2 Methodology

A detailed desk review was first undertaken of relevant policy and other documents on health promotion in Ghana and elsewhere. It involved reviewing MOH/GHS Strategic Plans, Health Promotion Policy of 2005 and 2015, the C4H project document, Annual reports of MOH/GHS and Health Promotion Department as well as the Regional strategy for Health Promotion. Data from DHS 2003, 2008 and DHIMS2 were also reviewed.

A bottleneck analysis workshop was organized to discuss and identify key bottlenecks preventing implementation of interventions for health promotion in Ghana, as well as suggest solutions to identified bottlenecks. This was followed by another workshop to agree on key components and activities for the proposed strategy. The draft National Strategy document was then prepared and shared with stakeholders, including ICC-HP, before finalization.

## **Structure of Document**

The document consists of four Chapters. Chapter 1 provides an overview of the context and rationale for Health Promotion and the Strategic Plan, methodology for developing the Strategic Plan and an outline of the document. Chapter 2 then discusses the concepts of HP as well as the current situation of HP in Ghana, including a summary of bottleneck analysis. The chapter ends with Knowledge, Attitudes, Beliefs, Perceptions and Practices (KABPP) in relation to Health Promotion in Ghana from published literature. This is followed by Chapter 3 which describes the proposed national Health Promotion strategies and action plan, conceptual framework of proposed strategy, goal, strategic objectives and intermediate result areas of the Health Promotion Strategy. Chapter 4 provides details of the proposed strategies and key activities to achieve them. An implementation arrangement, management approaches, and gender integration framework is also provided. A number of references and annexes are added to provide additional information on bottleneck analysis and proposed solutions to strengthen health promotion in Ghana as well as a draft Monitoring and Evaluation Framework for the National Health Promotion Strategy.

# Chapter Two:

## Current Situation of Health Promotion

### 2.1 Context and Concepts Globally

The term 'Health Promotion' was coined in 1945 by Henry E. Sigerist, the great medical historian, who defined the four major tasks of medicine as promotion of health, prevention of illness, restoration of the sick and rehabilitation. He went on to state that health was promoted by providing a decent standard of living, good labor conditions, education, physical culture, means of rest and recreation and required the coordinated efforts of statesmen, labor, industry, educators and physicians [**Henry Sigerist 1945**]. His views were reflected 40 years later in the Ottawa Charter for health promotion.

Health education and health promotion are two terms which are sometimes used interchangeably. According to Sanjiv K and Preetha GS, health education is about providing health information and knowledge to individuals and communities and providing skills to enable individuals to adopt healthy behaviors voluntarily. It is a combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes, whereas health promotion takes a more comprehensive approach to promoting health by involving various players and focusing on multisectoral approaches. Health promotion has a much broader perspective including developments which have a direct or indirect bearing on health such as inequities, changes in the patterns of consumption, environments, cultural beliefs, etc. [**Sanjiv Kumar and GS Preetha 2012; WHO 2008a**].

Health promotion received a major impetus in 1978, when the Alma Ata declaration acknowledged that the promotion and protection of the health of the people was essential to sustained economic and social development and contributed to a better quality of life and to world peace [**WHO Alma Ata 1978**]. The international community endorsed and re-affirmed holistic concept of health as a state of complete physical, mental and social

wellbeing and not merely absence of disease or infirmity. Primary Health Care (PHC) was identified as the main strategy to achieve Health For All (HFA), which is a vision that recognizes that health is determined not only by the provision of medical care or health services but also by economic, social, political and environmental variables in the communities in which people live. These forces largely shape the circumstances in which people grow, live, work and age as well as the systems put in place to deal with their health needs [WHO 2008b]. The complexity of health under this concept made it clear that no single ministry, agency or sector has all the requisite resources, skills and even authority to prosecute all the interventions required to improve health. Improving health therefore depends a lot on the role of other sectors outside the health sector, whose actions and inactions impact positively or negatively on health. The need to harness the different and varied resources of various stakeholders, individually and collectively, is therefore crucial and vital to improve health. In such a situation, health issues can be effectively addressed by adopting a holistic approach by empowering individuals and communities to take actions for their own health, foster leadership for public health, promote intersectoral action to build healthy public policies and create sustainable health systems in the society. According to Sanjiv Kumar and GS Preetha, these elements capture the essence of “health promotion”, which is about enabling people to take control over their health and its determinants, and thereby improve their health. It includes interventions at the personal, organizational, social and political levels to facilitate adaptations (lifestyle, environmental, etc.) conducive to improving or protecting health [Sanjiv Kumar and GS Preetha 2012; WHO 2009a; WHO 2009b].

The breakthrough for health promotion however came in 1986 when the International conference on Health Promotion was organized in Ottawa, leading to the “Ottawa Charter for Health Promotion” [WHO 1986]. The Ottawa Charter defined Health Promotion as the process of enabling people to increase control over and to improve their health. Health promotion thus is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. The Charter called for advocacy for health actions for bringing about favorable political, economic, social, cultural, environmental, behavioral and biological factors for health, enabling people to take control of the factors influencing their health and mediation for multi sectoral action. The Charter defined Health Promotion action as one a) which builds up healthy public policy that combines diverse

but complementary approaches including legislation, fiscal measures, taxation and organizational change to build policies which foster equity, b) creates supportive environments, c) supports community action through empowerment of communities – their ownership and control of their own endeavors and destinies, d) develops personal skills by providing information, education for health, and enhancing life skills and e) reorients health services towards health promotion from just providing clinical and curative services [WHO 2009b; Sanjiv Kumar and GS Preetha 2012].

## 2.2 Current Situation and Bottleneck Analysis of Health Promotion in Ghana

### 2.2.1 Policy, Leadership and Governance

The first major attempt to provide guidance and policy direction for health promotion in Ghana was in 2005 when the first Health Promotion Policy was drafted. The goal of that policy was:

“To create and sustain a frame work, in collaboration with partners, that will guide the provision of accurate and relevant health information and skills to the individual, family and community and control other factors in the environment that will help the population to make informed decisions to improve their health.” [MOH 2005].

There was however the need to revise the 2005 policy starting from 2013 to 2015 due to changing strategic directions and frameworks of the Ministry of Health /Ghana Health Service, the World Health assembly resolutions, the Regional Strategy for Health Promotion, the Millennium Development Goals and other international frameworks and best practices [MOH 2015].

The first draft of the policy was developed in August 2013 and finalized in December 2015. The new policy provides an overall framework for Health Promotion development and practice in the country. It also sets out health promotion policy objectives and measures which will lead to effective Health Promotion response to the needs of the health and health related sectors in the country. These Policy Objectives as outlined in the new HP Policy are as follows:

#### Policy Objective 1

- To strengthen leadership for health promotion at all levels.

#### **Policy Objective 2**

- To build capacity for health promotion at all levels and across sectors to respond to the needs of different people and groups.

#### **Policy Objective 3**

- To mobilize and empower communities to take actions to improve their health

#### **Policy Objective 4**

- To develop and implement comprehensive, holistic and multisectoral and multidisciplinary action for health promotion

#### **Policy Objective 5**

- To establish an effective system and mechanism for health promotion management, coordination and partnership at all levels

#### **Policy Objective 6**

- To advocate sustained government commitment for health promotion

#### **Policy Objective 7**

- To promote adoption of innovative financing mechanism for Health Promotion

#### **Policy Objective 8**

- To strengthen Research, monitoring and evaluation for evidence-based health promotion practice

#### **Policy Objective 9**

- To strengthen documentation and dissemination mechanism for Health Promotion

A summary of bottleneck analysis undertaken in 2014 under “Policy, Leadership and Governance” is provided below. See annex 1 for details.

- A detailed national Situational Analysis of health promotion has not yet been done
- Little priority has been given to health promotion. Health promotion is not properly and adequately defined in the National Health Strategy (2007-2011). The National Health



Policy (2007) does not address leading challenges to Health Promotion in Ghana.

- The current organizational structure which places health promotion as a department under Family Health Division of GHS makes it challenging to address the broader health promotion issues and play the cross-cutting roles and functional operations as envisaged in the health promotion policy.
- There is lack of legal and institutional backing for the regulation of health promotion in its broader scope in the country.
- The current ICC-HP is not adequately represented and it is not functioning effectively. The coordinating mechanism for Health Promotion (ICC-HP) does not meet regularly.
- There are no targets and indicators for measuring, monitoring and reporting on health promotion currently in Ghana.

### **2.2.2 Bottleneck Analysis of Health Financing**

- There is inadequate funding to support health promotion interventions
- Almost 98% of available funds come from external sources, mainly UNICEF, USAID, WHO and NGOs, leading to over-dependence on donor funding.
- GoG funding is unpredictable and released late.
- There is no strategy for resource mobilisation for health promotion
- Poor governance arrangement among MOH, GHS and Better Ghana Management Services Ltd (BGMSL) as well as uncoordinated implementation of health promotion activities is impacting negatively on funding allocation for health promotion especially in relation to funding from National Health Insurance Authority (NHIA).

### **2.2.3 Bottleneck Analysis of Health Work Force for Health Promotion**

- There is absence of staffing norms for health promotion staff

- Inadequate production of health promotion staff. There are only 70 health educators on MOH payroll while there were 33 on GHS payroll countrywide as of June 2013
- Institutions training Health Promotion staff are – Kwame Nkrumah University of Science and Technology (KNUST) – (Masters in health education and promotion; University of Ghana (Bachelors/Master in public health promotion); University of Cape Coast (UCC) (Masters in Health education); College of Health Science Kintampo (Diploma in health promotion); Catholic University at Fiapre (Public Health education); University of Health and Allied Sciences (UHASS) (Bachelor’s in Public Health [Health promotion]; UHASS/ Leeds Met (Msc Public Health [Health Promotion]).
- Only 42 out of the 216 districts have Health Promotion Officers
- There is no in-service training plan for health promotion Officers. No plan for Continuous Professional Development (CPD), certification and re-certification for health promotion officers
- Inadequate and out-dated guidelines, manuals and tools for health promotion
- Inadequate capacity for health promotion for various categories of health staff (e.g. Community Health Officers (CHOs)).

#### **2.2.4 Bottleneck Analysis of Essential Equipment, Materials and Technologies**

- Inadequate essential equipment and materials for health promotion

#### **2.2.5 Bottleneck Analysis of Health Service Delivery for Health Promotion**

- Un-coordinated production of health promotion materials and messages
- Irregular and inadequate monitoring and supervision of health promotion activities at all levels

- Inadequate use of CHPS potentials for undertaking health promotion activities
- Missed opportunities by health staff to embark on health promotion activities (e.g. at OPD)

### **2.2.6 Bottleneck Analysis of System for Information and Documentation for health information material.**

- No indicators for monitoring and reporting on health promotion
- The DHIMS2 does not capture Health Promotion indicators yet.
- There is no health promotion data from NGOs, Donor projects and private sector
- Non-functional health promotion resource centre
- Under-utilization of the Kumasi health-learning center

### **2.2.7 Bottleneck Analysis of Community Ownership and Partnership for Health Promotion**

- There is no elaborate guidelines for communication
- There is high cost of engaging the media in health promotion activities; weak partnership with media.
- Low stakeholder involvement at district and community levels; waning spirit of volunteerism due partly to un-equal incentive systems at community level.
- Inappropriate community perceptions, attitudes, social norms, beliefs, practices

## **2.3 Studies on Knowledge, Attitudes, Beliefs, Perceptions and Practices (KABPP) in relation to Health Promotion**

A number of studies mostly in Ghana have shown that inappropriate community perceptions, attitudes, social norms, beliefs, practices adversely affect uptake of services and promotion of health in general. A few are summarized below:

1. In a study of outpatient chronically ill patients recruited from the Korle Bu Teaching Hospital, Accra in 2012, it was found that

young adults had very low knowledge of chronic illnesses and did not consider themselves at risk to chronic diseases. Young adults diagnosed of certain chronic illnesses ascribe supernatural interpretations to their disease condition. The author concluded that these determine their attitude to their condition as well as health seeking behaviours adopted by them and their families. Responses interfered with their biomedical care and thus have implications for health promotion and healthcare planning and policy [**Atobrah D. 2012.**]

2. A study in the municipality of Komenda, Edina, Eguafu, Abrem district to adapt, implement, and evaluate an evidence-based hand hygiene public health initiative in elementary schools in Ghana was undertaken in 2012. All 4 participating schools gained the necessary resources to carry out proper hand hygiene practice. It was found that pupils were more likely to wash hands after using the toilets and teachers were better equipped to be good role models, and school children were the initiators of a behavior change in their community. Providing resources to schools was key to the success of the implementation. This partnership gave health and education workers in Ghana the tools, knowledge, and confidence to implement a simple, evidence-based, hand hygiene program [**Lang MC 2012.**]
3. Another study on reducing childhood diarrhea morbidity in Northern Ghana concluded that mothers' lack of understanding of the link between infections and diarrhea incidence is crucial and stresses that building the capacity of households and community members to recognize and change inappropriate behaviours can increase the efficiency and cost-effectiveness of child health intervention programs in Northern Ghana [**Osumanu IK 2008.**]
4. In 2003-04, a National Hand washing Campaign utilizing mass media and community events took place in Ghana. In an evaluation of the campaign a sample of 497 women with children <5 years was used. The unifying message across all communication channels was that hands were not 'truly' clean unless washed with soap. The campaign reached 82% of the study population. Sixty-two per cent of women knew the campaign song, 44% were exposed to one channel and 36% to two or more.

Overall, Television and radio had greater reach and impact on reported hand washing than community events, while exposure to both mass media channel and an event yielded the greatest effect, resulting in a 30% increase in reported hand washing with soap after visiting the toilet or cleaning a child's bottom [**Scott BE et al 2008**].

5. A study on the determinants of use of maternal-child health (MCH) services in rural Ghana by Addai I in 2000 revealed that the use of MCH services tends to be shaped mostly by level of education, religious background and region of residence, and partially by ethnicity and occupation [**Addai I 2000**].
6. Dodoo A and Hugman B found in another study the extent to which ethnic, religious and cultural issues influence popular perception, and the power of rumour and anecdote in shaping public opinion and official responses to events [**Dodoo A and Hugman B. 2012**].
7. Using qualitative interviews with women in three countries, a study examined what women feared, how they acquired this knowledge, and how it impacted on decision-making in relation to family planning. Across all countries, respondents had a similar host of fears and misinformation about family planning, which comprised of a mixture of personal experience and rumour. Most fears were method-specific and respondents overwhelmingly stated that they would be more likely to use the family planning method they feared if counseled that there were no side-effects. The authors suggested that programmes should focus on education about family planning methods and method mix and allay fears of side effects [**Diamond-Smith N et al 2012**].

# Chapter Three:

## Proposed National Health Promotion Strategies and Action Plan

### 3.1 Conceptual Framework of Proposed Strategy

In developing the proposed National Health Promotion Strategy, due cognizance is taken of the Health Promotion Policy 2015, the bottleneck analysis of health promotion in the country and proposed solutions, the concepts introduced by the C4H joint project with HPD, as well as the African Health Promotion Strategy (WHO). The conceptual framework (Figure 1) is based on the modified work of Tanahashi (1978) used to develop coverage models for the evaluation of health services, as well as on the WHO's health systems strengthening model.

In summary, the model indicates that Effective Coverage (of say health promotion interventions) is predominantly influenced by three main factors: Supply of services, Demand for services and Quality of services. Supply for services is controlled by the health care delivery system and is dependent upon availability of essential commodities; availability of trained, qualified service providers (human resource) and availability of service delivery points for health promotion (geographic access).

Demand for services is controlled by the community and has two important components: initial utilization and continuous utilization of services. Quality of services is controlled by the health care delivery system and relates to the services being able to meet the set standards [Tanahashi 1978].

## Determinants of Health Service Coverage

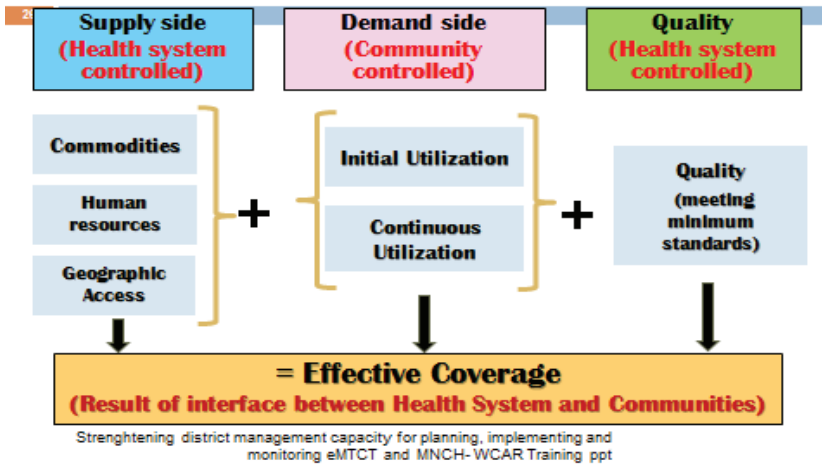


Figure 1: Conceptual Framework for Determinants of Health Service Coverage [Tanahashi 1978].

The essence of the Strategy is to advocate for or provide the particular-health enhancing services, facility or information, as well as to mitigate the health-minimizing factors including addressing unfavourable political, legal and other environmental issues, in collaboration with all relevant stakeholders at all levels for health improvement in the country. The underlying assumption is that through effective health promotion interventions, all things being equal, uptake of health services will increase, and health enhancing behaviours will be adopted (individual and community levels) leading to improvement in health indicators. Multiple approaches will be adopted for the Strategy including health promotion efforts directed toward priority health conditions involving a large population and promoting multiple interventions. This issue-based approach will be complemented by settings-based designs. The settings-based designs can be implemented in schools, workplaces, markets, residential areas, etc. to address priority health problems by taking into account the complex health determinants such as behaviors, cultural beliefs, practices, etc. that operate in the places people live and work.

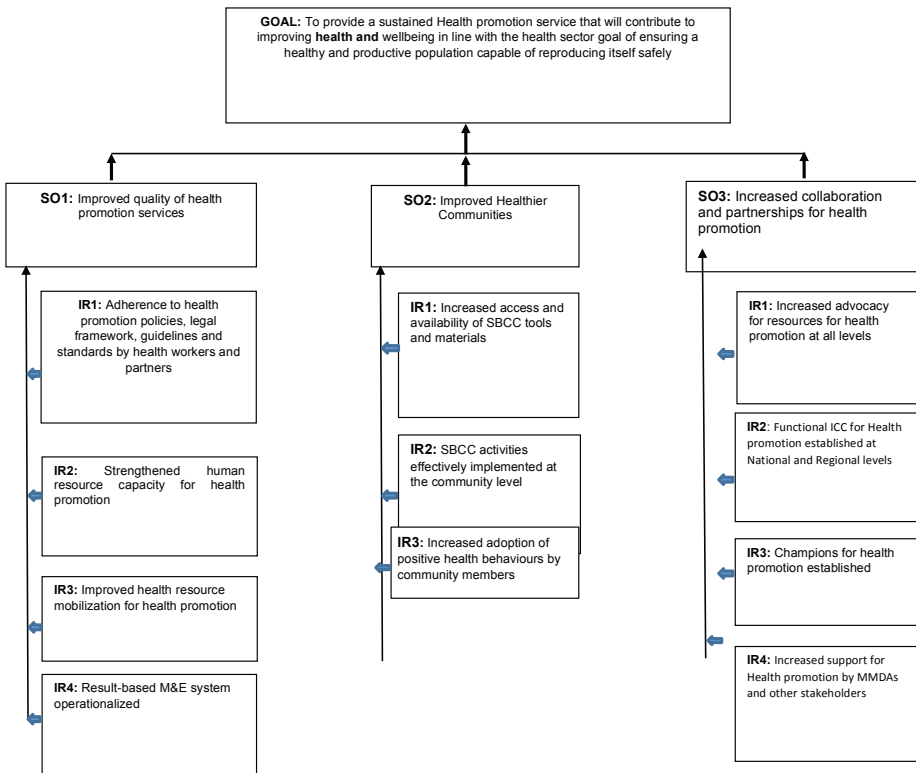
## 3.2 Goal, Strategic Objectives, Intermediate Results and Indicators

### The Goal

To provide a sustained Health promotion service that will contribute to improving health and wellbeing in line with the health sector goal of ensuring a healthy and productive population capable of reproducing itself safely.

Three Strategic Objectives and corresponding Intermediate Result areas have been proposed to achieve the goal as per the Results Framework. (Figure 2)

Figure 2: Results Framework for HP Strategy





## **Strategic Objective (SO) 1: Improving quality of health promotion services**

### **Outcome Indicator for SO1**

Percentage of clients satisfied with health promotion services

### **Intermediate Result (IR) areas for SO1:**

- IR1: Adherence to health promotion policies, legal framework, guidelines and standards by health workers and partners.
- IR2: Strengthened human resource capacity for health promotion
- IR3: Improved health resource mobilization for health promotion

### **Output Indicators for SO1**

- Number of Health Promotion documents developed.
- Proportion of Health Promotion Officers receiving Continuous Professional Development (CPD).
- Proportion of health promotion personnel/focal persons trained on HP protocols and guidelines

## **SO2: Improved Healthier Communities**

### **Some outcome indicators**

- Percentage of districts designated as “healthy” as per the national best health promoting district award criteria.
- Proportion of youth with adequate knowledge about healthy lifestyles (exercise, diet, non-smoking etc.)
- Percentage of community members practising desired health behaviours

### **Intermediate Results areas for SO2**

- IR1: Increased access and availability of SBCC tools and materials
- IR2: SBCC activities effectively implemented at the community level
- IR3: Increased adoption of positive health behaviours by community members

### **Output Indicators for SO2**

- Number of media houses engaged to undertake health promotion activities
- Number of programmes and messages aired by media houses.
- Number of target audience reached with SBCC activities

## **SO3: Increased collaboration and partnerships for health promotion**

### **Outcome Indicator for SO3**

- The number of HP events/ programs jointly held with partners
- Number of functional district health committees

### **Intermediate Result Areas for SO3**

- IR1: Increased advocacy for resources for health promotion at all levels
- IR2: Functional ICC for Health promotion established at National and Regional levels
- IR3: Champions for health promotion established
- IR4: Increased support for Health promotion by Metropolitan Municipal and District Assemblies (MMDAs) and other stakeholders

### **Output Indicators for SO3**

- Number of advocacy sessions held with key decision-makers and partners
- Number of ICC-HP meetings held
- Proportion of recommendations implemented as planned by the ICC-HP
- Number of Health Promotion Champions (HPC) identified
- Number of active Health Promotion Champions (HPC)
- Proportion of activities in the action plan implemented by HPC

# Chapter Four: Strategies and Key Activities

## 4.1 Proposed Strategies

Based on the Strategic Objectives and IRS, a number of strategies and key activities are proposed using a modified WHO Health Systems approach [WPRO 2015]

The proposed Strategies are:

1. Improving policy, legal framework, and guidance for health promotion
2. Strengthening capacity/human resources for health promotion
3. Strengthening advocacy, social and behavioural change communication and social mobilization
4. Strengthening partnership, coordinating mechanisms and governance for health promotion
5. Improving health financing for health promotion
6. Improving supervision, monitoring and evaluation, and health management information for health promotion
7. Undertaking research to support delivery of health promotion interventions

## Strategies and Key Activities

### 4.1.1 STRATEGY ONE: Improving Policy, Legal Framework, and Guidance for Health Promotion

All important policies, legal framework, and guidelines required for effective health promotion in Ghana will be developed as appropriate for adherence. In line with this the draft health promotion policy will be

finalised. Specifically, guidelines on the following, among others, will be developed and printed:

- material development and usage for health promotion;
- media and advertising;
- community-based/schools and workplace health promotion and communication;
- gender mainstreaming
- assessment of healthy public policies and projects, and
- advocacy, lobbying and networking .

The new draft National HP Policy is designed to support a national shift toward a vision of health promotion that addresses the social determinants of health and engages government, community, and the private sector. Addressing the broader determinants of health involves engaging various stakeholders, most of which are beyond the traditional health sector and requires a voice at the strategic management level with clout to engage them at their level. A Deputy Director status, as currently in place, does not provide such clout and authority for such important cross-cutting engagements. In furtherance to this vision, it is proposed the GHS Council should establish a strong Health Promotion Division manned by skilled, knowledgeable and motivated staff who will provide the momentum to achieve the nation's health objectives and help Ghanaians realize optimal health outcomes. The Division will be headed by a Director and supported by a number of Deputy Directors. Ultimately it is proposed to establish a National Health Promotion Council with legal backing.

### **Key Activities**

- 1.1. Finalize the draft national health promotion policy
- 1.2. Develop guidelines on materials development and usage for health promotion
- 1.3. Develop guidelines on media and advertising
- 1.4. Develop guidelines for community-based/schools and workplace health promotion and communication
- 1.5. Develop guidelines for assessment of healthy public policies and projects

- 1.6 Develop guidelines for advocacy, lobbying and networking
- 1.7 Develop guidelines for gender mainstreaming
- 1.8 Print copies of various guidelines, health promotion policy and health promotion strategy
- 1.9 Advocate for elevation of HPD to Divisional status
- 1.10 Advocate for the creation of National Health Promotion Council ultimately
- 1.11 Advocate for legislating Employee Wellbeing Programme into national labour laws
- 1.12 Develop an implementation plan with targets for the implementation of the Strategy

#### **4.1.2: STRATEGY TWO: Strengthening Capacity/ Human Resources for Health Promotion**

This strategy will be in three parts: repositioning and rebranding HPD; providing various capacity building support to HPD at all levels; other Human Resource (HR) strengthening initiatives to enhance HP.

##### **4.1.2.1: Strengthen institutional leadership, repositioning and rebranding of HPD**

The key objective for the rebranding and repositioning of HPD is to create an institutional vision and identity that projects the Department as a preferred communication partner inside and outside GHS. People and institutions have to take the Department seriously by recognising its potential and capacity to deliver, with ability to assume leadership position in all matters related to Health Promotion in Ghana, and capable of collaborating with and coordinating activities of relevant partners to enhance health promotion in the country. In other words, the HPD should be recognised as a national health communication resource in terms of talent pool as well as accessibility to health promotion materials and tools.

To achieve these objectives, a key step is to create an institutional buy-in into the new holistic vision of Health Promotion, and the need for the rebranding among staff of HPD. Furthermore, the profile and visibility of HPD within the GHS and outside has to increase by encouraging them to

be proactive, represented, and engaged in relevant internal activities and national planning and programming structures of MOH and GHS. This also requires building leadership and capacity at HPD as well as working on changing work ethic and attitudes. The core values of GHS (professionalism, people centredness, honesty, accountability, excellence and team work) have to be internalized by the staff. Senior staff of both MOH and GHS have also to buy into and support the new vision and strategy through advocacy and networking.

The strategy for rebranding will include co-locating with C4H team at the premise of HPD at national level, to facilitate the application of an effective and efficient form of institutional and individual capacity building. Regular combined staff meetings, collaborative work planning, and implementation of joint activities will create an atmosphere of mutual trust and respect. As the project rolls out, C4H staff will support, coach, and problem-solve with their HPD counterparts, enabling them to take the lead in planning, implementing, and monitoring project activities.

### **Key Activities**

1. Sensitize HP staff and GHS/MOH to buy into the new HP Policy, Strategy and C4H project
2. Develop and implement HP rebranding strategy and action plan
3. Develop co-location Memorandum of Understanding (MOU) and implement it
4. Assess institutional and individual capacity for Health Promotion at all levels
5. Appoint specialist professionals for health promotion in specialized areas for the health promotion department
6. Appoint short term embedded officers in HPD for technical support
7. Provide for operational and administrative support for the health promotion department
8. Refurbish and upgrade the health promotion department building.
9. Provide essential equipment and logistics for HPD

#### 4.1.2.2 Capacity Building Support for Health Promotion

A number of capacity building initiatives and systems will be undertaken with support from partners, notably C4H. These will include:

- Change Agent Development (CAD) Programme: The programme involves one week development programme covering a range of technical areas and skills through taught lectures, use of case studies and practical group work. The CAD program is a layered learning approach that directly connects to participants' daily work at the regional and district levels.
- Set for Change (SfC) Learning sets: The Learning set will cover a limited number of Technical Officers-HP (TOSHHP) from the district level at a time that will meet four times for 1.5 days over a six month period. These sets will be facilitated by a qualified and experienced learning set facilitator and cover personal development and effectiveness, technical skills for problem solving and development of HP practice for TOSHHP in their new role. Six cohorts of "Set for Change" action learning sets will be organized spanning over Years 2, 3 and 4, with up to 10 participants in each cohort.
- On line courses in technical aspects of designing and conducting SBCC from Witwatersrand University, South Africa.
- Support to individuals in creating personal development plans and gaining access to free on line resources continuing professional development will be provided at the end of the *CAD programme* and the *Set for Change* learning sets using a standardized template together with the GHS HR Division.
- Gender integration trainings to improve technical competencies in creating gender sensitive programming and activities for national and regional staff.
- Stretch assignments for regional and district level staff to work at the national or regional level on a specific task or activity such as developing a campaign or the M&E framework.
- Stretch assignments for national and/or regional staff to work with C4H core partners (Ghana Community radio Network,

vOTO Mobile, Creative Storm) and contractors (Lowe Lintas) to learn elements of SBCC skills on the job.

- Peer Mentoring: Selected past participants of CAD and SfC will be asked to offer support and mentoring to their colleagues who have yet to have attended a development programme.
- Change Challenge Fund: A competitive performance-based grants will be instituted to allow recently trained change agents to conceive of, develop, and implement small-scale SBCC activities/campaigns at the district or regional level that are aligned with the overarching *Good Life* strategy.
- Post Training motivational support through mobile phone messages, prompts to act and reminders on behaviors and practices, refresher tips, quizzes and games to consolidate learning and reinforce the adoption of particular skills or actions on the job will be received by all CAD and SfC graduates.
- Sponsoring for international and national workshops, conferences and short courses for capacity building

Depending on additional funding and availability of facilitators it is expected that additional HP staff will benefit from the above capacity building initiatives at all levels.

## **Key Activities**

1. Develop and implement Change Agent Development Programme
2. Develop and implement “Set for Change” Action Learning Sets
3. Establish on line courses in technical aspects of designing and conducting SBCC
4. Establish Peer Mentoring system for HP staff
5. Establish and operationalize Change Challenge Fund
6. Establish and operationalize stretch assignment systems for national, regional and district levels
7. Develop and implement Post Training motivational support system



8. Sponsor HP staff to attend international and national workshops, conferences and short courses

#### **4.1.1.3 Other HR strengthening initiatives**

The job description and staffing norms for health promotion will be updated aligned to the current human resource strategy of MOH. In service and pre-service training will be provided for various categories of health staff (public and private; including community level workers and CSOs/NGOs) in the areas of manual and material development, community-based/schools and workplace health promotion, health impact assessment, health promotion M&E etc. Pre-service institutions will be supported to review their curricula to provide various post-training courses up to Masters level on various aspects of health promotion.

The capacity of the HPD will be further strengthened by setting up a printing press and an FM station in the long term. The printing press is supposed to cut cost of the excessive cost of contracting out the many printing jobs to external printers. The FM station is expected to provide a major platform and avenue for IEC messages and discussions to promote health.

#### **Key Activities**

1. Update job description and staffing norm for health promotion throughout the entire system with support of HRDD at MOH and GHS levels
2. Recruit additional staff for HPD
3. Provide structured in-service orientation for various categories of health staff (CHOs, PHNs, Disease Control Officers, CSOs etc) on health promotion
4. Support review and update of existing pre-service curricula of training institutions to cover new HP perspectives
5. Develop and implement a Continuing Professional Development (CPD) plan for health promotion staff with Certification and re-certification of health promotion officers

### **4.1.3 STRATEGY THREE: Strengthen Advocacy, Social and Behavioural Change Communication and Social Mobilization**

As already noted, promotion of health is the responsibility of all stakeholders, most of which are not under the purview of MOH/GHS. They however play major roles in promotion of health and therefore a number of advocacy initiatives will be undertaken targeting all these group of stakeholders: Ministries Departments and Agencies (MDAs); Metropolitan, Municipal and District Assemblies (MMDAs); media, CSOs/NGOs, keep-fit clubs as well as the community to ensure that they play their various roles in promoting health. An advocacy, social behavioural change communication and social mobilisation strategy will therefore be developed and implemented at all levels, to include people with special needs such as visually impaired and physically challenged.

To improve behavior change a massive SBCC and social mobilization interventions will be pursued together with relevant partners at all levels. In collaboration specifically with C4H there will be a focus on the delivery of a “Good Life, Live it Well” campaign as an integrated umbrella SBCC campaign promoting social norms and behavior change. There will be inventory and review of the current Good Life, Live it Well materials and update and refresh the campaign, solicit new public and private collaborators, and roll it out to a national audience. With support of C4H, HPD will work with creative firms (such as Lowe Lintas) to lead the development of creative re-design, refreshing, and repositioning of the overall Good Life brand using life stages approach; Facilitate integrated health campaign development; and Support campaign rollout and scale-up at national, regional, district, and community levels using multiple media strategies.

Employee Wellbeing Programmes (EWPs) will be promoted in all institutions and advocacy will be undertaken to provide legal backing for EWP as part of the national labour law. Links will be made with existing EWP committee supported by GIZ to strengthen the partnership.

#### **Key Activities**

1. Review and inventory all existing SBCC materials
2. Develop creative brief for refreshing and repositioning Good Life, Live it Well brand
3. Develop creative designs

4. Develop key messages
5. Print SBCC materials
6. Launch the refreshed brand
7. Undertake SBCC campaigns using multiple channels
8. Support community groups such as women's groups, other significant groups for empowerment of women, men and families, for health education, for early recognition and timely care seeking among others
9. Promote Community Mobilization
10. Appoint and support national and regional level HP champions
11. Celebrate national and international health promotion events/ days linked to specific health conditions or programmes
12. Organise monthly, quarterly and Yearly health promotion press briefings
13. Support community health officers to undertake health promotion activities as part of CHPS programme
14. Promote appropriate rewards such as certificates of recognition and awards for well performing centers/groups/health workers
15. Design models for healthy settings (including criteria for selection) and operationalize a yearly award for best HP (districts, communities, schools, health facilities and work places)
16. Institutionalize Employee Well-being Programme (EWP) in workplaces
17. Institutionalize annual checkup of all staff of MOH/GHS

#### **4.1.4 STRATEGY FOUR: Strengthen Partnership, Coordinating Mechanisms and Governance for Health Promotion.**

As has been noted earlier, health is determined not only by the provision of medical care or health services but also by economic, social, political and environmental variables in the communities in which people live. The complexity of health under this concept make it clear that no single ministry, agency or sector has all the requisite resources, skills and even

authority to prosecute all the interventions required to improve health. Hence there is the need to foster partnership among various stakeholders to improve health. Unfortunately, in Ghana, the practice of health promotion has been fragmented over the years with no systematic effort to coordinate and harness the resources of all stakeholders in health promotion. This has led to multiplicity of HP actions by different stakeholders resulting in duplication of effort, inefficient use of scarce resources and conflicting messaging on health issues due to lack of communication among various stakeholders. There is therefore the need to re-fresh the existing ICC-HP, review its composition and structure and give it an updated mandate to harness and coordinate the collective resources of all stakeholders to achieve the goal of the National Health Promotion Strategy. Ultimately, the ICC-HP may be transformed into a National Council for HP through an Act of parliament.

### **Key Activities**

1. Review TOR and membership of the ICC-HP at national and regional levels
2. Support quarterly meetings of the ICC-HP at national and regional levels
3. Support other activities of ICC-HP as per its TOR

#### **4.1.5 STRATEGY FIVE: Improving Health Financing for Health Promotion**

Funding for implementing health promotion activities as envisaged in the National HP Policy and Strategy is crucial. A number of initiatives are therefore proposed to ensure effective funding. These will include carrying out advocacy activities for increased allocation of funds with various stakeholders, (Ministry of Finance, MOH and GHS managers at all levels, Donors etc), developing and implementing Health Promotion resource mobilization strategy, developing proposals for funding Health Promotion activities. Extractive industries, TELECOMS, irrigation schemes authorities and other relevant stakeholders will be engaged to leverage funds for health promotion as part of their social/corporate responsibility. The NHIA will be lobbied for direct funding support for health promotion activities by GHS.

## **Key Activities**

1. Develop and implement an efficient Health Promotion resource mobilization strategy
2. Carry out advocacy activities for increased allocation of funds for Health Promotion.
3. Develop proposals for funding Health Promotion activities
4. Advocate for direct funding support from NHIA for health promotion

### **4.1.6 STRATEGY SIX: Improving Supervision, Monitoring and Evaluation, and Health Management Information for Health Promotion**

Monitoring and Evaluation form part of components for effective implementation of the National HP Strategy. They will be integrated into existing M&E frameworks of the health system, including DHIMS2. A Performance Monitoring and Evaluation Plan (PMEP) will be developed to measure, analyze, interpret, disseminate, and report on activities and outcomes of the HP Strategy to ensure effective implementation and achievement of results. A record of evidence-based progress, results, and lessons learned will be provided for informed decision-making. An indicator table that specifies indicators, baselines and benchmarks, data sources, data collection methods, and annual and end of term targets will be developed.

The resource centre of HPD will be made functional to provide useful and up-to-date information on issues promoting health, including latest research materials and databases. This will ultimately lead to an integrated electronic health promotion information system to be based in the resource centre. Key health information indicators for reporting routinely or otherwise will be updated and linked to DHIMS2. Adapted tools for collection of health information data will be operationalized through monthly and quarterly reporting through DHIMS2. Half yearly and annual performance reviews will be organized at national and regional levels. Mid-term and end-term reviews of the Strategic Plan will be undertaken as part of M&E framework.

See Annex 2 for the M&E Framework and indicator table for measuring the progress and performance of the National Health Promotion strategy.

A number of initiatives will be undertaken to improve quality of health promotion services provided. Supervisory support visits will be undertaken quarterly to lower levels.

## **Key Activities**

1. Develop performance health promotion M&E guidelines and Plan
2. Develop key indicators and targets for M&E for health promotion
3. Adapt tools for data collection and reporting
4. Update HMIS / DHIMS2 to include key Health Promotion indicators
5. Operationalize use of adapted data collection tools (electronic and hard copies as applicable)
6. Support data validation and analysis meetings for improving quality at all levels. (Monthly, quarterly, and annual meetings)
7. Undertake half-yearly and annual health promotion performance reviews
8. Undertake regional level half-yearly and annual health promotion performance reviews
9. Link up with partners such as VOTO to undertake periodic and continuous monitoring of media health promotion messages
10. Undertake midterm and end term evaluation
11. Develop Supervisory tools including checklists
12. Undertake quarterly supportive supervisory visits
13. Make the resource centre functional (to include an integrated electronic health promotion information system to be based in the resource centre)

#### **4.1.7 STRATEGY SEVEN: Undertaking Research to support delivery of Health Promotion Interventions**

There is the need to undertake operational research as part of the Strategy. We need evidence:

- to identify the best possible ways to promote health;
- to make decisions for policy development and funding allocation;
- to demonstrate to decision makers that health promotion works and is an effective strategy in public health;
- to support practitioners in project development and evaluation;
- to show the wider community the benefits of health promotion actions; and
- to advocate for health promotion development [**C4H Project proposal to USAID**]

Research on health promotion interventions and other health-related areas will be promoted in collaboration with relevant stakeholders such as NGOs, academia and donor community. A baseline national health promotion survey will be undertaken to provide current information on the status of health promotion and actors in the country. Operational research will be promoted and all HP concepts will be evidence – based and supported by field research.

#### **Key Activities**

1. Conduct baseline survey on critical health promotion indicators
2. Undertake various operational research on health promotion
3. Support HP research by key stakeholders

#### **4.2 Implementation Arrangement, Management Approaches, Gender Integration**

The implementation of the National HP Strategy and Action Plan will be the responsibility of all stakeholders (public and private) at all levels. However, the Health Promotion Department of Family Health Division will be directly responsible for its implementation on behalf of the Ghana Health

Service under the overall coordination of the ICC-HP. The Deputy Director HP will be the overall coordinator of the Strategic Plan. Implementation at the regions and districts will follow existing structures. Regional and District HP officers will coordinate and monitor the implementation of the Strategy on behalf of the respective Regional Health Management Teams (RHMTs) and District Health Management Teams (DHMTs).

A range of channels will be used to provide opportunities for scaling up and reaching large population segments. Community-based delivery platforms will be used for scaling up coverage of interventions, and strategies that have the potential to reach poor and difficult to access populations will be promoted.

Implementation will be based on multi-stakeholder approach including community involvement. Gender inequities will also be addressed.

Groups of inter-related activities, such as development of guidelines and training manuals will be contracted to one technical task team with specified terms of reference. Similarly, the review and development of SBCC materials will be contracted out to specific agencies. Other task teams will be made responsible for advocacy and resource mobilization activities under the guidance of the ICC-HP.

Input, process and output indicators will be monitored as described under the M&E framework on a continuous basis at all levels to form the basis for addressing emerging challenges.

## **Gender**

Gender transformative approaches will be used to examine, question, and change rigid gender norms and the imbalance of power that affect both men and women's health behaviour. Gender integration will be pursued to assess the implications for women, men, boys and girls of any of the planned activities and policies on HP to ensure that both women's and men's concerns and experiences are an integral part of the design, implementation, monitoring and evaluation. The goal is to achieve gender equality and gender transformation. Hence, every effort will be made to intentionally recognize and respond to the unique needs of youth, women, men, boys, girls and key populations at every stage of life [Source: C4H project unpublished].



# Chapter Five: Estimated Cost of the Plan

## 5.1. Estimated Project Cost

The estimated total cost of the plan is GHC 11,391,365. The estimate is based on current projections. Provision should therefore be made for changes in market prices at the time of implementation. It is also important to continuously review all project schedules to ensure that priorities are reset as necessary to capitalise on new opportunities for cost-effectiveness and cost savings. The estimated costs are distributed as shown in Table 1 which is derived from the plan implementation matrix.

**Table 1: Summary of Estimated Costs of the Plan**

#	THEMATIC AREA	2015 (GHS)	2016 (GHS)	2017 (GHS)	2018 (GHS)	2019 (GHS)	ESTIMATED TOTAL (GHS)
0	PRE-IMPLEMENTATION ACTIVITIES	100,000	0	0	0	0	100,000
1	DEVELOP/UPDATE POLICIES, GUIDELINES, STANDARDS AND COORDINATING MECHANISMS TO SUPPORT HEALTH PROMOTION ACTIVITIES.	444,677	265,843	133,080	114,360	131,080	1,089,040
2	HEALTH FINANCING	49,500	94,692	265,769	94,692	187,000	691,653
3	PROCUREMENT AND MAINTENANCE OF ESSENTIAL MEDICAL DEVICES AND COMMODITIES FOR HEALTH PROMOTION	1,800,000	0	0	0	0	1,800,000
4	CAPACITY BUILDING/HUMAN RESOURCES	65,000	1,710,000	68,800	171,000	10,000	2,024,800
5	SUPPORTIVE SUPERVISION / METHODS TO MAINTAIN AND FURTHER IMPROVE QUALITY OF HEALTH PROMOTION SERVICE	118,800	118,800	80,000	158,573	138,800	614,973
6	STRATEGIES FOR ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION (ACSM) AND OTHER COMMUNITY BASED INTERVENTIONS	398,000	398,000	398,000	433,000	398,000	2,025,000
7	MONITORING AND EVALUATION FRAMEWORK	326,250	365,000	305,000	305,000	305,000	1,606,250
8	RESEARCH/PILOTS	50,000	35,000	1,290,649	24,000	40,000	1,439,649
	ESTIMATED TOTAL COSTS	3,352,227	2,987,335	2,541,298	1,300,625	1,209,880	11,391,365

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# Annexes

## Annex 1: Bottleneck Analysis and Proposed Solutions to strengthen Health Promotion in Ghana

Tracer Intervention	Identified Bottlenecks	Strategies and solutions to address identified challenges and bottlenecks
1. Leadership, Governance & Policy	1. Little priority is given to health promotion. Health promotion is not properly and adequately defined in the National Health Strategy (2007-2011)	1.1.1 Advocate for adequate inclusion of health promotion in the current Health Strategy (2014-2017)
		1.1.2 Make inputs into the development of strategic plans at the MoH and GHS levels
	2. Lack of awareness about National Health Strategy among Health Promotion Officers and other health staff	1.1.2 Adequately disseminate and orient health staff on national health policy, MoH and GHS strategic documents (especially. National Health Promotion Policy, Health Promotion Strategic Plan)
	3. National situational analysis of health promotion not done, including SWOT analysis at the community level	1.1.3 Undertake situational assessment of the state of health promotion in Ghana in 2014
	4. There are no targets for Health promotion. No targets and indicators for monitoring and reporting on health promotion	1.1.4 Include targets and indicators in the health promotion strategic plan (2014-2018)

	5. The National Health Policy (2007) does not address leading challenges to Health Promotion in Ghana	1.1.5 Linked to 1.1.1
	6. The current organizational structure which places health promotion as a department under family health division makes it challenging to address the broader Health promotion issues and play cross-cutting roles and functional operations as envisaged in the health promotion policy	1.1.6 Advocate for the establishment of Health Promotion Division in the Ghana Health Service
	7. Lack of institutional backing for the regulation of health promotion in its broader scope in the country	1.1.7 Advocate for the creation of National Health Promotion Council
		11.7 .2 Advocate for National Champion for Health Promotion
	8. The current ICC-HP is not adequately represented and it is not functioning effectively. The coordinating mechanism for Health Promotion (ICC-HP) does not meet regularly	1.1.8 Review the ToR of the ICC-HP to expand its representation
	9. The revised health promotion policy (2013) is not finalized and adopted yet	1.1.9 Finalize and initiate the process for the adoption and dissemination of the New Health Promotion Policy (2013)
2. Health Financing	1. Inadequate funding to support HP interventions	2.1.1 Develop and implement Health Promotion resource mobilization strategy
		2.1.1.1 Develop proposals for funding Health Promotion activities

	2. Unpredictable and late release of GoG funds	2.1.2 Engage GHS/PPMED and MoH for increase in budgetary allocation and timely release of GoG funding to support Health Promotion activities
	3. Over dependence on external funding (About 98% of funding come from external sources (UNICEF, USAID, WHO, BCS/ USAID))	2.1.3 linked to 2.1.1
	4. No strategy for resource mobilization for health promotion	2.1.4 linked to 2.1.2
	5. Diverse and un-coordinated funding for HP interventions embedded in various programmes	2.1.5 ICC_HP to effectively coordinate diverse and embedded programmatic funding for health promotion as part of ToR
	6. Poor governance arrangement between MOH, GHS and Better Ghana Management Services Ltd (BGMSL) impacting negatively on funding allocation for health promotion especially in relation to funding from NHIA	2.1.6 Advocate for direct funding support from NHIA for health promotion by GHS
	7. Uncoordinated implementation of health promotion interventions between the MoH and GHS (E.g. Ministry involvement of direct implementation of interventions at the lower levels )	2.1.7 Advocate for the closer collaboration between MoH and GHS for implementation of health promotion activities (HPD to be proactive in engaging with MoH)

3. Health Work Force	1. There is the absence of staffing norms for health promotion staff	3.1.1 Develop a staffing norm for health promotion throughout the entire system (This should be aligned to the current human resource strategy)
	2. Inadequate training of health promotion staff	3.1.2 Advocate for increase production of health promotion staff of various categories at various levels
	3. Inadequate quality of health promotion staff being produced by the training institutions (Challenging issues of accreditations and adequacy of the curriculum of training institutions in Ghana)	3.1.3 Advocate for the revision of accreditation, certification and curriculum for health promotion training institutions in Ghana
	4. There is no in-service training plan for health promotion Officers. No plan for CPD, certification and re-certification for health promotion officers	3.1.4.1 Develop and implement in-service training plan for health promotion officers
		3.1.4.2 Develop and implement a CPD plan for health promotion staff
		3.1.4.3 Certification and re-certification of health promotion officers to be an integral part of the ToR for the Council (Linked to 1.1.7)
	5. Only 42 out of the 216 districts have Health Promotion Officers	3.1.5 linked to 3.1.2
	6. Inadequate and out-dated guidelines, manuals and tools for health promotion	3.1.6 Review existing guidelines, manuals and tools for health promotion



	7. Inadequate capacity for health promotion for various categories of health staff (e.g. CHOs)	3.1.7 Build capacity in health promotion for various categories of health staff
4. Essential Equipment, Materials & Technologies	1. Inadequate essential equipment and materials for health promotion	4.1.1.1 Develop the list and specification of needed commodities, equipment and materials for health promotion
		4.1.1.2 Develop a procurement plan for health promotion
5. Health Service Delivery	1. Un-coordinated production of health promotion materials and messages	5.1 Establish a clearing house for all health promotion materials and messages
	2. Irregular and inadequate monitoring and supervision of health promotion activities at all levels	5.2 Strengthen monitoring and supervision of health promotion activities at all levels
	3. Inadequate use of CHPS potentials for undertaking of health promotion activities	5.3 .1 Advocate for scale up of health promotion activities at the CHPS level
		5.3.2 Build capacity of staff at the CHPS level to undertake health promotion activities
	4. Missed opportunities by health staff to embark on health promotion activities (e.g. at OPD)	5.4 Linked to 1.1.3
6. Health Information Systems	1. No indicators for monitoring and reporting on health promotion	6.1 Develop indicators for monitoring and reporting in the Health Promotion Strategy (2014-2018)
	2. The DHIMS does not capture Health Promotion indicators as at yet.	6.2 Engage PPMED/IME to capture health promotion indicators in DHIMS

	3. There is no health promotion data from NGOs, Donor projects and private sector	6.3 Use the potential of ICC_HP to engage stakeholders in reporting on health promotion activities
	4. Non-functional health promotion resource centre	6.4 Refurbish and upgrade the health promotion resource centre
7. Community Ownership & Partnership	1. There is no elaborate guidelines for community empowerment	7.1 Develop a comprehensive community empowerment guideline
	2. There is high cost of engagement of media in health promotion activities	7.2 Continuous and sustained advocacy and engagement with media
	3. Low stakeholder involvement at district and community levels	7.3.1 Strengthen engagement with district assembles and community/traditional authorities and other local stakeholders
		7.3.2 Advocate for strengthening of the District Health Committee
	4. Inappropriate community perceptions, attitudes, social norms, beliefs, practices	7.4.1 Undertake BSCC activities at all levels
	5. Waning spirit of volunteerism due to unequal incentive systems	7.5.1 Advocate for better harmonization and coordination of incentive packages
	6. Community apathy and ownership for self-help health promotion activities	7.6.1 Intensify community engagement

**Annex 2: Draft Indicator table for Monitoring and Evaluating the National Health Promotion Strategy (Source: C4H Project)**

CATEGORY	INDICATOR	DISAGGREGATIONS	DEFINITION	REPORTING FREQUENCY	SYSTEMS FOR DATA COLLECTION
SO1: Improved quality of health promotion services	Percentage of clients satisfied with health promotion services	<p><b>Type of client:</b> Community members, internal GHS programmes</p> <p><b>Type of service:</b> Material development, training, advisory service, event organisation</p>	Number of clients (internal and external) who are satisfied with the services provided by health promotion	Half year, Annual	Survey
IR1: Adherence to health promotion policies, legal framework, guidelines and standards by health workers and partners	Number of Health Promotion documents developed.	<p>status and type</p> <p><b>Type:</b> Policy, legal framework, guidelines, SOP, other</p> <p><b>Status:</b> drafted, reviewed, approved, launched, in-use by stakeholders</p>	Health Promotion documents developed e.g. Guidelines on material development and usage, media, advertising, policy on advocacy lobbying and networking, resource mobilization plan/ strategy and IE&C materials.	Half year, Annual	Facility (Head Quarters) Survey

<p><b>IR2:</b> Strengthened human resource capacity for health promotion</p>	<p>Proportion of trainings conducted by HPU</p>	<p>Partner, program, region, district</p>	<p><b>NOTE:</b>  <b>Short term training</b> should be &lt;1month  <b>Long term training</b> should be &gt; 1 month  <b>Training for Continuous Professional Development (CPD)</b> should be influenced by training needs assessment of the individual  <b>Category:</b> Volunteers, CBS, HP Focal persons, Committee members, others  <b>Program</b> E.g. Health, ICT, SBCC, etc.  <b>Partners:</b> E.g. Communicate for Health, UNICEF, Evaluate for Health, etc.  <b>Type:</b> Formal (Specialized), Informal (On the job training, Internship, on the job shadow), online training, etc.</p>	<p>Annual, As per new guidelines and protocols developed</p>	
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	Proportion of Health Promotion Officers receiving Continuous Professional Development (CPD).	Region, sex, units (material development, healthy life styles. etc.)		Quarterly	Routine
	Number of trainings received	region, duration External, internal HP technical, other technical, non-technical e.g. managerial, leadership, etc		Quarterly	Routine
	Proportion of health promotion personnel/focal persons trained on HP protocols and guidelines	Partner, program , sex			

			partner, program, sex	Number of HP personnel practicing HP according standards and guidelines	Quarterly	Supervisory check list
Proportion of trained health promotion personnel complying with HP protocols and guidelines	Number of front-line health workers trained in the utilization of SBCC materials	By programmes Region, District, sub-districts Material type (print, audio and audio-visual)		Utilization refers to materials being used for their intended purpose Front-line health workers includes staff at the lowest level of health delivery (Community Health Nurses, Field Technician, Enrolled Nurses, community volunteers)		
	Number of HPOs at post	Region, sex		The number of HPOs engaged and posted	Monthly, quarterly, annual	Routine

<b>IR3:</b> Improved resource mobilization for health promotion	Number of proposals for funding health Promotion Activities submitted	funding source (and value (USD)), other resources	<b>Funding Sources:</b> NHIA, Development Partners (USAID, DFID, UNICEF, etc.), MMDAs, others	quarterly	Routine
	Proportion of resources budgeted by GHS for Health Promotion activities	GHS Budget, health promotion budget	Proportion of resources refers to GHS budget allocation for HPD out of the total GHS budget	Annual	Supervisory Check list
	Proportion of resources received for Health Promotion Activities	Value, Source, Type of resource	All forms of resources (monetary value or in-kind support, material e.g. equipment) received for HP activities from all sources	Monthly, quarterly, annually	Supervisory Check list
<b>IR4:</b> Result-based M&E system operationalized	Number of meetings organised to review HPD performance indicators	Level of implementation (National, regional, districts)	Number of meetings organised to specifically assess HPD performance	bi-annually	Routine

	Number of verification and validation meetings of HPD data	Level of implementation (National, regional and districts)	Number of meetings held to verify and validate data.	quarterly	Routine
	Number of monitoring/ supervisory visits conducted	Level of implementation (National, Region, districts)	Monitoring/ supervisory visits should include the following activities – adherence of SOPs, protocols, guidelines, and compliance to campaigns and its programmatic implications in the field (this includes regional, district, community, etc.)	Quarterly	Routine



	Number of evaluations conducted by HPD for key health behaviours.	Programmes and type of evaluation, Half and annual review Region, district	Type of programme: 1. CH/ EPI 2. FP 3. Malaria 4. Safe Motehrhood 5. Nutrition 6. TB 7. HIV 8. NCDs 9. NTDs	Quarterly, half year, annual	Desk review
SO2: Improved Healthier Communities	Percentage of districts designated as healthy as per the best health promoting district award criteria	District	A district is designated as healthy if the district scores above 50% as per the health promoting district award criteria	annual	best health promoting district assessment check list

<p><b>IR1:</b> Increased access and availability of SBCC tools and materials</p>	<p>Number of SBCC materials developed and disseminated</p>	<p>Region, District, sub-districts, Material type (print, audio and audio-visual)</p>	<p>SBCC materials developed at the Headquarters level or any level with support from HPD (National). Dissemination refers to training and the distribution of material for their intended purpose</p>	<p>Quarterly, annual</p>	<p>Supervisory check list</p>
	<p>Proportion of SBCC materials used</p>	<p>By programmes Region, District, sub-districts Material type (print, audio and audio-visual)</p>	<p>Utilization refers to materials being used for their intended purpose</p>	<p>Quarterly</p>	<p>Supervisory check list</p>
	<p>Number of SBCC resource centres (e.g. library, electronic catalogue, portal) established</p>	<p>National, Region, Type: Old, new</p>	<p>SBCC resource centre refers to a repository of electronic and print materials on health where people can easily have access to. Examples of SBCC resource centre include section of a regional library, cabinet in the RHD, approved HPD online library.</p>	<p>Annual</p>	<p>Regional report</p>

<p><b>IR2:</b> SBCC activities effectively implemented at the community level</p>	<p>Number of media houses engaged to undertake health promotion activities</p>	<p>Region, District, type of media house</p>	<p>The number of media houses (TV, Print, radio, social media) contacted (contracted, agreement reached) by HPD to air health promotion messages</p>	<p>Monthly, quarterly, annual</p>	<p>Routine</p>
	<p>Number of programmes and messages aired by media houses.</p>	<p>Media houses, print, electronic, health program</p>	<p>The number of health messages/ programmes being aired on media platforms Health program: EPI, Nutrition, MH, etc.</p>	<p>Monthly, quarterly, annual</p>	<p>Routine</p>

	<p>Number of target audience reached with SBCC activities</p>	<p>Channel (durbars, radio discussions, Home visits, IPC, facility activities, social media channels), target audience (adolescent, mothers with children under 5, etc.), sex, etc.  <b>Programmes:</b> FP, NUT, Maternal Health, Malaria, healthy life styles, etc.  Regions, Districts, Sub-districts <b>Audience</b> pregnant women, school children, adolescent, community members</p>	<p>The number of participants (primary, secondary, tertiary) who were reached by messages on health issues.  NOTE:  Primary participant groups refers to immediate beneficiary groups e.g. pregnant women, children &lt; 5, etc.  Secondary participant groups refers to those who influence the decision on the primary participant groups, e.g. husbands, wives, mothers, etc.  Tertiary participant groups refers policy or decision makers at the community level (traditional and religious leaders, other opinion leaders, etc.)</p>	<p>Monthly, quarterly, annual</p>	<p>Survey</p>
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<p>IR 3: Increased adoption of positive health behaviour by community members</p>	<p>Percentage of community members practising desired health behaviours</p>	<p>Type of behaviours:  1. CH (ORS and Zinc for diarrhoea, new born care, CWC attendance, etc.)  2. Reproductive Health (skilled delivery, teenage pregnancy, etc)  3. Communicable diseases. Malaria (sleeping under LLINs, TTTs, IPT, etc.)  4. Nutrition (early initiation of breastfeeding, exclusive breastfeeding and complementary feeding)  5. Hygiene (handwashing with soap under running water, use of latrines)  6. NCDs</p>	<p>Desired health behaviours refers to sustained positive practises with respect to the health areas (CH, FP, MH, etc)</p>	<p>Monthly, quarterly, half year, annual</p>	<p>Routine, surveys</p>
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<p><b>SO3:</b> Increase collaboration, coordination and partnerships for health promotion</p>	<p>The number of HP events/ programs jointly held with partners</p>	<p>Type of partners (local – inter/ intra-partnership), international – intra, inter-partnership) Funding partners (UNICEF, USAID, WHO, GIZ), Implementing partners of projects (VOTO Mobile), Social marketing companies, VOTO Mobile Type of activity (meeting, monitoring and evaluations, training, campaigns, SBCC materials) etc.)</p>	<p>The number of health promotion events/ programs conducted with implementing partners</p>	<p>Quarterly</p>	<p>Routine</p>
<p><b>IR1:</b> Increased advocacy for health resources for health promotion at all levels</p>	<p>Number of advocacy sessions held with key decision-makers and partners</p>	<p>National, region</p>	<p>The number meetings held by ICC-4-HP with MOH, GHS Council, HRD, RHMT to support the provision of health promotion resources at all levels (national, regional, district)</p>	<p>Quarterly</p>	<p>Supervisory Check list</p>

	Number of functional district health committees	District	A functional health committee refers to a group of stakeholders who have an action plan and meet regularly to discuss health issues affecting their district	Quarterly	Supervisory visits
<b>IR2:</b> Functional ICC 4 health promotion established at national and regional levels	Number of functional ICC 4 health promotion established	National and Regional	Functional ICC refers to committees meeting at least once quarterly with evidence of implemented key recommendations during the period of measurement or assessment	Quarterly	Supervisory Check list
	Proportion of recommendations implemented per planned by the ICC4HP	National, Region	The number of recommendations implemented as against number planned		

<b>IR3:</b> Champions for health promotion established	Number of Health Promotion Champions (HPC) identified	National, Regional, Program	CHP refers to recognized people undertaking advocacy activities for health promotion which includes influential people, satisfied clients, etc.	Monthly, quarterly, annual	Routine
	Number of active Health Promotion Champions (HPC)		An active CHP is one who implements activities according to the TOR.	Monthly, quarterly, annual	Routine
	Proportion of activities in the action plan implemented by HPC		The number of completed activities as per TOR/ action plan	Monthly, quarterly, annual	Routine
<b>IR4:</b> Increased support for health promotion by MMDAs and other stakeholders	Proportion of resources allocated to the health system by MMDAs and other stakeholders	Type (this includes monetary value or in-kind support received) Source, Level (District)	Support received for HP activities from MMDAs and stakeholders (this includes monetary value or in-kind support received)	annual	supervisory visits