HEALTH, DEVELOPMENT AND ANTI MALARIA ASSOCIATION (HDAMA)

STRATEGIC PLAN

2023-2027

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal Care
ACSOs	Authority for Civil Society Organizations
AYSRH	Adolescent Youth Sexual and Reproductive Health
CCRDA	Consortium of Christian Relief and Development Associations
CSA	Central Statistical Agency
CSO	Civil Society Organization
EDHS	Ethiopian Demographic and Health Survey
FGC/FGM	Female Genital Cutting/Female Genital Mutilation
FP	Family Planning
HAPCO	HIV/AIDS Prevention and Control Office
HDA	Health Development Army
HDAMA	Health, Development and Anti-Malaria Association
IESO	Integrated Emergency Surgery and Obstetrics
HEW	Health Extension Workers
HEP	Health Extension Program
HIV	Human Immune Virus
HR	Human Resource
HRH	Human Resources for Health
HSTP	Health Sector Transformation Plan
ICT	Information and Communication Technology
IEC/BCC	Information, Education and Communication/Behavioral Change Communication
ITN	Insecticidal Treated Net
KM	Knowledge Management
LLIN	long-lasting insecticidal nets
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Developmental Goads
MoH	Ministry of Health
NCD	Non Communicable Disease
NGO	Non-Governmental Organizations
PNC	Postnatal Care
PwD	People With Disabilities
RH	Reproductive Health
RDT	Rapid Diagnostic Tests
ROI	Return on Investment
SBCC	Social Behavioral Change Communication
SGBV	Sexual and Gender Based Violence
SHG	Self Help Group
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Diseases
TVET	Technical and Vocational Education and Training

EXECUTIVE SUMMARY

The Health, Development and Anti Malaria Association (HDAMA) is an Ethiopian Residents' Charity, which was first established in 1998 to respond to the increasing problem of malaria and its high morbidity & mortality in Ethiopia. The organization has been officially registered as an indigenous NGO the following year, by the Ministry of Justice. Currently the organization has renewed license as an Ethiopian Resident Charity in accordance with the Charities and Societies Proclamation 621/2009 and Regulation 168/2009 by the Council of Ministers. During the last 24 years HDAMA has been implementing a range of health and development projects under its core strategic areas of intervention that saved lives, protected health and improved the living conditions of hundreds thousands of the needy population. The contribution and the record achievements of HDAMA are widely known by communities, the government, partners and the general public at large.

The organization designed a five years strategic plan for the period 2023-2027. This strategic plan serves as a strategic guidance on the options that HDAMA has laid out for the entire planning period. The development of this strategic plan document passed through participatory processes, reviews and consultations with staff and management of HDAMA as well as other stakeholders, relevant government offices and community based organization and target groups. Key strategic issues were identified from organizational effectiveness and efficiency and program development, implementation and results areas. The first sets of strategic issues which were seen from the organizational development, efficiency and effectiveness domain have brought core issues that need to be given a strong emphasis for HDAMA to continue to grow and become effective. The second sets of strategic issues were focused towards the core issues behind the organization's fundamental purpose, existing and persisting problems that have significant impact on the lives, livelihoods, health and wellbeing of the primary targets. Thus, this strategic plan has identified six broader areas for engagement in the five year period. These are organizational/institutional transformation; prevention and control of malaria and other communicable diseases; prevention and control of non-communicable diseases; adolescent, youth sexual and reproductive health (AYSRH) and enhancing livelihood opportunities for youth and women

HDAMA recognizes the central role of its members, volunteers, stakeholders, the community and staff in achieving this ambition over the coming five years. Monitoring and evaluation will be carried out based on the indicators developed subsequently. The major assumption in the strategic plan is that the socio-economic and political situation will remain conducive for the implementation of the objectives and strategies and also the availability of the financial resources estimated to be birr **249,261,041.90 (Birr Two hundred forty nine million two hundred sixty one thousand forty one and ninety cents) is** expected from the existing and future partnerships. By this investment HDAMA aspires to reach over 100,000,000 people in the proposed project areas. In its commitment to design and implement gender sensitive programs, proportion of women will be more than 50% and this will be ensured through a rigorous planning, monitoring and evaluation strategies.

1. EXPLANATION OF THE PROCESS, METHODOLOGY USED AND ACTIVITIES COMPLETED

The following steps were followed as a basic approach and processes in the course of developing the strategic plan. Major steps included initiation consultations; general discussions; document review; interviews and analysis of strengths, weaknesses, opportunities and threats; and assessment of national policies and strategies.

1.1. Initiation consultations

The initiation consultations were conducted with the key staff from program department and management teams. Main agenda of the consultation was deliberations on two major areas. The first is strategic issues and directions for the next five years and the second was the organization's branding policy and identity. The need for revisiting communication strategy and re-branding was considered as an entry point of the overall strategic planning process. The aim of dealing with the communication strategy and re-branding is to adopt a revised and contextually relevant communication strategy and branding policy that explicitly reveals organization's identity.

1.2. General Discussions

General discussion was conducted with the management of the organization led by the Executive Director, deputy executive director and other members. Management members were engaged in to the main subject matter focusing on the vision, mission and values of the organization. Management members discussed over whether the existing vision, mission and values could continue without alteration or could be revisited. The management eventually agreed that these components being fundamental elements of the organization need to be revisited in response to the current situation.

1.3. Document Review

Pertinent documents like previous strategic plan document; project proposals; reports; human resource manuals; and financial management manuals were gathered from the organization and carefully reviewed.

1.4. Interviews and Group Discussions

Interview with different persons was conducted. Internally, interview was conducted with the management, program staff and HDAMA board members. Externally, experts and officials from Amhara region bureaus and institutions; representatives from other agencies were interviewed. Views of beneficiaries and communities were also included through group discussions and interviews.

1.5. SWOT Analysis conducted

Organization's strengths, weaknesses, opportunities and threats were assessed during discussions with different groups and with HDAMA staff from regional coordination office and head office.

2. INTRODUCTION

2.1. Brief Overview of the Genesis and Evolution of the Organization

2.1.1. Genesis of the Organization

Health, Development and Anti Malaria Association, HDAMA, formerly known by the name "Anti Malaria Association, AMA)" was established in 1998. It was first established by Volunteers who were deeply concerned about the increasing problem of malaria caused high morbidity and mortality in Ethiopia, particularly in Amhara. The Association has been re-registered and accorded legal personality with Registry Number 0419 on May, 2019 as a local organization in accordance with Civil Society Organizations Proclamation No. 1113/2019. HDAMA was conceived and came in to existence in response to the deadly and horrific impact of malaria epidemic on the society. As a result, visionaries of the organization were inspired to fight against the malaria epidemic and prevent and control expansion of the epidemic. Hence, the organization adopted the first name, "Anti Malaria Association, (AMA)". The fundamental cause to adopt the name was because of the adverse impact of malaria on Ethiopians health, life and livelihood.

2.1.2. Evolution of the Organization

By ways of realizing its vision and accomplishing mission, in the last 24 years, HDAMA has been aggressively implementing a range of projects. Malaria prevention and control that saved lives, ensured health and improved the living conditions of the community has been one of the projects worth mentioning in relation to its very existence. Building on experience and lessons from past interventions, HDAMA diversified its program portfolio to including similar projects geared towards improving the life of the community. A project on food policy referred to as "Media Advocacy Campaign to Intensify Support for the Adoption of the Draft Unhealthy Food Control Proclamation in Ethiopia" was one of the flagship projects. Moreover, project on Tobacco Control which is referred to as "Media and communication campaign to increase awareness on the smoke-free provision and its effective implementation in public places in Addis Ababa" was also another project HDAMA embarked on since recently.

Started with the social mobilization and communication project on malaria prevention and control project executed in 480 Kebeles of 39 Weredas with the Global Fund round 8 supports in 2010/11 and continued until 2019 with other donors, HDAMA initiated different projects in various programmatic areas. That means, in the past 24 years, HDAMA has gained significant experience in

initiating and implementing development projects of the different types. In doing so, the organization developed solid and commendable experience which proved reliable reputations in development sector.

Table 1: Program Components

S/No.	Name of the Project/Program	Objective/Goal	Sector/sub-sector
1	Community Based Awareness Raising and Behavioral Change to Reduce Malaria Burden in Amhara National Regional State, Ethiopia Project	to enhance the impact and sustainability of the existing malaria communication efforts through advancing community's appropriate knowledge and health behavioral practices in 36 districts with emphasis given to the 6 main districts	Health/malaria prevention and control
2	Media communication for malaria elimination: TV and Radio spots development, production and transmission through notational media	To increase adoption of appropriate behavior and practices towards antimalarial interventions by households living in malaria endemic areas through key messages dissemination using national Medias.	Health/malaria prevention and control
3	Media Advocacy Campaign to Intensify Support for the Adoption of the Draft Unhealthy Food Control Proclamation in Ethiopia.	To build media capacity and generate media support at the national level that would enable an effective environment for policy advocacy by amplifying the message on the necessity of passing of Unhealthy diets control Proclamation.	Health/Food policy
4	Media and communication campaign to increase awareness on the smoke-free provision and its effective implementation in Addis Ababa City public places.	To promote smoke-free provisions and educating the general public, law enforcement authorities, and controlled companies about applicable laws and what is authorized and banned under them is a critical step toward full implementation.	Health/Tobacco control

3. COUNTRY CONTEXT AND ANALYSIS OF THE EXTERNAL ENVIRONMENT

3.1. Country Context

With its total area of 1,127,127 sq.m, Ethiopia is considered as the 27th largest country in the world. The government of Ethiopia is structured in the form of a federal parliamentary republic, where executive power is exercised by the government while legislative power is vested in the Parliament. The Federal Republic comprises of the Federal Government, the 11 autonomous Regional States (*Killils*) and two city administrations. Both the federal and regional governments are organized into three branches of government – legislative, executive, and judicial. The Federal legislative organ constitutes two houses (a bicameral parliamentary system): the House of People's Representatives (HPR) usually known as Lower chamber and the House of Federation (HoF), Upper chamber. The highest legislative authority is vested in the HPR whose members are elected by a plurality of votes cast in general elections every five years. The State Council is the highest organ of the state legislative authority.[1]

Ethiopia is the 2nd most populous country in Africa and ranked 13th in the world. The projected population for the year July 1, 2027 (period where this SP ends) was estimated to be 115,946,201 (58,074,006 male and 57,872,195 female). Urban population constitutes 29,311,431 (14,566,208 male and 14,745,223 female) which is 25.3% of the total population. On the other hand, rural population of the country was estimated to be 86,634,770 (43,507,798 male and 43,126,972 female) which is 74.7% of the country's total population.[2]



Figure 1: Map of Ethiopia

[1] Haradhan Kumar Mohajan. Ethiopia: A socio-economic study. Journal of Business Management and Administration Vol. 1(5), pp.59-74, November, 2013 http://www.peakjournals.org/sub-journals-JBMA.html ISSN: 2329-2954 ©2013 Peak Journals.

[2] FDRE. Central Statistical Agency. Population Projections for Ethiopia (2007-2037). Addis Ababa. July 2013

3.2. Situational Analysis and Review of the External Environment

3.2.1. Economic Growth and Challenges

Ethiopia made significant and continuous economic growth over the past decade. Achievement has also been witnessed in its commitments in the Millennium Developmental Goals (MDGs) completed in 2015 and striving to achieve some of the critical development indicators of the Sustainable Development Goals (SDGs). Ethiopia has seen the second fastest rate of reduction of poverty in Africa over the past 10 years with poverty headcount falling from 38.7 percent in 2005 to 29.6 percent in 2011[3]. However, despite the fastest and high economic growth and gains over the past, over the past ten years, sustaining the growth was remained a serious challenge. The major challenges were attributed to a number of factors.[4]

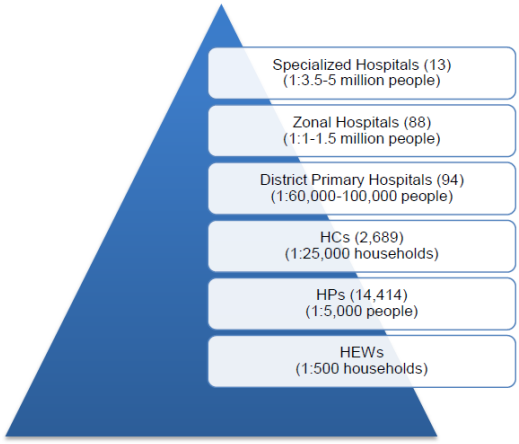
One is failure explained by gaps in the areas of creating adequate job opportunities, ensuring equitable distributions, ensuring structural transformations, and creating sectoral linkages and synergies. Secondly, external debt stress and limited competitiveness in international markets constrained sustainability of economic growth. Imbalance between domestic savings and investment characterized by the inability to satisfy the domestic investment demand was the third factor for limiting sustainability. Besides, challenges related to stabilize inflation; rise in unemployment; sluggish structural transformation and weak sectoral linkages; poor capacity to mobilize domestic resources; limited access to finance; deficient and low quality provisions of social services and basic infrastructure were main bottlenecks. Above all, lack of robust system to correct the failures and ensure accountability become additional challenge.[5]

3.2.2. Ethiopian Health System: General Overview

Ethiopia has a three-tiered system of primary, secondary, and tertiary care. Tertiary care is delivered by specialized hospitals with catchment areas of 3.5–5 million people; secondary care is delivered by general hospitals with catchment areas of 1–1.5 million people, and primary care is delivered by primary hospitals, health centers, and health posts serving 60,000–100,000 or more people at the woreda level. The woreda-level primary health care system typically includes a woreda health office,

[3]World Bank (2015), 4th **Ethiopia Economic Update: Overcoming Constraints in the manufacturing Sector.**
[4] FDRE, Planning and Development Commission. Ten Years' Development Plan. A Pathway to Prosperity. 2021-2030.
[5] Ibid

a primary hospital, at least 5 health centers, 25 health posts, and 50 health extension workers (HEW), two per health post.



Source: FMoH, HSDP IV 2010-2011, 2014-2015, October 2010

Figure 2: Structure of the Ethiopian Health Care System

As more than 80 percent of the Ethiopian population resides in the rural part of the country, more focus is given to the primary health care units while strengthening the referral care at secondary and tertiary levels. Ethiopia's flagship Health Extension Program (HEP)[6] is the platform for delivery of community based basic promotive, preventive and curative health services. Two Health Extension Workers (HEWs), based in the health posts serve an average of 5,000 populations, and are the primary point of entry to the health system for the rural community. HEWs, supported by the Health Development Army (HDAs) created between five households and one model family to influence one another in practicing healthy life style, work to empower the community to generate its own health[7].

Ethiopia is addressing major challenges in the health sector, including lack of human resources for health (HRH) and low utilization of health services, through its innovative Health Extension Program (HEP), accelerated midwifery training, Integrated Emergency Surgery and Obstetrics (IESO) task shifting, and scaling up family planning (FP). HEWs were trained to deliver a basic package of preventive and a few curative health services, including maternal and child health services. Thus, over 38,000 health extension workers were trained and deployed under the HEP scheme. In addition,

[6] The government has created and deployed more than 38,000 health extension workers, established more than 16,000 health posts and approximately 3,500 health centers, and is now establishing primary hospitals at the district (woreda) level.

[7] National Newborn and Child Survival Strategy Document. Brief Summary. 2015/16-2019/20. June 2015. FMoH https://www.unicef.org/ethiopia/Child_Survival_Strategy.pdf

approximately 16,000 health posts and 3,000 health centers have been constructed to increase access to essential services[8].

Maternal Health

Ethiopia has been ranked fifth in the world as having the greatest potential to save maternal, perinatal and neonatal lives by 2025. The country has achieved impressive progress on child survival, cutting under-five mortality by 67 per cent since 1990 and meeting its Millennium Development Goal 4 target three years ahead of deadline and is one of only twelve low income countries to do this[9]. There has been a steady decline in infant, child, and under-5 mortality over the last 16 years in Ethiopia. For example, under-5 mortality rates (<5MR) declined from 166 deaths per 1,000 live births to 123 deaths per 1,000 live births in 2005, to 67 deaths per 1,000 live births in 2016. Similarly, infant mortality (IMR) decreased from 97 deaths per 1,000 live births, to 77 deaths per 1,000 live births, and to 48 deaths per 1,000 live births in the same period. The neonatal mortality rate (NMR) has declined, in the same period, from 47 deaths per 1,000 live births, to 46/1000 live births, and to 29/1,000 in 2016.[10]

The leading causes of maternal death in Ethiopia are postpartum hemorrhage (PPH), unsafe abortion, infection, pregnancy related hypertension, and obstructed labor. Ensuring availability of modern contraceptives and essential life-saving maternal and reproductive health care is a major challenge in Ethiopia, where unmet need is very high and funding for supplies is almost completely donor dependent[11]. Moreover, 80 percent of births to urban mothers in Ethiopia were assisted by a skilled provider and 79 percent were delivered in a health facility, as compared with 21 percent and 20 percent, respectively, of births to rural women. Mothers' educational status is highly correlated with whether their deliveries are assisted by a skilled provider and whether they are delivered in a health facility.[12]

As regards to the critical MCH indicators such as ANC, PNC, institutional delivery, etc. results from the 2019 mini-DHS indicted a steady improvement. The report showed that 74 percent of women age

[8] Success Factors for Women's and Children's Health. MoH Ethiopia. WHO 2015: http://www.who.int/pmnch/knowledge/publications/ethiopia_country_report.pdf

[9] Levels and Trends in Child Mortality. Report 2015. Estimates Developed by the UN Inter-Agency Group for Child Mortality Estimation. UNICEF. http://www.apromiserenewed.org/focussing-on-every-newborn-ethiopia-taking-action/

[10] Ethiopia Demographic and Health Survey. Key Indicators Report 2016. Central Statistical Agency, Addis Ababa, Ethiopia. October 2016.

[11] Raifman, S. et al. *Assessment of the availability and use of maternal health supplies in the primary health care system in Amhara region, Ethiopia*. Final Report. Population Council 2013 https://www.popcouncil.org/uploads/pdfs/2013RH_MaternalHealthSuppliesEthiopia.pdf

[12] Ethiopia Demographic and Health Survey. Key Indicators Report 2016. Central Statistical Agency, Addis Ababa, Ethiopia. October 2016.

15-49 with a live birth in the 5 years before the survey received antenatal care (ANC) from a skilled provider for their most recent birth. Urban –rural disparity is high in terms of use of ANC. In this case, urban women (85%) are more likely than rural women (70%) to receive ANC from a skilled provider. Furthermore, education is an important factor to get ANC services from a skilled provider. That is, ANC utilization increases with increasing mother's education, from 62% among women with no education to nearly 100% among women with more than a secondary education. Women in the highest wealth quintile (95%) are more likely than those in the lowest quintile (47%) to receive ANC from a skilled provider. The report further disclosed that institutional deliveries increased from 26% in 2016 to 48% in 2019, while home deliveries decreased from 73% to 51% over the same period. On the other hand, 34 percent of women and 35 percent of newborns received a postnatal check within the first 2 days after birth which showed low performance.[13]

Child Health

The 2019 mini DHS results show that the neonatal, infant, and under-5 mortality rates for the 5 years before the survey were 33, 47, and 59 deaths per 1,000 live births, respectively. In other words, 1 in every 30 children in Ethiopia die within the first month, 1 in every 21 die before their first birthday, and 1 in every 17 die before their fifth birthday. Rural urban disparity is clearly observed in under 5 mortality. Mortality rate of the under 5 infant is higher in rural areas than in urban areas (51 and 32 deaths per 1,000 live births respectively. The under-5 mortality rate decreases with increasing household wealth. Under-5 mortality is 77 deaths per 1,000 live births in the poorest households and 46 deaths per 1,000 live births in the wealthiest households[14]. That is, among others, settlement (rural) and poverty explained by a low household income contributes towards increased under 5 infant mortality rate.

Sexual and Reproductive Health (SRH) Environment

SRH being a comprehensive concept and implies a broad range of health and non-health related interventions, overview of the larger social and institutional contexts that influence reproductive health (RH) in Ethiopia. It highlights the ways in which those conditions affect the RH status of women and men in the country. To this end, poverty, education, the legal environment, status of women and the health care system become crucial aspects. Poverty is considered as one of the most

[13] Federal Ministry of Health. Mini Demographic and Health Survey 2019;. Ethiopian Public Health Institute. Addis Ababa. May 2021

[14] Ibid

important determinants influencing the RH status. Ethiopia is one of the poorest countries in the world, with an estimated gross national product (GNP) per capita income of US$100. Today, it is estimated that 47 percent of the population still lives below the poverty line[15].

On the other hand, the low status of women in Ethiopia underpins, and often directly undermines each of the negative RH outcomes addressed in the national strategy. Most Ethiopian women lack the reproductive and social self-determination needed to exercise their reproductive rights – a condition that, in turn, perpetuates their low RH and social status. Despite a biological tendency towards higher survival rates, girl children are 4 percent more likely to die during infancy than boys. Between 60 and 80 percent of Ethiopian women have experienced some form of female genital cutting (FGC), a practice with potentially severe health consequences.[16]

The health care system, traditionally the public sector which was overburdened and has primary responsibility for the delivery of health care services through government-owned facilities. Nevertheless, since recent years, non-governmental organizations, private for-profit clinics, traditional practitioners and rural drug vendors together make up about one third of all service provision. RH is not a standalone program in the health care delivery system. Instead, it is integrated and mainstreamed across the health sector. That means, facilities are shared, staff are shared, resources are shared, and opportunities (both realized and lost) are shared.[17]

Diversity is another factor worth considering in relation to SRH. Ethiopia is characterized by unique demographic, cultural and geographic diversity. It entails for multiple and diversified approach that responds to a number of social and cultural elements. Apparently, the need arises to understanding factors that effectively differentiate society and their RH needs. In this case it is vital to account for inclusion-exclusion aspects considering the pastoral populations, urban migrants, aging population, adolescents, displaced populations, those in conflict situations, etc. In other

[15] Federal Democratic Republic of Ethiopia MINISTRY OF HEALTH NATIONAL REPRODUCTIVE HEALTH STRATEGY 2006 - 2015 March 2006

[16] Federal Democratic Republic of Ethiopia MINISTRY OF HEALTH NATIONAL REPRODUCTIVE HEALTH STRATEGY 2006 - 2015 March 2006

[17] Ibid

words, it means using approaches that are needs-driven and segmented by residence, geography, culture, age, marital status, disability status, sex, etc.[18]

RH of young people – reports indicated that while approximately 60 percent of Ethiopia's population falls between the ages of 10-29, few national programs or policies are specifically targeted towards addressing their most pressing RH needs. In urban areas, new research suggests that existing RH coverage is limited, with only 12 percent of young people sampled in Addis Ababa visiting youth centers and only 20 percent reached by peer educators. In addition, most programs for young people in Ethiopia, as well as in sub-Saharan Africa generally, tend to deliver generic, age- and gender-blind messages that fail to recognize the distinct needs of girls versus boys at different ages, as well as the unique needs of married adolescent girls. This limited access to targeted RH care and services for young people contributes to, and exacerbates, many of the RH problems outlined above.[19]

3.2.3. Prevention and Control of Major Diseases

Estimated 4.4 percent (1.5 million) Ethiopian adults are currently infected with HIV. Prevalence rates are much higher among women (5.0 percent) than men (3.8 percent), highlighting an increased social and physiological vulnerability to the disease for females. The epidemic appears to have plateaued at 12.6 percent in urban areas. Over half of AIDS patients were male, despite the higher rates of infection among women, reflecting important gender biases in access to care. This suggests that most women with HIV/AIDS do not receive sufficient care, including gender-specific interventions such as prevention of mother to child transmission (PMTCT) and relevant contraceptive options. As a result of the epidemic, number of AIDS orphans increased in the country.[20]

The country is among the countries with the highest number of AIDS orphans and ranked seventh in the world. In 2003 alone, an estimated 539,000 children lost at least one parent to AIDS. Outside their parents' protective care, and most frequently supported by poor relatives, the physical, educational, or health needs of these orphans are not routinely met. As recent studies demonstrate, AIDS orphans are much more likely to drop out of school or repeat classes than those not affected by

[18] Ibid

[19] Ibid

[20] 2014 Spectrum Projection for Ethiopia

the epidemic. Remarkable advancement was made to reduce prevalence and an incidence of HIV/AIDS, however, there is still 753,100 people who are HIV positive in Ethiopia[21].

Currently, the country is in a low generalized HIV epidemic with significant heterogeneity among regions and population groups. The prevalence has now reported that decline from 1.5% in 2011 to 1.1% in 2015. Apart from the regional and population groups' differences, prevalence also varies between urban and rural as well as male and female, with urban population more affected than a huge reduction to 2.1% in 2012 –which clearly suggests a decline in the new infections, especially in the younger generation, ages 15-24 on new infection. However, women and girls are still predominantly affected by the epidemic due to socio-cultural, economic and biological reasons. In rural areas females are twice affected than male population with HIV. Recent data on antenatal surveillance on HIV prevalence among 15 - 24 year-old pregnant women has indicated factors widening vulnerability dimensions. Access to information and services related to health and HIV/AIDS is very limited to marginalized people, especially those living in urban slums.[22]

Malaria Prevention and Control

The Ethiopia's flagship Health Extension Program (HEP), that is serving as a platform for delivering community based basic promotive, preventive and curative health services contributed significantly in the reduction on malaria prevalence nationally. The latest status from the MoH indicates that mortality and morbidity due to malaria has reduced, while an outbreak has not been observed for the last 7 years. Currently prevention and management of malaria through the health system has helped 65% of under 5 children to sleep under ITN with IRS reaching 47% of houses in endemic areas in 2011. Through interventions implemented by the health sector, with the supports of partners has seen successes in diagnosing and treating malaria at the earlier stages of the infection. A progress was also made in the national pan for selective vector control, though not sufficient.

The country being one of the most affected by malaria epidemic, still there is the need to move further steps in the prevention and eradication of malaria by 2020, as set out in the HSTP (2015-2020). Interventions aimed at increasing access to knowledge, attitudes, and practice toward malaria

[21] Ibid

[22] Ethiopian Demographic and Health Survey (2011)

prevention and control for the population in malaria endemic areas are critical to any success expected. Achieving and sustaining zero indigenous transmission of malaria in 50 selected districts, diagnosing all suspected malaria cases using RDTs or microscopy within 24 hours of fever onset, ensure treatment for all malaria cases according to the national guidelines, universal access of the population at risk to at least one type of globally recommended anti-vector intervention are among the top targets for Ethiopia that needs to be addressed by 2017. An improvement is also expected in evidence based programming and decision making through ensuring generation of complete data and evidence at all levels to facilitate appropriate decision making

3.2.4. Emerging health sector concerns and threats

COVID – 19, mental health, NCDs, risky health behaviors such as smoking, alcohol and drug use (substance use and abuse); and other unforeseen and un anticipated diseases/epidemic outbreak were among the future risks. Mental health problem, substance use and abuse; emergencies, accidents and injuries, conflict, war, and natural disasters resulting in displacement and mass destruction (destruction of health facilities & infrastructures) were expected to exacerbate health and health related problems. Such incidents significantly deteriorated capacity which was already diminished. The impact of climate change and global warming is also becoming more realistic and disastrous risk. Apart from global warming, drought and desertification are visible obstacles for the society, affecting health and livelihoods. There is a strong responsibility for everyone, in promoting actions that are ideal for climate change mitigation in order to determine what the future holds for people and the next generation. Building on this fact, project interventions that promote climate change mitigation and environmental protection strategies are essential.

4. ANALYSIS OF THE ORGANIZATIONAL CONTEXT

4.1. The Journey of HDAMA in the Past

The Health, Development and Anti-Malaria Association/HDAMA/ formerly the Anti-Malaria Association was established in response to the 1998/99 catastrophe due to malaria in the north western part of Ethiopia. HDAMA is an Ethiopian Residents' Charity Association with a national presence currently operating in different regions mostly in the Amhara region and Addis Ababa City administration.

The association has considerable track records especially on malaria prevention and control. HDAMA has contributed to and paved the way to bring malaria to the attention of higher level decision makers. The attitude of the people has also stepped up from a level where malaria was considered something related to evil spirits to a level where people strongly believed it is a preventable disease. In addition, the association is continually contributing to the efforts in reducing HIV and other STIs infection among Most at Risk Populations. HDAMA diversified its programs through engaging in interventions on the risk of non-communicable diseases, unhealthy food and tobacco.

Led by the Executive directors, the HDAMA secretariat is further structured with different departments at the national and branch offices levels at the regional, zonal and district levels. The management committee is established to ensure the smooth, efficient and effective implementation of programs, human and financial management and administration. Currently, the association is operating with 42 full-time and two par time professionals at the head, branch and field offices. Cognizant of the availability of enormous workforce and untapped expertise (especially, youth) HDAMA is promoting volunteerism. In this regard, the association recruited and mobilized volunteers which have been central to HDAMA's success in realizing organizational goals during the last 24 years. Currently, HDAMA has more than 194, 360 active members and 2,120 volunteers registered under the 69 district-level volunteer-based grass root structures.

For the last 24 years, HDAMA has been implementing a range of health and development projects under its core strategic areas of intervention that saved lives, protected health and improved the living conditions of thousands of needy populations. The contribution and the recorded achievements of

HDAMA are widely acknowledged by communities, the government, partners and the general public at large. Some of the major community based interventions of HDAMA included prevention of the transmission and reduce the impact of malaria disease. Interventions under this project saved lives of thousands of people that are affected by malaria; effectively advocated critical issues to secure the attention of concerned officials to accept that malaria is the number one public health threat; increased adoption of appropriate healthy behaviours through increased knowledge, skill and attitude of households on malaria; successfully introduced malaria early warning systems in collaboration with Amhara Health Breau and Bahirdar University. Through promoting the reproductive health HDAMA enhanced the capacity of vulnerable youth to demand and utilize SRH services; provided an integrated comprehensive package of SRH services; built the capacity of the social environment to effectively respond to the rights and needs of vulnerable youth.

Furthermore, in its Tobacco control project initiated recently, HDAMA was able to deliver activities successfully in the adoption of strong comprehensive TC law through aggressive media communication advocacy and promoted smoke-free provision enforcement in Addis Ababa. Through the project focused on the provision of care and support to orphan and vulnerable children, HDAMA provided educational support to vulnerable children and supported over 160 vulnerable girls to pursue secondary education in a group home seating.

The association is also initiated project on non-communicable diseases and increased the public level of understanding of the health impact and economic burden of unhealthy diet associated with non-communicable diseases. HDAMA also provided water, hygiene and sanitation education and reached the unreached and underserved segments of the population. To ensure access to low-cost health care services, HDAMA established a health centre in Bahirdar and the surrounding and improved access to the local community. HDAMA also advocated the eradication of Guinea worm with WHO.

5. ANALYSIS OF KEY STRATEGIC ISSUES

5.1. Organizational/Institutional Transformation

Over the last 24 years, HDAMA accounted for a number of remarkable achievements that have a powerful influence to the status that it has now. Transforming organizational efficiency and effectiveness is of the paramount importance for HDAMA given the long-standing service in the civil society sector and accumulated organizational experiences and track-records. There are core staffs with long institutional memory to coach, mentor, and train others. As such organizational transformation endeavor of HDAMA could be understood as a business plan/blue print to manage change. In its 24 years journey, HDAMA anticipates some sort of change which determines its destination. The strategy shows a pathway of change from where it is currently to the desired future. It guides organization's growth and success.

Realties revealed that the need for organizational transformation is driven from two sources: Internal and External. Internally, the need for transformation comes from the organization's past and present reputation and experience. The leadership, management and staff to introduce a system that fully responds to the contemporary global, national and local circumstances have also been a significant factor. Innovations, good practices and implementation capacity developed over years and trust from its partners were assets for HDAMA to reposition itself in a manner that overhauls its strategies for better service in the future. Externally, there is high expectation from partners and stakeholders in terms of designing and implementing high-impact programs. Partners and stakeholders have trust and strong confidence in the delivery of services and the institutional capacity of HDAMA.

Hence, HDAMA is envisioned to strengthen its systems and work diligently in the coming five years so that its institutional capacity is transformed to a better, more efficient and effective organization to realize its vision. Significant change is required in the areas of human resource development; strengthening constituencies; improving infrastructure (including ICT, workplace and office); adopting and adapting policies and strategies; building a robust monitoring, evaluation, reporting and learning system; etc.

One of the core areas in organizational transformation is adopting/developing organizational policies and procedures to be used during the strategic plan years. Some of these materials include Organizational Communication Strategy; Performance Management Policy and procedure manual

(updating and enforcement); Safeguarding policy; Data protection policy/regulations; Supply chain management policy/manual; Policy in code of conduct against modern slavery; Anti-bribery policy; Security policy/guidelines (Update and separate); Policy on the conflict of interest policy; Digital/IT Strategy or policy.

Another important aspect of the organizational transformation is enhancing Data storage/IT capacity which is crucial for organizational transformation. These are an electronic/digital procurement system; an electronic/digital Human Resources system; an electronic/digital timesheet submission process; an electronic/digital M&E platform; an online folder-sharing system within the organization; a video call/conference platforms (such as Google meetings/zoom/Microsoft Teams); internet/email, etc. Enhancing organizational capacity in employing Digital health / Data for decision making/ is another dimension that organizational transformation takes in to account. In this case the organization uses Ethiopia's electronic Community Health Information System (eCHIS); uses Community Health Information System (CHIS) and create dashboards using health information data, etc.

5.2. Prevention and Control of Communicable diseases

Malaria has remained one of the major threats of humanity since ancient times and still remains an adverse public health concern. In many parts of the world, while it is preventable and treatable, malaria continues to cause a devastating impact on the health and livelihoods of people. Globally, malaria killed about 409, 000 people, mostly children under the age of 5 in sub-Saharan Africa. Those who have limited access to health facilities and can barely afford the recommended treatment due to marginalization, social exclusion, deprivation from resources and poverty were disproportionately affected by malaria. Hence, malaria is both a consequence and a cause of poverty and inequality (P.1).[23]

In Ethiopia, malaria is a major public health concern considered to be one of the leading causes of morbidity and mortality. Apparently, 75% of the country's landscape areas below 2000 m above the sea level are affected by malaria cases. Of the estimated population of above 100 million, approximately 68% of the population is at risk of the disease. Every year, about 2.9 million cases of malaria and 4,782,000 related deaths have been reported, and the rate of morbidity and mortality dramatically increases during epidemics. Malaria causes much damage to the health and

[23] Global technical strategy for malaria 2016–2030, 2021 update. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO

socioeconomic development of the country. The disease is more severe in children and pregnant women in the country. Although several malaria prevalence studies in different parts of Ethiopia have focused on all age groups of individuals, only a few studies have indicated that adulthood malaria is still one of the major public health problems in the country. To date, however, estimate of adulthood malaria in the country is not known (P.2).[24]

The poor and vulnerable groups of the society were exposed to the severe consequence of malaria. Despite the incredible increase in access to services in the last two decades, too many people are still missing out on the malaria interventions they need, and more than half the world's population is still unable to access health services without incurring financial hardship. For example, 36% of households in moderate- and high-transmission settings had one net for every two persons, and only 46% of the population at risk of malaria uses an ITN. One third of those with fever did not seek care and only 38% of those who sought care were tested for parasites. Many of those missing out are the poorest and most marginalized, which calls for a deliberate approach to reach the unreached. The future seems not promising, however. High-impact and emerging health emergencies (epidemics, pandemics, conflicts, natural and technological disasters) may be halting malaria interventions. Many people agree that the next decade may face further disruptions, including natural disasters, unnatural catastrophic events and violent conflicts that impact malaria by disrupting the ecology, displacing people from their homes, and compromising access to and quality of health services.[25]

Malaria prevention and control intervention/program is an asset to HDAMA. The organization spent a considerable amount of time, energy and built solid expertise for years and accumulated proven experience in the area. Malaria intervention/program could still be taken as one of the pillars (core programmatic areas) by revisiting and shaping the existing geographical and programmatic scope and approach. Key stakeholders and partners suggested the expansion of malaria program by including new activities and re-designing the approaches. Some partners recommended that HDAMA can implement and manage a national pilot malaria program and the National Malaria Elimination Program (FMoH) may delegate and empower HDAMA to pilot the country wide community empowerment and mobilization activities in selected weredas of the country.

[24] Fasil Adugna Kendie et al. Prevalence of Malaria among Adults in Ethiopia: A Systematic Review and Meta-Analysis. Hindawi Journal of Tropical Medicine ;Volume 2021, Article ID 8863002, https://doi.org/10.1155/2021/8863002. March 2021

[25] Global technical strategy for malaria 2016–2030, 2021 update. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO

The National Malaria Elimination Program may also consider HDAMA as a Technical Assistance (TA) provider in the areas of malaria and help HDAMA build its capacity further so that it shares its wealth of knowledge (good practices and lessons learned) with the wider CSO sector. It was witnessed that community empowerment, mobilization and awareness creation has been one of the national pillars in which HDAMA had a strong reputation.

5.3. Prevention and Control of Non Communicable Diseases

According to sources, about 41 million people die each year due to non-communicable diseases (NCDs) constituting equivalent to 74 per cent of all deaths globally. Reports further revealed that about 17 million people die from a NCD before age 70 each year. Eighty six per cent of these deaths are premature deaths and occur in low- and middle-income countries. Deaths due to NCDs are disproportional where of all NCD deaths, 77% happen in low- and middle-income countries. Cardiovascular diseases account for most NCD deaths, or 17.9 million people annually, followed by cancers (9.3 million), chronic respiratory diseases (4.1 million), and diabetes (2.0 million including kidney disease deaths caused by diabetes). These four groups of diseases account for over 80% of all premature NCD deaths. On the other hand, Tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets all increase the risk of dying from an NCD.[26]

In Ethiopia, four most common types of NCDs were identified and known. These are cardiovascular diseases (such as heart attacks and stroke); cancer; chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma); and diabetes. In addition, it was reported that NCDs in Ethiopia share several common, modifiable risk factors such as tobacco use, harmful alcohol use, physical inactivity, and unhealthy diet (high consumption of sugar, salt, saturated fats, and Trans fatty acids). On the other hand, other NCDs which have public health importance were emerged. These include mental health; neurological and substance use disorders; chronic kidney disease; injuries; eye diseases; oral-dental diseases; thyroid disorders; musculoskeletal disorders; plus chronic diseases of an infective origin like rheumatic heart diseases and chronic liver diseases. It is suggested that mitigating the effects of these common risk factors is critical to combatting NCDs nationally and worldwide.[27]

[26] WHO Key facts- https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases (May 2, 2023)
[27] FMoH. NATIONAL STRATEGIC PLAN FOR THE PREVENTION AND CONTROL OF MAJOR NON-COMMUNICABLE DISEASES. 2013-2017 EFY (2020/21-2024/25). Strategy on Prevention and Control of Cardiovascular Diseases, Diabetes Mellitus, Chronic Kidney Diseases and Chronic Respiratory Diseases. July 2020 Addis Ababa, Ethiopia

The adverse economic impact of NCDs is obviously clear in Ethiopia. The risk of premature mortality due to NCDs in Ethiopia was 18.3 per cent. The impact is manifested in affecting the non-health sector by reducing workforce and negatively affecting productivity. Studies estimated that NCDs cost Ethiopia at least 31.3 billion birr (US$ 1.1 billion) per year which is equivalent to 1.8 per cent of the gross domestic product (GDP). Strictly speaking, the nation loses 26.6 billion birr due to the loss of work forces and reduced productivity. In addition, as a result of the one of the four NCDs, about 18 per cent people were dying prematurely. The main behavioral risk factors for NCDs are also identified: tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity[28].

From investment perspective, 242.2 billion birr is required to implement some selected best intervention packages over a 15-year period: (tobacco control package (2.8 billion); alcohol control package (6.1 billion); salt reduction package (6.2 billion); physical activity awareness package (5.8 billion) and CVD and diabetes clinical interventions (221.4 billion). As every investment entails either returns (return on investment, ROI) or losses in the course to time, investment of 242.2 billion birr over the same period of time will have the following return (Table 2)[29]

Table 2: Burden of NCDs

S/No	Intervention Package	ROI	Lives saved	Overall ROI over 15 years period (Billions of birr in productivity benefits)
1	Tobacco control package	3.1	220,000	9.3
2	Alcohol control package	1.4	211,000	8.9
3	Salt reduction package	3.3	455,000	21
4	Physical activity awareness package	1.8	200,000	8.8
5	CVD and diabetes clinical interventions	0.1	353,000	14.2
	TOTAL	**9.7**	**1,439,000**	**62.2**

Strengthening advocacy, coordination, planning and financing are crucial steps to mitigate problems posed by the spread of NCDs. Some of the activities include advocacy and concerted actions and awareness-raising in non-health sectors. The advocacy activities need to embrace parliamentarians, the Cabinet, civil society, local media, academia, the private sector and the general public. Strengthening coordination and planning among the key stakeholders (including major financers) such as the Government, the United Nations and other stakeholders is another strategic approach.

[28] Dombrovskiy, V., Asmamaw Workneh, Fassil Shiferaw Roy Small & Nicholas Banatvala. Prevention and control of non-communicable diseases in Ethiopia: The case for investment, including considerations on the impact of khat. World Health Organization, 2019

[29] Ibid

Using the political good will and support starting from the Prime minister and President's office down to the relevant sector administrators (Ministerial offices and local government structures) pursuing whole-of-society initiatives against NCDs is possible. In this regard, creating and empowering a multi-sectoral body on NCDs and integrating NCDs into suitable platforms (nutrition, tobacco control and other relevant platforms) becomes vital. Furthermore, increasing excise taxes on harmful products to protect the population, avoid spending on NCDs and other health problems, avoid productivity losses and raise reliable domestic revenue to finance health, universal health coverage and development may support the fight against the impact of the NCDs. Pollution (like indoor and outdoor pollution), mental health, road traffic injuries and khat use need proper attention vis-à-vis NCD.[30]

HDAMA has already been engaged in addressing some of the risk factors associated with NCDs, identification and mitigation of the risk factors. Its media and communication campaigns to increase awareness of the smoke-free provision and its effective implementation in the public places of Addis Ababa City Administration; and media advocacy campaign on food policy were some of the advocacy interventions HDAMA has embarked on and piloting. Given the empirical data above and continued rise of the NCDs and its massive burden against the vulnerable groups of the society, upholding and expanding (considering additional geographical locations) the ongoing interventions on NCDs becomes imperative. On the other hand, HDAMA's past track record in implementing projects on NCDs and solid experience in SBCC, networking efforts with likeminded organizations; its contribution to the introduction and implementation of Tobacco control proclamation in Ethiopia puts HDAMA in the right position to upscale projects in the areas of NCDs,

5.4. Adolescent, Youth Sexual and Reproductive Health (AYSRH)

By ways of giving a perspective as regards to youth and young people, the age aspect is defined as follows. Different countries define youth and young people in different ways. For example, for Uganda youth and young people mean those people in the age range between 12-30; Mauritius 14-29; South Africa 14-28; India 15-35; Nigeria 18-35; Djibouti 16-30. In this regard, Ethiopian Youth Policy defines youth and young people as people who fall in the age range of 15-29. [31] On the other hand, according to the African Youth Charter, youth and young people are those persons between the

[30] Ibid

[31] FDRE, National Youth Policy. Ministry of Youth, Sports and Culture; March 2004. Addis Ababa

ages of 15 and 35 years. The African Youth Charter details a number of development issues directed towards youth of which health is one. The Charter in terms of health of youth and young people pointed out the need for identifying reproductive and health needs and designing responsive and relevant programs for vulnerable and disadvantaged youth. In addition, it was asserted in the Charter that reproductive health services need to be youth friendly which includes variety of services such as contraceptive, ANC and PNC services. Introducing a comprehensive program geared towards preventing HIV/AIDS; STIs, harmful traditional practices including gender based violence and female genital cutting/mutilation (FGC/M) was also suggested with emphasis[32].

As indicated in the HSTP II, adolescents and youth constitute 42% of the total population in Ethiopia. However, about 20% of adolescent girls aged 15-19 years are anemic and underweight. Most young people in Ethiopia lack comprehensive knowledge on sexual and reproductive health (SRH), often engaging in risky behavior. Urban-rural disparities are wide as regards to comprehensive knowledge about HIV and HIV testing. About 37% of girls and 43% of boys aged 15-19 year consume alcohol. About 57% of boys also chew Khat. Despite high prevalence of health problems and risk factors among adolescents and youth, access to and utilization of health services is limited; and health education and life skills trainings for youth are often inadequate and fragmented (P.25).[33]

On the other hand, improving maternal health, promoting gender equality, and combating HIV/AIDS were considered to be three core issues and also identified as providing an entry point to address variables and indicators that effectively cross-cut the entire domain of reproductive health. Issues such as fertility, gender, age of first birth, contraceptive prevalence, method choice, traditional practices, literacy and other factors have direct implications for the health of men and women throughout their lifecycles. Responding to the socioeconomic and demographic realities of the country was the other priority. It was argued that although "inclusion" remains a hallmark of the concept of RH, the reality is that nearly 80 percent of Ethiopians live in rural areas; 60% are under the age of 20; nearly all are married by the age of 18; and few will ever reach their 55th birthday. So,

[32] African Youth Charter. Adopted by the Seventh Ordinary Session of the Assembly held in Banjul, The Gambia; on 2nd July 2006

[33] Health Sector Transformation Plan II (HSTP II) 2020/21-2024/25 (2013 EFY - 2017 EFY). February 2021

it remains difficult to address the full range of activities theoretically subsumed under the rubric of reproductive and sexual health (PP 1&2)[34]

The Reproductive Health Environment

Reproductive health (RH) being a comprehensive concept and implies a broad range of health and non-health related interventions, overview of the larger social and institutional contexts that influence RH in Ethiopia is necessary. It highlights the ways in which those conditions affect the RH status of women and men in the country. To this end, poverty, education, the legal environment, status of women and the health care system become crucial aspects. Poverty is considered as one of the most important determinants influencing the RH status. Ethiopia is one of the poorest countries in the world, with an estimated gross national product (GNP) per capita income of US$100. Today, it is estimated that 47 percent of the population still lives below the poverty line (P.3).[35]

Furthermore, investments in education, particularly for women, lead to better child health, lower fertility and reduced maternal mortality contributing to the success of the RH initiatives. However, educational status is a serious challenge in Ethiopia, where only 18.5 percent of women and 39.6 percent of men are literate. As far as legal environment is concerned while the Government of Ethiopia has adopted numerous laws and policies that advance women's social and reproductive rights, the implementation of these protections is constrained by low implementation capacity, low awareness among the general public and especially women (PP.3&4).

Status of Women

Status of women in Ethiopia is low. The low status of women in Ethiopia underpins, and often directly undermines each of the negative RH outcomes addressed in the national strategy. Most Ethiopian women lack the reproductive and social self-determination needed to exercise their reproductive rights – a condition that, in turn, perpetuates their low RH and social status. Despite a biological tendency towards higher survival rates, girl children are 4 percent more likely to die during infancy than boys. Between 60 and 80 percent of Ethiopian women have experienced some form of

[34] Federal Democratic Republic of Ethiopia MINISTRY OF HEALTH NATIONAL REPRODUCTIVE HEALTH STRATEGY 2006 - 2015

[35] Federal Democratic Republic of Ethiopia MINISTRY OF HEALTH NATIONAL REPRODUCTIVE HEALTH STRATEGY 2006 - 2015

female genital cutting/mutilation (FGC/M), a practice with potentially severe health consequences (P.4)[36].

Reports showed that the trend in controlling their earnings by husbands and wives is improving regardless of their educational background and urban-rural settings. However, slightly men have more dominance in rural areas than urban. Along with access to employment, control over cash earnings is a dimension of gender empowerment that women who are employed and who receive cash earnings are more likely to have control over their own earnings. In terms of ownership of assets, men's dominance is obviously high. Lack of assets makes women vulnerable to various forms of violence and affects their decision-making power in the family. Although the Ethiopian laws give equal property rights to women, traditional misperceptions, attitudes and women's low social and economic status limits their ownership of assets. Women's ownership to land and house is unlikely low. This means that major assets are at the hands of men or their spouses which makes women weaker in power of negotiation.[37]

Gender-Based Violence

In Ethiopia, violence against women and girls continues to be a major challenge and a threat to women's empowerment. Women and girls face physical, emotional, and sexual abuses that undermine their health and ability to earn a living; disrupt their social systems and relationships; and rob them of their childhood and education. According to the EDHS 2016, among women age 15-49, 23% of them have experienced physical violence and 10% have experienced sexual violence. Four percent of women have experienced physical violence during pregnancy.

In terms of marital control, 16% of ever-married women have experienced at least three types of marital control behaviors by their husbands or partners. Concerning spousal violence 34% of ever-married women age 15-49 have experienced spousal physical, sexual, or emotional violence. Physical and emotional violence were experienced by 24% each and sexual violence by 10%. Injuries due to spousal violence were also reported. According to the report 22% of ever-married women who experienced spousal physical or sexual violence reported injuries, including 19% who reported cuts, bruises, or aches and 10% reported deep wounds and other serious injuries.

[36] Federal Democratic Republic of Ethiopia MINISTRY OF HEALTH NATIONAL REPRODUCTIVE HEALTH STRATEGY 2006 - 2015

[37] Ethiopian Demographic and Health Survey, 2016

A study conducted by UN Women indicated that 25% of Ethiopian women experienced their first sexual experiences under coercion. The study also showed a high level of acceptance of violence against women, both by women and men by asserting that over 69% of the respondents beating a wife is justifiable for reasons such as refusing sex, neglecting a child and arguing with a husband. The study also pin pointed that 10% of married young women aged 15 to 24 years, experience physical domestic violence and 7% of ever-married women had experienced psychological abuse and insults. Though there is some statistics on early marriage, FGC/M and to some extent on reported cases of civil and crime cases, nonetheless, other forms of violence such as economic and psychological violence may be underreported or even not recognized, according to the study.

Studies indicated that absence of Civil Remedies for Victims or Survivors remains serious gap. It is noticed that the Ethiopian law lacks any kind of civil remedies against domestic violence. It was identified that the law does not have separate domestic violence act or law which provides specific civil remedies for victims/survivors such as right to obtain protection order, monetary or compensation relief, custody order, residence order, shelter or medical benefits or more than one such order. Secondly, the law does not have sufficient Criminal Liabilities on Perpetrators. It is obvious that there are some affirmative improvements, but the new Ethiopian Criminal Code has still some critical gap of addressing the problem of domestic violence in sufficient manner.[38]

RH of young people

Reports indicated that while approximately 60 percent of Ethiopia's population falls between the ages of 10-29, few national programs or policies are specifically targeted towards addressing their most pressing RH needs. In urban areas, researches suggested that existing RH coverage is limited, with only 12 percent of young people sampled in Addis Ababa visiting youth centers and only 20 percent reached by peer educators. In addition, most programs for young people in Ethiopia, as well as in sub-Saharan Africa generally, tend to deliver generic, age- and gender-blind messages that fail to recognize the distinct needs of girls versus boys at different ages, as well as the unique needs of married adolescent girls. This limited access to targeted RH care and services for young people contributes to, and exacerbates, many of the RH problems outlined above.

[38] Megersa Dugasa Fite. The Ethiopia's Legal Framework on Domestic Violence against Women: a Critical Perspective. *International Journal of Gender and Women's Studies*. March 2014, Vol. 2, No. 1, pp. 49-60
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HDAMA has been implementing the Sexual Reproductive Health and Gender Based Violence Prevention and Management Project targeting Industry Park Workers of Debrebrehan, Kombolcha & Bahirdar and the surrounding Community. Its goal was strengthening capacity of adolescent and young peoples' capacity to make informed decision on their sexual and reproductive health right in Ethiopia. Overall objective of the project was to contribute towards empowering the vulnerable groups to exercise their human rights including SRH and create an environment which is free from violence, exploitation, and discrimination. By meeting the above objective the project aspires to achieve the following expected outcomes. These are: (1) increased awareness and utilization of quality SRH and SGBV services by the vulnerable groups; (2) improved accessibility and availability of integrated packages of SRH services; (3) institutions and social environment strengthened and effectively responded to the rights and needs of vulnerable groups; and (4) enhanced networking, partnership, collaboration and engagement of stakeholders.

While maintaining the on-going interventions HDAMA may address vulnerability, inherent economic problems and gender inequality and needs to devise an inclusive and right-based approach that empowers adolescents, youth and women meaningfully. Land and property/asset ownership and inheritance and other forms of HTPs may be critical issues to consider as regards to women. Adolescents and youth constituting a significant proportion of the country's population were exposed to severe social and economic challenges. In this case, ensuring access to and quality sexual and reproductive health (SRH) services becomes urgent.

5.5. Enhancing Livelihood Opportunities for youth and women

Household Poverty and Unemployment

Household poverty is affecting marginalized communities. Household poverty is a cause of poor health and education outcomes, and is believed to be one of the key drivers for the spread of HIV/AIDS. Women are among those groups of communities that are being affected most and are forced to be engaged in commercial and transactional sex and are exposed to exploitations and abuses. Unemployment and underemployment especially in younger people (15-29 years old) is continuing to be a serious challenge, including for those who have finished secondary education, TVET and college graduates.

The recent urban employment and unemployment survey indicates high youth unemployment of 23% (29.6% female and 16.4% male), which indicates the problem is even more severe for women. The

problem partially imparts on lack of access and quality skills training beyond secondary education – that focuses on equipping youth with employable skills or that opens market opportunities to create job, addressing the tendency to expect work that will pay them a salary, and a lack of innovation and initiative to become self-employed. Youth and women have been exposed to illegal migration and are in increased susceptibility to other socio-economic and health risks, in addition to keeping them in the cycle of poverty.

Apart from lack of access to information related to employment, they have no necessary skills and knowledge that can help them engage in safer livelihood opportunities and improve incomes to support their lives and the lives of people who live with them. To this end, interventions in livelihood development for women and youth and those that create opportunities to enhance their skills and improve income are necessary. The objective of the Livelihood Program is, hence, to reduce poverty and inequality by generating employment among poor households and by moving highly vulnerable households into sustainable livelihoods and toward economic stability. Thus, livelihood program focuses on the following major areas.

- Provide skills trainings for economic empowerment; create jobs and employment opportunities for vulnerable youth and women
- Facilitate access to finance, trainings, market and linkages for micro and small enterprise development
- Collaborate with TVET agencies in providing formal and non-formal skills training for the youth to create employment or business opportunities
- Promote opportunities for job creation, entrepreneurship and linkages with Micro and Small Enterprises

Women and youth constituting a large proportion of the country's population need proper attention with regard to economic empowerment. HDAMA may embark on agricultural activities. This can be considered from two perspectives. One is helping marginalized women and youth engage in small farm activities such as dairy production; vegetable and fruit development and growth; poultry; beef; fishery, etc. by ways of job creation and ensuring food security. The second is from the investment perspective. HDAMA can invest in agriculture as Amhara region possesses plenty of labor; water and land resources. This has a significant importance: ensure financial, program and organizational sustainability of HDAMA gradually building a self-reliant organization and on the other hand creates

job opportunity to youth, adolescent girls, women and other vulnerable social groups. Through its organizational transformation interventions, HDAMA need to consider creating the necessary technical and institutional capacity that encompasses the above interventions.

Along with this the following activities are recommended. The first is providing skill-based trainings for economic empowerment; create jobs and employment opportunities for vulnerable youth and women. The second is facilitating access to finance, trainings, market and linkages for micro and small enterprise development. The third is building alliance and strong collaboration with TVET agencies in providing formal and non-formal skills training for the youth to create employment or business opportunities. Lastly, promoting opportunities for job creation, entrepreneurship and linkages with Micro and Small Enterprises becomes vital for enhancing livelihood opportunities and job creation.

6. CONSULTATIONS WITH THE STAKEHOLDERS

6.1. External Stakeholders

As part of the strategic revision and planning process, a series of consultations were conducted with stakeholders in order to collect and reflect their views about the organization's work in to the strategic plan. The consultation with these stakeholders has also informed us in developing and validating strategic focuses. The stakeholders involved in the strategic planning process, their roles and areas of influence are presented in table-5 below.

6.2. Internal Stakeholders

Being the most valuable assets for the organization, internal stakeholders (staff, management and board members) play key role in implementing strategies both in the short and long terms. Staff and management members within the organization, who are working in fulltime basis, were represented in the strategic planning team –providing supports and overall guidance to the consultant. The board members, being the high-level decision makers under the general assembly, have conducted meetings with the planning team and provided feedbacks and views throughout the process.

The staff, management and board members well understood the need for developing a new strategic plan for the period from 2023-2027, thoroughly reviewing the current situations both within and outside the organization. The need for strategic actions on key and persistent issues that are affecting the organization was also highly reflected.

6.3. Stakeholders Analysis

The organization highly recognizes the central role of stakeholders in achieving its vision. Hence, the process of developing this strategic plan significantly involved stakeholders at different levels in the identification of the strategic priorities and provided feedbacks and accommodated their reflections on their expectations. This has ensured the stakeholders consciously accept and commit for supports. The consultation processes took place during the planning made classification of HDAMA's stakeholders in to the following categories.

6.4. Feedbacks from Stakeholders

Selected stakeholders consulted during the strategic planning process provided feedbacks to the organization based on their participation in the implementation of the programs funded by them. They have also active membership in the CCRDA, and involved in different working groups with HDAMA staff. Stakeholders have shared their perspectives, feedbacks and an assessment of

challenges and opportunities in the external environment as well as recommendations for the organization. The key feedbacks provided from the internal stakeholders have been used in the development of the strategic objectives and overarching issues reflected in the strategic plan.

6.5. Internal gaps that needs to be filled

Stakeholders critically reflected on the accountability mechanisms embedded in to resource consumption and allocation, witnessing that HDAMA allocates significant proportion of money in the benefit of the target community. The responsiveness by the leadership, the very strong bond with the community and local stakeholders including wide acceptability and volunteerism, community mobilization experiences and capacities, mobilizing community contributions for projects and interventions are the areas that stakeholders believed the organization has demonstrated strengths. However, it was also denoted that the organization needs to put more efforts towards improving the technical capabilities, strengthen program quality control and involvement and participation in taskforces and networks at different levels: local, regional and national.

6.6. Challenges Faced

Regarding the challenges that stakeholders mentioned during the consultative meetings includes the confusions around community services versus clinical services in health programs. Government counterparts and communities prefer clinical services and undervalue the other services at community levels that are focusing on awareness raising and behavioral change communication (BCC). Stakeholders also stressed the existing challenges for organizations like HDAMA in staying along their strategic pathways, experiences and the communities' need as donors are the biggest influencers in shaping the directions for programs; and even organizational visions and directions. That is, some programs are donor driven and at times it becomes difficult to address local needs (donor interest may not comply with the needs on the ground)

Most donor funds are coming with several issues already defined (tailor made), there is a small room for CSOs to influence. Lack of harmony and coordinated approach in the CSO sector; poor practices of hasty generalization like labeling some CSOs by authorities, donors and the public; gaps in the knowledge and understanding on development practices; lack of strategic flexibility and adaptation in the changing environment and the limited opportunities in CSO development and capacity building supports by donors are also among the perceived bottle necks.

6.7. Analysis of Strengths and Weaknesses

Results of interview and discussions on the organization's strengths and weaknesses provided some essential outcomes worth considering in the future. Details are provided in Tables 3 & 4 below.

Table 3: Internal Strengths and Weaknesses

Strengths	Weaknesses
Governance, Board, Leadership and Legal Status	
• strong membership base – support and participation of the different segments of the population to uphold organization's objectives high • increased geographic coverage, thus increased outreach to the community in need • diversified partnership and program, thus, becoming financially and programmatically agile • engaging in advocacy and media activities to reach population at risk of NCDs • the organization guided by the SP adopted for five years • Availability of working materials and strategic policies and excellences like safeguarding policy; protection from sexual exploitation, gender equality, care for environment; etc. • availability of committed staff with long institutional memory • meeting compliance requirements internally and externally • strong governance system with able and matured leadership experience • Board members meets periodically to discuss on progress and approve plans; and have a good practice in monitoring and reviewing organizational function and constituency	• programmatically overstretched dealing with a number of issues, i.e. lacks thematic approach • slow pace in selling organization's best reputations and lack of a well-developed electronic/digital media system • slow pace of networking and dissemination to increase public visibility of the organization • last SP was not evaluated and reviewed • Lack of organized membership data disaggregated by geographic, gender and other socio demographic characteristics of members • Board members' effort in increasing profile of stakeholders and external relationship and resource mobilization is limited; engagement of board in strategic partnership; representation of board with partners
Organizational Vision, Mission, Strategies and Work planning	
• There is a written vision and mission statement for the organization • Mission and vision, being used in strategic communications, posted in key locations such as project, regional and head offices • The organization has prepared and implemented a five-year strategic plan, prepared through participatory processes that reflect internal and external stakeholder priorities. • The strategic plan is used as the basis of the organization's annual plans, and it appears to be used regularly as a leadership tool	• Mission and vision are ambitious and lacks specificity or clear focus as to the organization's comparative advantage and specific offers • Inconsistency in using and communicating the organization's vision

M&E, Knowledge Management, Communication and Organizational Sustainability	
• Has fairly sufficient monitoring and evaluation system (has M& E guideline) in place for projects implemented by the organization; developed a data quality assurance and M&E plans, which include different tools and checklists and are being used in monitoring progress and quality of data. • Conducts joint monitoring and review sessions with partners • Have worked with diversified groups of donors • Have developed a resource mobilization manual and also established a new fundraising committee and staffed a planning structure • Received positive feedbacks and appreciation from donors and governmental partners • Have built strong relationships and partnerships with stakeholders at the implementation level	• Systems for consistently capturing, documenting and sharing knowledge in the organization are weaker collecting and documenting success stories and lessons learned not done consistently to ensure strong knowledge management system • Limited efforts in fundraising and inadequately set or track proposal submission targets or win rates • The organization does not have a website that is continuously being updated with relevant contents • Do not use social media for communication
Organizational Structure and Management	
• There exists an organizational structure that puts most of important functions in the organization • There is a leadership structure cascaded at regional and zonal level that serves a proxy board, with the guidance of the main board and leadership of the organization from the head office	• Organizational structure doesn't include some essential structures and functions (like communication and business development) that can be further strengthened through time
Human Resources Development and Management	
• There are travel policies and procedures in place • There exists an up-to-date, comprehensive and functional HR manual • Transparent staff recruitment procedure and practice exists • Conducts staff performance appraisal every six months • Have salary scale in place • Reference checks are being conducted during new staff recruitment	• There is no up-to-date staff retention strategy in place • Inadequate organization and documentation of personnel files • Limited opportunities for staff development • lack of insurance and medical

• Gender composition in staffing, both at head and field levels is encouraging • Conducts exit interview when staff leave the organization • There is 12 per cent Provident Fund scheme for staff as part of the staff motivation factor (in addition to pension contribution)	coverage/allowance in the benefit package;
Financial Systems, Budgeting and Property Management and Operational Policies	
• Follows participatory budget preparation and management • Good budget planning and expenditure and very good practices in maximizing expenditure on direct program for the benefit of the target community • Budget utilization reports are submitted to donors on a monthly or quarterly basis, depending on the grant agreements. • Have financial policies and procedures manual, that is up to date which also includes supplies management and operating policies and procedures • Good experience in donor compliance and reporting • There is a segregation of duties for requesting, approval of requests, preparation of vouchers, approval of cheque and vouchers • Strong financial control mechanism including reconciliation with field office done on a monthly basis • There was no major incident identified through audits internally or externally • Clear and organized documentation of accounts and financial reports • Transparent and strong policies and procedures in procurement and fixed asset management	• There is no multi-year forecast for revenue and expenditures
Working Space and Office Facilities	
• office secured from government and was strong achievement • Have fairly sufficient working spaces in offices at head office level • All staff have got computers and internet connection is also available at HQ and Regional office	• Inadequate ICT infrastructure – data base; networking; digitalizing; SharePoint • Setup of the office for teams not attractive much • Field offices may not have sufficient equipment and suitable working space

Stakeholders Involvement, Partnership, Networking and Visibility	
• Have developed stakeholder engagement and community involvement strategies • Have got technical taskforces and working groups at the community and Woreda levels, beneficiaries • Signs a memorandum of agreements with local groups and hold monthly and quarterly meetings with them • Shares reports with key stakeholders regularly, solicits feedback • Conducts consultations with stakeholders in project design, stakeholders are involved in raising local resources for the project • Have membership in national consortiums like (Coalition against malaria in Ethiopia (CAME); Country coordinating mechanism (CCM)); PHE and CCRDA) and participates in relevant regional forums • Have good relationships with other likeminded organizations • Shares experiences to partners • Good efforts in regional and national peer mechanism, networking; coordination and communication	• organization has been unable to always consult target communities in project design due to resource issues • Minimal participation of stakeholders and target group in program design and formulation • There is no partnership strategy that can guide in creating, development and managing partnerships
Technical and Program Operations	
• Follows the national service delivery standards for health services • The organization has rich experience in programming experience in Malaria, SRH, Health and livelihood interventions • Targets the neediest and usually neglected groups and most at risk population • Uses government, religious and community structures to deliver programs and services • Good in crosscutting issues of gender, environment and disability in to the key project activities • Good in collecting baseline information through gap assessments to inform actions • HDAMA is trusted by donors, partners and beneficiaries	• Sometime there appears a lack of clarity on organizational focus and primary targets • Comparative advantage in pioneering and leading was not sufficiently leveraged (on malaria programming) • Have limitations in building a stronger technical capability on the key focuses of the organization

6.8. Analysis of Opportunities and Threats

Table 4: Opportunities and Threats

Areas/ Factors	Opportunities	Threats
Technical	• availability of wide membership base that likely a venue to gain huge resources • Availability of professional expertise within HDAMA • Availability of committed volunteers across intervention weredas and zones to promote the work of HDAMA • ANRS has a good number of professionals in different fields which could be considered as an asset for HDAMA and they could be used as volunteers as needed	Fear of membership decline due to unmet expectation that members contributing fees have high expectation of getting some sort of services in return. Unless and otherwise the organization treats this strategically and timely, members may withdraw at some point in time; and hence lacks membership base
Political	• Existence of favorable government policies and good political commitment on malaria, HIV/AIDS, SRH, Climate Change and other development issues • The federal and regional governments have clearer guidance in administering and regulating the CSOs • Regional and local government structures provide necessary supports when there is a need • ANRS pledged support for actions being implemented by HDAMA	• Gaps in implementing pertinent policies and strategies by the respective government authorities • Some stakeholders may not be as supportive as they are expected to be • Instability and insecurity that could affect program implementation
Economic	• engage in strong business development activities • Improving road infrastructure and telecom services • Improving health and education infrastructure at the community level • High commitment from the government to promote microfinance and enterprise development interventions in low-income communities • Access to credit services has improved –an ample opportunity for women's' economic empowerment	• Limited economic and employment opportunities for youth • High inflation rate and increasing living cost • Lack of land and other essential infrastructures such as water, power and market outlets for engaging women and youth in income generating activities (IGAs) • Limited livelihood and employment opportunities for marginalized communities residing in slum areas • Donor fatigue and shrinking funding opportunities

Social	• Improved educational opportunities that will contribute to better outcomes in health, economic wellbeing • Improving health care seeking behavior of the community • High interest from the community on the project activities that the organization is currently implementing on –puts the collaboration and participation at a high caliber	• Continuing prevalence of social and economic and environmental factors for the spread of communicable diseases and poverty • Increasing number of vulnerable population and risky behaviors, mostly commercial sex workers, university students and café and brothel based transactional workers • Un-informed rural urban migration and trafficking of persons • Lack of youth friendly services and service providers • man-made and natural disasters such as eruption of civil war/conflict; displacement; prolonged drought and floods
Technological	• Rapid changes in technology and introduction of new tools and techniques that can transform work • Access to information communication technology is becoming less difficult • Increased access for delivery of online services; hence reduced cost of business	• High cost of acquisition and maintenance of the ICT infrastructure due to rapid technological changes • Weak ICT establishment and readiness to implement changes in the near future • ICT literacy and experience limited in the youth population in rural areas
Legal	• The latest Civil Society organizations Proclamation put a clearer guidance, supporting and monitoring mechanisms that ensures transparency and accountability • Civil Society organizations' legislation allows the CSO's to engage in public collection and income generating activities	
Environmental	• Ethiopia is key player in global climate change leadership and the green growth	• Global warming and environmental degradation • Rapid increases in natural disasters, drought and global warming • New health hazards and increasing spatial and temporal distribution of communicable diseases due to climate change/weather variability

6.9. Conclusion on SWOT Analysis

HDAMA demonstrates internal organizational strengths that can be used as a starting point for its effort in achieving its results and bring about organizational change and shaping the organization's future. Continuous commitment and dedication to transform the organization is seen from the board, staff and management, which is a massive asset. Board's commitment is demonstrated by frequent meetings to discuss on organizational issues, approving plans and reviewing progress. However, commitment of board in areas such as fund raising has been limited. The board also shows openness to contribute more when needed. Organizational systems and procedures are backed up with written standard policy and procedure manuals that are being applied by the staff and management in finance, human resources and other administrative issues which are essential in promoting transparency and accountability within the organization.

The organization has a strong and positive relationship with its partners: government; non-government; community organizations; beneficiaries and target groups. The credibility and reputation gained can be a vital and instrumental to influence future collaboration and partnership building efforts that HDAMA has outlined to achieve in the next 5 years (2023-2027). HDAMA complies with government and donor requirements and has no any issue of concern in the near future and the organization will stay stable. The organization's deep experience on the main issues embedded into the current and upcoming programs will be of an added value to its effectiveness in the future, and also built trust to stakeholders working with it. In order to successfully implement the strategic plan and pave ground for achieving the aspired vision, the gaps that the organization identified needs to be addressed.

The key areas spotted for weakness during the internal environmental analysis includes inadequate involvement of the board in resource mobilization, lack of strong and continued action in fund raising and partnership, absence of staff development opportunities, absence of vibrant system in the HR, M&E and knowledge management (KM). The strengths mapped within the organization will be essential in overcoming the threats identified in the external environment and minimize the impact in program operation and organizational sustainability and also address internal weaknesses, also leveraging from the opportunities expected from the external environment as listed in the tables above.

As stated above, the board and staff commitment towards the organization's purpose is remarkable. Further to this, these groups represent the most valuable assets for the organization, on which successes are relied on. Hence, having a committed, talented and inspired staff, board and management can add a power for HDAMA and this power can be used to minimize the impact of the external threats and reduce

internal weaknesses. However, there appears the need for a continuous discussion and review on the system in order to improve its approaches on human resources and leadership, by ways of strengthening the motivational and inspirational factors and reduce issues that could possibly play against this. Issues related to job design (the nature of the work), the rewards and recognition system, the feedback and support mechanisms, the organizational culture and values, the personal and professional growth opportunities (including staff development plan); leadership/management style, etc. are worth considering.

Although organizational systems are fairly sufficient to ensure accountability and a transparent process across the budget management, recruitment and administration functions, there appears a need to make continuous improvements to deal with organizational growth and expansion and in order to ensure compliance and meeting requirements and needs by the donors, supporters and the government. Strategic communication needs to be enhanced and used as a means to engage more supporters and donors through disseminating relevant information about what the organization has done and results gained, including its intentions in the future.

Summary of Feedback from Internal Stakeholders

- Consider a revision on the current vision, mission, thematic areas and primary targets to respond to and comply with the contemporary development issues; funding landscape; changes in the global and national policies; etc.
- Consult external stakeholders during the strategic planning process
- Scale up existing interventions, incorporating lessons and innovations
- Intensify efforts to diversify donor/revenue base and widen the financial resource bases
- Improve systems and working environment for staff
- Increase staff development, retention and career advancement opportunities
- Strengthen partnerships and networking at community, regional, national and international levels
- Expand programmatic focuses beyond existing interventions by making them responsive to the emerging needs of the primary target groups
- Revise organizational systems, policies, structures and functions in line with the fast-changing circumstances (change management)

Figure 3: Summary of feedback from Internal Stakeholders

6.10. Recommendations from External Stakeholders

Recommendations from External Stakeholders

- Continuous learning and modification of projects and programs
- Improved coordination and harmonization within the sector–and engage in constructive dialogue with the government and donors
- Strengthened internal organizational communication and partnership framework
- Enhance reputation and credibility by the government, donors, community and other partners(HDAMA's strength)
- Elevate efforts in strategically communicating, presenting and promoting
- Explore and expand membership in the existing national and regional coordinating platforms and networks
- Look for local income-generating opportunities and schemes
- Critically review current thematic issues and strategic pillars in order to make sure that the organization's interventions are well aligned to the development challenges at the community level and also connected to national frameworks and the strategic direction of the organization
- Follow youth-friendly, holistic and integrated approaches in programming
- Strengthen partnerships with youth groups and other CBOs in conducting community mobilization and training activities
- Increase geographic scope –beyond the current target areas, but focus on selected thematic issues on which the organization has already gained strong experience on
- Create and improve linkages with different stakeholders at different levels
- Strengthen strategies for phase-out and ensure smooth handover of project activities to the designated government and community structures
- Strive to become a ' Center of Excellence' on malaria and NCDs in Ethiopia
- Increase youth and women-focused health and livelihoods interventions
- See the 'bigger picture in partnerships' not only the shorter gains
- Mobilize more volunteers and members

Figure 4: Recommendations from External Stakeholders

Offers from External Stakeholders

- Share experiences in income generating projects to HDAMA
- Participate and contribute in joint planning and review platforms
- Create and strengthen referral linkages for services to beneficiaries
- Provide technical support through resource persons and professionals
- Provide existing infrastructures, such as school Mini Medias and airtime on Education Medias, facilities at woreda and community level that are owned by the public

Figure 5: Offers from the External Stakeholders

Table 5: Summary of Feedbacks, Expectations and Proposed Actions

Stakeholders	Expectations	HDAMA's Expectations from the Stakeholder	Proposed Actions to be Taken by HDAMA	Consequences, if not met
1 **Internal Stakeholders (Board, Management & Staff)**	• Improve and strengthen systems and capacities for fundraising and organizational visibility • Improve staff development, recognition and career advancement opportunities • Expand thematic and geographic coverage • Revise the existing vision and mission to gain more clarity • Strengthen partnerships, networking and stakeholders' participation • Revise and improve organizational structure, reporting lines and other policies	• Share organizational vision and respect organizational values • Commit more in enhancing the organization's status, visibility and capacity • Increase engagement and contribution for the organization in strategic communication, networking, resource mobilization • Active leadership and involvement in the preparation, implementation, monitoring and follow-up of this strategic plan • Carry out duties with due diligence, efficiency, integrity and professionalism	• Provide timely reports, clear plan and information to the Board • Create a conducive working environment, reward, career development, recognition and motivation system • Increase engagement of stakeholders through consultations • Increase efforts to make the vision and mission understood and shared by internal and external stakeholders	• Decline in organizational resources, networks and visibility • Loss of commitment and engagement • Reduced efficiency and effectiveness • Reduced impact on the mission and vision • loss of trust and desire for partnership
2 **Legislators and Government Counterparts**	• Comply with regulations, policies and meet government requirements for ACSOs in Ethiopia • Ensure transparency and accountability • Extent to which HDAMA's priorities and focus aligned with government priorities • Ensure smooth working relationship with government and other partners • Focus on youth, child and women empowerment, water sanitation and health, HTPs & Malaria programs • Consider geographic expansion • Scale programs that are proved to be successful in the existing target areas • Increase community participation in project activities • Ensure integration, quality and equity in services	• Enhanced contributions from stakeholders to speed up activities • Increased participation and timely provision of feedbacks • Increased supports from signatory and co-signatory offices in facilitating agreements and subsequent follow-up supports • Increased supports in creating partnerships with other organization and donor agencies when possible • Supports in community mobilization, facilitation, assigning personnel and support the planned project demands, provides support for HDAMA	• Conduct joint planning and reviewing meetings periodically • Ensue consultation and participatory approaches in program design, implementation and monitoring and evaluation • Timely submission of reports • Ensure accountability and transparency in the management of funds and implementation of programs • Provide accurate and timely information • Increase participation of target community groups and extended government structures at woreda, kebele and sub-kebele levels	• Loss of trust and decline from partnerships and agreements • Negative influence on organizational existence and success • Affect quality and cost of program implementation

3 **CSOs and Networks**	• Focus on empowerment – not provision of free services • Increase stakeholders and community involvement in the design, implementation and evaluation of project activities • Provide capacity development support to community structures • Increase partnerships with mass-based organizations benefiting women and youth in the community • Conduct intensive assessments and build evidences in order to target the neediest groups and address pertinent and most challenging issues • Strengthen partnerships with CSOs and their networks at national and regional levels	• Mobilize members and increase their participation and ownership in project activities • Represent and reflect the views, ideas and feedbacks of their respective members in joint consultative meetings and discussion forums • Provide recommendations to the organization during project design and implementation • Provide volunteering support to the works of the organization for the common good • Take the leadership at community level in efforts to sustain projects after phase out	• Conduct, facilitate, collaborate and participate in regular consultations with INGOs, NGOs and CSOs to expedite policies, discuss and enhance implementation strategies, facilitate training and capacity building and conduct monitoring and evaluation • Map out and include CSOs in project target areas in partnership forums, project implementation, review and consultations forums • Conduct joint review and reflection consultative meetings with them • Incorporate feedbacks in to project design and implementation • Provide capacity development support to community groups	• Lose of trust and desire for partnership • Withdraw supports in project implementation • Fail to mobilize members and provide volunteering supports • Increase cost of implementation • Failure to get buy in from the community • Withdraw ownership and leadership in sustaining project activities
4 **Members, CBOs & FBOs**	• Continue to work with CBOs in order to address marginalized and hard to reach community and beneficiary selection • Continue to focus on youth and women empowerment and SRH issues • Target youth at early stages of adolescence in order to empower and build their skills for resilience • Increase partnerships with NGOs, CSOs, FBOs and CBOs at community level	• Provide supports in reaching the most vulnerable, hard to reach and invisible (marginalized/isolated) community member • Mobilize volunteers from the community • Integrate the HDAMA's agenda within community meetings and gatherings • Enhance voluntary supports at the community, local and regional levels • Increased involvement in program design, monitoring and evaluation • Support in beneficiary selection, sustaining interventions on project phase out	• Include capacity building initiatives in project target areas through partnership with forums, project implementation, reviews and consultations, partners' capacity building initiatives • Conduct joint review and reflection consultative meetings Incorporate feedbacks from CSOs • Enhance our engagement with youths, women and children, take their views and encourage their active participation on matters that concern them at the local and national levels	• Lose of trust and interest to participate and support HDAMA's activities • Fail to mobilize members and provide volunteering supports • Increase cost of implementation • Withdraw ownership and leadership in sustaining project activities

5 **Beneficiaries in Target Communities**	• Improve health and socio-economic conditions of the poor • Improve access to and quality of healthcare services • Address economic vulnerability by focusing on creating and sustaining income generating opportunities • Continue to support youth structures, clubs and youth groups in health education, HIV/AIDS and life skills • Continue to organize trainings to selected community members in order to enable them to train others and become the lead change agents	• Participate and contribute ideas and resources to improve programs • Support the organization through promoting its agendas • Increase sense of ownership and participation in project interventions to sustain the benefit in the long term • Mobilize others in the community to support and participate in awareness raising activities • More commitment in applying the knowledge and other supports obtained through the organization in to life to bring the desired result	• Include community groups at all phases of the project cycles • Conduct consultative and join review meetings with representatives of the community • Build capacity of community representatives to increase their participation and leadership • Incorporate feedbacks from the community in to lessons learned and future programming • Conduct discussion with community representatives in mobilizing community contributions	• Loss of trust and decline to support or participate in HDAMA's activities • Loss of desire to take inputs of projects in to action to achieve results • Withdraw ownership and leadership in sustaining project activities • Fail to mobilize members and provide volunteering supports • Increase cost of implementation

7. HDAMA STRATEGIC PLAN (2023-2027)

7.1. Purpose of the Strategic Plan

HDAMA prepared this strategic plan with the overall purpose of adopting a strategic guidance on the efforts towards achieving its vision through shaping its fundamental purpose and actions required.

7.2. Vision, Mission and Values

7.2.1. Vision

- To be a leading civil society organization striving to enhance the socio-economic well-being of the society

7.2.2. Mission

- Health, Development and Anti-Malaria Association (HDAMA) is committed to bring sustainable change in alleviating critical social and economic problems by fostering participation of people, ensuring poverty reduction and overall social development

7.2.3. Organizational Values and Principles

a) **Accountability**: The organization is committed to demonstrating accountability in using resources and rolling out its responsibilities to the community, donors, government and members.

b) **Integrity**: The organization pursues its mission with commitment, discipline and rigor at all times.

c) **Transparency**: The organization acts in a thoroughly transparent manner in all its undertakings

d) **Participation & Partnership**: The organization forges partnerships and engages communities and diverse stakeholders in participatory approaches for development

e) **Volunteerism**: The general assembly, Board, management, staff and members of HDAMA intend to always volunteer and contribute

f) **Diversity**: The organization engages and serves diverse population. Decisions undertaken on behalf of the organization are made with the greatest respect and support of everyone within and around differences

g) **Environmental Care**: The organization promotes environmental friendly technologies, approaches and actions

7.3. Organizational Identity and Branding

7.3.1. Logo and its meaning

Ethiopia Map Shape (Ethiopian Based)

Human Shape (Advocacy, Community)

Heart Shape (Health, Love, Care)

Developing Graph Shape (Development)

7.4. Core Programmatic Areas

Organizational/institutional transformation; prevention and control of malaria and related communicable diseases; mitigation of risk factors of non-communicable diseases; adolescent, youth and women empowerment, Enhancing Livelihood Opportunities for youth and women and Disaster prepared ness and humanitarian response are core programmatic areas of HDAMA for the next five years.

7.5. Target groups and beneficiaries

Across the interventions, HDAMA thoroughly considers who the primary beneficiaries and end users are and would be. HDAMA believes that its very existence as an entity is to serve project beneficiaries and target groups. In this regard, HDAMA is concerned over positively shaping life of the beneficiaries through its interventions. Thus, HDAMA have a philosophy in terms of selection, targeting and reaching people and working with people. HDAMA identified and is going to identify unique beneficiaries and target groups to reach and work together under each intervention.

HDAMA targets, selects and reaches beneficiaries systematically using selection criteria that avoid bias, inclusive and which is evidence and right based. HDAMA during the project design considers vulnerability, disability, demographic and gender parameters to elucidate that its programming are right-based; gender sensitive and addresses vulnerability and critical development issues. In this regard, programming of HDAMA considers the following target groups and beneficiaries.

Table 6: Beneficiary Profile by Core Program Areas

Core Program Area	Age
Prevention and control of Malaria and other communicable diseases	Infancy - elderly
Prevention and Control of non-communicable diseases	3 - elderly
Adolescent, Youth Sexual and Reproductive Health (AYSRH)	10-49
Enhancing Livelihood Opportunities for youth and women	15-49

8. CROSS-CUTTING ISSUES

8.1. Promoting gender equality and empower women

Considering the gaps that exists in access to services and participation for men, women, boys and girls, HDAMA will conduct a robust gender analysis as part of planning, and also incorporate strategies to increase women and girls' participation and representation in the implementation, monitoring and reporting, to make sure that needs and concerns of both genders to clearly identify and respond. HDAMA's commitment for gender equality will also be visible at organizational level through paving the paths for increased representation of women at different roles, including the board and key staff.

8.2. People with Disability (PwD)

HDAMA strongly believes in the inclusion of the marginalized and underserved people and groups. In this regard, the organization ensures inclusion of the PwDs in its project cycle management (design, implementation, monitoring and evaluation) and committed towards ensuring meaningful inclusion and effective participation of the PwD in program/project processes and decisions. The organization will not discriminate people based on disability status in any form, in its programs, services and staffing. Monitoring tools will be customized to capture data on PwDs as well.

8.3. Promoting Environmentally Friendly Technologies and Approaches:

HDAMA cares for the environment in order to minimize the challenges that the world is facing due to climate change. The organization practices environmental friendliness in its work and mainstreams this across the range of project portfolios.

8.4. Child Protection and Safeguarding

Understanding the risks of harm to children that can arise from a range of sources –from within the family and community to their participation in work or school and related programs or through accessing services; HDAMA will put in place everything possible to prevent harm arising on children involved in programs, respond to harms once they appeared and build reporting and service linkages with relevant service providers. Child protection policy with the code of conduct will be developed and everyone working for or with us will sign and acknowledge the acceptance in advance.

8.5. Conflict Resolution and Management

HDAMA recognized frequent occurrence of conflicts and the resultant loss of life, property and trauma. HDAMA also believes that conflict erodes the value system of the society and impedes development undertakings. To this end, HDAMA aspires to be engaged in conflict resolution and

management endeavors. The organization cultivates indigenous conflict resolutions and management approaches. Strengthening early warning systems may be some of the methods HDAMA will consider.

8.6. ICT and Digitalization

The role of ICT and digitalization in organizational transformation is manifold and clear. It provides the organization with tools and systems that enable efficient communication, data management, analysis, and decision-making processes, as well as to enhance productivity, engagement, and competitive advantage. On the other hand, digitalization using technology reduces operating expenses and inefficiency. When business/activities are unified with technology, organizations achieve their goals easily.

In its SP period and beyond; HDAMA highly utilizes information and communication technologies (ICT) and digitalization system. HDAMA uses diverse set of technological tools and resources to transmit, store, create, share or exchange data and information. The organization progressively moves from a paper based and manual type of operation (communication and documentation) to the electronic communication and documentation system. This, of course smoothly facilitates organizational transformation by creating a fast and easy communication among the staff. It ensures organizational effectiveness and efficiency as data are stored, retrieved and exchanged electronically. Overall, ICT and digitalization helps the management to make data-driven decisions conveniently.

9. STRATEGIC FRAMEWORK AND OBJECTIVES

9.1. Strategic Framework

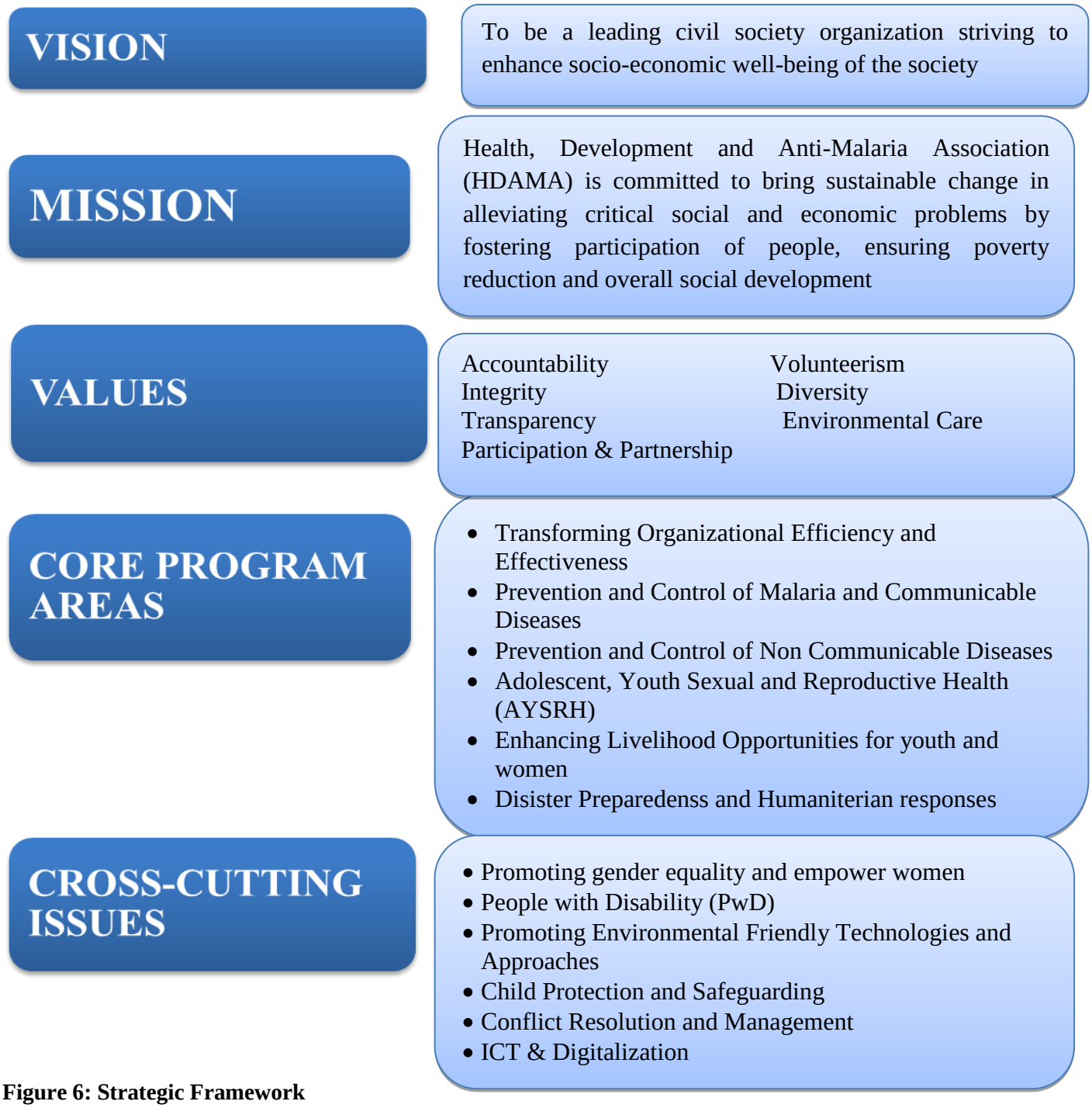


Figure 6: Strategic Framework

9.2. Strategic Objectives (SO) and Proposed Actions

SO1: Transforming Organizational Efficiency and Effectiveness

Key intervention areas under this strategic objective:

- Establish/Strengthen lower-level organizational structures to work for and with targeted communities closely – establish and strengthen grass-roots structures, Wereda and Zonal levels
- Improve stakeholders' engagement, partnership, participation and organizational visibility
- boost membership by increasing number of members continuously and achieve one million by the end of the SP period (2027)
- Strengthen systems for HR, finance and procurement management
- Strengthen systems for resource mobilization and raise organizational income from diversified sources
- increase budget share to 50:50 by the end of the SP period (i.e. 2027); that is, by 2027 share of internal revenue will reach 50% of the total organizational revenue
- Strengthen systems for internal and external capacity development
- Develop and enhance the engagement of board, leadership, staff, volunteers and members
- Enhance organizational systems and practices in monitoring, evaluation, research and knowledge management
- Strengthen IT infrastructure, marketing and communication system
- Enhance the organization's visibility through mainstream media, website, social media and leverage national and international forums to showcase HDAMA's impact and exhibit its best practices

SO2: Prevention and Control of Malaria and other Communicable Diseases

Key intervention areas under this strategic objective:

- Improve the knowledge, attitude and practice of the community towards malaria prevention and control
- Support the primary healthcare system to improve their capacity in malaria prevention, treatment and control
- Strengthen community structures in malaria prevention and control
- Improve the consistent and regular utilization of long-lasting insecticidal nets (LLINs)

- Align engagements and strengthen reporting of routine data and information as provision of comprehensive account of strategic information for malaria M&E nationally

SO3: Prevention and Control of Non Communicable Diseases

Key intervention areas under this strategic objective:

- Advance awareness and understanding of the general public, public place business owners/managers, legislators and law enforcement bodies about smoke free provisions of the Proclamation through intensive and direct engagement of media and communication.
- Promote the city government's accountability to implement smoke-free provisions by making the gaps between current and desired performances a public agenda through direct engagement of the media and placement of billboards.
- Assist the Addis Ababa (other big cities as the need arises) smoke-free effort in increasing the visibility of enforcement actions carried out in all sub-cities by establishing smoke-free workplaces, particularly in media and educational institutions.
- To build the capacity of journalists and other media stakeholders to report on unhealthy diets and NCDs and use their capacity to pivot discussions to unhealthy diet control regulations and implementation.
- Generate sustained traditional and social media coverage to build support for a strong regulatory framework to be adopted and implemented for unhealthy foods control in Ethiopia.
- Media monitoring and countering industry/front group related to unhealthy diet control in Ethiopia towards timely adoption of the unhealthy diet control law in Ethiopia.

SO4: Adolescent, Youth Sexual and Reproductive Health (AYSRH)

Key intervention areas under this strategic objective:

- increased awareness and utilization of quality SRH and SGBV services by the vulnerable groups improve accessibility and availability of integrated package of SRH services
- strengthen institutions and social environment to enable them effectively respond to the rights and needs of vulnerable groups
- improve networking and partnership to strengthen collaboration and engagement of stakeholders
- Promote family planning education and information dissemination, increase contraception use and reduce unintended pregnancy for adolescent youth

- Promote youth friendly services within public service providers and ensure youth friendliness in the healthcare services that HDAMA is providing
- Promoting and engaging in safe space program for girls which believed to increase knowledge of girls on SRH and educational issues and minimize vulnerability to different hazards/risks – boarding space for girls

SO5: Enhancing Livelihood Opportunities for youth and women

- Provide skills trainings for economic empowerment, create jobs and employment opportunities for vulnerable youth and women
- Facilitate access to finance, trainings, market and linkages for micro and small enterprise development
- Collaborate with TVET agencies in providing formal and non-formal skills training for the youth to create employment or business opportunities
- Promote opportunities for job creation, entrepreneurship and linkages with Micro and Small Enterprises

SO5: Enhancing Livelihood Opportunities for youth and women

- Support national scale up and implementation EPDEMIA systems to detect and provide early warnings for Malaria.
- Providing need based food and nonfood items duding emergencies using own fund and in partnership with donors
- Logistics and Supply Chain Management: Coordinating the delivery of items and services to affected areas.

10. IMPLEMENTATION PLAN: TARGETS AND ACTION PLAN

During the next five years (2023 - 2027) HDAMA shall strive to attain four strategic objectives (SOs) through strategies suggested. Three of the proposed SOs was programmatic whereas the other one focuses on organizational transformation.

10.1. Planned Targets for the Years 2023-2027

Table 6 below depicts estimation of the targets for the SP period spanning from 2023-2027. Accordingly, through three programmatic interventions HDAMA intends to process and acquire total of 67,542,027 products/outputs in different forms. The products and outputs are classified in to five different categories. These are advocacy campaigns; media interventions; community conversation education and community mobilization sessions; trainings; policy advocacy; and capacity building activities.

Throughout the strategic plan period total of 21,080 campaigns are planned by the projects. In terms of production of media awareness-raising materials (TV and radio spots; IEC/BCC materials; audio& video); total of 6,272,009 materials/products are estimated to be produced and disseminated. Moreover, total of 30,880 community conversation and mobilization sessions are planned. As far as training is concerned, 918,451 trainings are planned. Furthermore 16,181 institutions and organizations benefit from the capacity building intervention throughout the SP period. Finally, it is planned to prepare, endorse and implement three policy documents in the areas of unhealthy food and tobacco. As a result, it is planned to reach total of 90,271,212 people through the above methods.

Table 7: Output Target Plan (2023-2027)

S/No.	Name of the Project	Indicator	Unit	Total Target for the SP Period	Target by Year					Remarks
					2023	2024	2025	2026	2027	
1	*Organizational transformation*	Wereda Level Grass Root Structures (committee) Established /strengthened	No	162	24	28	32	37	42	
		Wereda Branch offices Established /strengthened	No.	27	2	3	5	7	10	
		Zonal Level Grass Root Structures (Committee) Established /strengthened	No.	12	2	2	2	3	3	
		Regional Branch offices strengthened	No.	1	1	1	1	1	1	
		Budget share increased	NA	50:50	20:80				50:50	
		Membership increased	No.	1 million	250,000	187,500	187,500	187,500	187,500	
		Capacity building training for Board members; management and staff provided	Activity	5	1	1	1	1	1	
		Organizational policies, procedures, strategies and manuals developed and/or adapted/updated	Document	12	2	4	4	2	-	
		Proposals, concept notes and business ideas developed and submitted to donors	Document	35	7	7	7	7	7	20 proposals 15 concept notes/business plans

S/No	Name of the Project	Indicator	Unit	Total Planned Target for the SP Period	Target by Year					Remarks
					2023	2024	2025	2026	2027	
2	Community Based Malaria communication (SCBMC)	Number of individuals reached in malaria SBC messages and actions	No.	24,891,012	4,077,085	4,484,794	4,933,273	5,426,600	5,969,260	
		Number of individuals trained on SBC	No.	917,230	75,217	165,264	181,790	199,969	219,966	
		Number of IEC/BCC materials (audio, video, print) disseminated	No.	6,222,753	1,019,271	1,121,198	1,233,318	1,356,650	1,492,315	
		Number of Social Mobilization conducted (Community conversations, community mobilizations)	No.	30,880	5,058	5,564	6,120	6,732	7,405	
		Number of all kinds of Major Campaigns	No.	20,586	3,372	3,709	4,080	4,488	4,937	
		Number of organizations or institutions that received Capacity Building interventions or support on SBC	No.	15,690	2,570	2,827	3,110	3,421	3,763	
		Policy documents prepared and endorsed	No.	1	-	1	-	-	-	
Sub Total				**32,098,152**	**5,182,573**	**5,783,356**	**6,361,691**	**6,997,860**	**7,697,646**	

3	Media Advocacy Campaign to Intensify Support for the Adoption of the Draft Unhealthy Food Control Proclamation in Ethiopia		**Unit**	**Total Planned Target for the SP Period**	**2023**	**2024**	**2025**	**2026**	**2027**	**Remarks**
		Policy document prepared	No.	2	-	2	-	-	-	
		Number of institutions capacitated through technical and other types of supports	No.	61	10	11	12	13	15	
		Number people capacitated through various trainings	No.	1221	200	220	242	266	293	
		Number of printed advocacy materials disseminated	No.	12210	2000	2200	2420	2662	2928	
		Number of awareness-raising productions (Tv and radio spots) produced and Broadcasted	No.	10	2	2	2	2	2	
		Number of policy advocacy campaigns conducted (mainstream and social media campaigns)	No.	183	30	33	36	40	44	
		Number of public awareness Campaigns conducted	No.	275	45	50	54	60	66	
		Number of public reached	No.	12,210,200	2,000,000	2,200,000	2,420,000	2,662,000	2,928,200	
		Sub Total		**12,224,163**	**2,202,518**	**2,422,770**	**2,665,045**	**2,931,549**	**2,931,548**	

4	Media and communication campaign to increase awareness on the smoke free provision and its effective implementation in Addis Ababa City public places.		**Unit**	**Total Planned Target for the SP Period**	**2023**	**2024**	**2025**	**2026**	**2027**	**Remarks**
		People touched through media and communication work (both traditional and digital media)	No.	42,735,700	7,000,000	7,700,000	8,470,000	9,317,000	10,248,700	
		Number of IEC/BCC materials (audio, video, print) disseminated	No.	90,832	14,878	16,366	18,002	19,803	21,783	
		Number of all Major Campaigns	No.	67	11	12	13	15	16	
		The number of media and institutions that received Capacity Development interventions or support for the proclamation of a smoke-free workplace	No.	794	130	143	157	173	190	
		Sub Total		**42,827,392**	**7,015,019**	**7,716,521**	**8,488,173**	**9,336,990**	**10,270,689**	

			Unit	Total Planned Target for the SP Period	2023	2024	2025	2026	2027	Remarks
5	Adolescent, Youth Sexual and Reproductive Health (AYSRH)	Number of vulnerable groups increased awareness and utilization of quality SRH and SGBV information and services	No.	21,656	3548	3902	4292	4721	5193	
		Standardized comprehensive age appropriate and gender sensitive SRH training program provided for out of school adolescents and young adults	No	17,095	2,800	3080	3388	3727	4100	
		IEC/BCC Materials produced and distributed to the community health workers, youth and community information dissemination centres	Copies	212,099	34,700	38,987	41,817	45,998	50,597	
		Unintended pregnancy and STI screening conducted for adolescents	No	7,972	5,448	5,992	6,591	7,250	7,975	
		Number of institutions and social environment strengthened and effectively responded to the rights and needs of vulnerable groups; and	No	18	12	13	14	16	18	
Sub Total				**258,840**	**46508**	**51974**	**56102**	**61712**	**67883**	

6			**Unit**	**Total Planned Target for the SP Period**	**2023**	**2024**	**2025**	**2026**	**2027**	**Remarks**
	Enhancing Livelihood Opportunities for youth and women	Trained Youth have self-employ ability to develop their own income generating scheme	No.	5,000	500	1,125	1,125	1,125	1,125	
		Women from targeted communities are organized into Self Help Group (SHGs) with requisite skills in SHG management	Group	1,500	100	600	600	200	-	Each group consists of 15-20 members
		SHG members are engaged in a viable enterprise/Business through improved vocational skills on livelihood acquired from the project.	No.	30,000	2,000	12,000	12,000	4,000	-	20 members in one SHG
		Families are aware and explored livelihood opportunities in their communities	Households	5,000	500	1,500	1,500	1,500	-	
		Youth from targeted families have income source	No.	1,500	250	375	375	250	250	
Sub Total				43,000	3350	15,600	15,600	7,075	1,375	

10.2. Detailed Action Plan (2023)

Table 8: Action Plan for the Malaria Prevention and Control Project for the Year 2023

Objectives & Activities	Strategy	Unit	Five Years' Plan (2023-2027)	Plan for 2023	Remarks
Project Title: Community Based Malaria Communication (CBMC)					
Objective 1: Reduce malaria morbidity and mortality by 30% in vulnerable groups in the 5 target districts in the Amhara region by 2025					
Increased coverage and quality of seasonal mobile workers friendly malaria services in 5 target districts in Amhara region	Targeted intervention	Population	269,000	50,000	
Train health workers on malaria service provision	Training	Number	3,675	553	
Improve malaria surveillance	System development	Number	2	2	
Develop malaria service provision manual to seasonal mobile workers	Policy development	Number	3	1	
Objective 2: Improve adoption of appropriate health behavior by 85% in utilization of malaria services in target districts by 2027					
Train health workers on malaria service provision	Training	Number	223,769	31,967	
Improve community empowerment on social behavior change/SBC approaches	Capacity building	# institutions	24,680	4,936	
Improve community behavior on malaria services utilization	Use the health network	Population	14,491,012	5,235,486	
	Community discussions	# sessions	101,140	20,550	
School malaria programs	SBC	Population	4,400,012	3,020,240	
	School interventions	# of schools	1,351	536	
	Peer education	# sessions	251,140	12,550	
	Literature competition	# of sessions	21,446	1,072	
	School mini media	# of sessions	21,440	428	
	Train teachers	Number	50,335	10,067	
	Train peer leaders	Number	166,187	33,223	
Broadcast key malaria message to community through national radio and television	Spot production	# of spots	50	10	
Distribute key malaria message to community through printed media	Billboard	Number	553	535	
	Poster	Number	13,300	1,330	
	Stickers	Number	710,240	142,048	
	Leaflets	Number	3,551,200	4,500	

	Interpersonal communication	# of sessions	819,150	35,646	
Community campaigns	Community wide events, campaigns	# of sessions	30,880	4,824	
Develop malaria communication manuals	Manual development	Number	5	1	
Total Material Products/Outputs					
Direct/Indirect Beneficiaries Reached					

Table 9: Action Plan for the Unhealthy food control for the Year 2023

Objectives & Activities	Strategy	Unit	Targeted Output (Qty.)	Five Years' Plan (2023-2027)	Plan for Year 2023	Remarks
Project Title: Media Advocacy Campaign to Intensify Support for the Adoption of the Draft Unhealthy Food Control Proclamation in Ethiopia						
Objective 1: To build the capacity of journalists and other media stakeholders to report on unhealthy diets and NCDs and use their capacity to pivot discussions to unhealthy diet control regulations and implementation.						
Fact sheet preparations, printing, and distribution to the public, private, and social media reporters/ journalists/activists as a talking point.	Capacity building	# of copies	2,000			
Organize 4 rounds of sensitization and partnership-building workshops on the importance of adopting the unhealthy diet control proclamation with participants from public and private media journalists		# of participants	160			
Objective 2: Generate sustained traditional and social media coverage to build support for a strong regulatory framework to be adopted and implemented for unhealthy foods control in Ethiopia.						
Run social media campaigns	Effective Media Communication and Outreach	# of round	12			
Produce and disseminate newspaper articles		# of NP	3			
Develop, print, and distribute IEC materials.						
Posters		# of copies	1,000			
Flyers		# of copies	3,000			
Facilitate media debate in collaboration with the media on unhealthy food control proclamation adoption where celebrities, influential people, religious leaders, etc. take part		# of rounds	3			
Facilitate panel discussion in collaboration with the media on unhealthy food control proclamation adoption where celebrities, influential people, religious leaders, etc. take part		# of participants	50			
Objective 3: Media monitoring and countering industry/front groups related to unhealthy diet control in Ethiopia towards timely adoption of the unhealthy diet control law in Ethiopia.						
Monitor the misinformation spread by the food and beverage industry about ultra-processed foods and beverages	Media Monitoring	# of rounds	4			
Counter to the misinformation provided by the food and beverage industry		# of rounds	4			
Maintain consistent and close coordination with GHAI advocacy partners to support and amplify their policy advocacy efforts the s on the Unhealthy diets control Proclamation through regular coverage via traditional and social media in Ethiopia						
Organize periodic experience-sharing meetings with GHAI partners to amplify their policy advocacy efforts on unhealthy diet control	Coordination and Partnership Building	# of rounds	4			
Organize discussion forums on the challenges and		# of rounds	4			

opportunities of policy advocacy efforts on unhealthy diet control.						
Work closely with GHAI partners to leverage its relationships with media outlets so these media outlets will provide coverage for major activities implemented by EMA and MWECS, and other food policy partners.		# of rounds	3			
Total Material Products/Outputs						
Direct/Indirect Beneficiaries Reached						

Table 10: Action Plan for the Smoke Free Campaign for the Year 2023

Objectives & Activities	Strategy	Unit	Targeted Output (Qty.)	Five Years' Plan (2023-2027)	Plan for Year 2023	Remarks
Project Title: Media Advocacy Campaign to Intensify Support for the Adoption of the Draft Unhealthy Food Control Proclamation in Ethiopia						
Objective 1: To build the capacity of journalists and other media stakeholders to report on unhealthy diets and NCDs and use their capacity to pivot discussions to unhealthy diet control regulations and implementation.						
Fact sheet preparations, printing, and distribution to the public, private, and social media reporters/ journalists/activists as a talking point.	Capacity building	# of copies	2,000			
\Organize 4 rounds of sensitization and partnership-building workshops on the importance of adopting the unhealthy diet control proclamation with participants from public and private media journalists		# of participants	160			
Objective 2: Generate sustained traditional and social media coverage to build support for a strong regulatory framework to be adopted and implemented for unhealthy foods control in Ethiopia.						
Run social media campaigns	Effective Media Communication and Outreach	# of round	12			
Produce and disseminate newspaper articles		# of NP	3			
Develop, print, and distribute IEC materials.						
Posters		# of copies	1,000			
Flyers		# of copies	3,000			
Facilitate media debate in collaboration with the media on unhealthy food control proclamation adoption where celebrities, influential people, religious leaders, etc. take part		# of rounds	3			
Facilitate panel discussion in collaboration with the media on unhealthy food control proclamation adoption where celebrities, influential people, religious leaders, etc. take part		# of participants	50			
Objective 3: Media monitoring and countering industry/front groups related to unhealthy diet control in Ethiopia towards timely adoption of the unhealthy diet control law in Ethiopia.						
Monitor the misinformation spread by the food and beverage industry about ultra-processed foods and beverages	Media Monitoring	# of rounds	4			
Counter to the misinformation provided by the food and beverage industry		# of rounds	4			
Maintain consistent and close coordination with GHAI advocacy partners to support and amplify their policy advocacy efforts the s on the Unhealthy diets control Proclamation through regular coverage via traditional and social media in Ethiopia						
Organize periodic experience-sharing meetings with GHAI partners to amplify their policy advocacy efforts on unhealthy diet control	Coordination and Partnership Building	# of rounds	4			
Organize discussion forums on the challenges and		# of rounds	4			

opportunities of policy advocacy efforts on unhealthy diet control.						
Work closely with GHAI partners to leverage its relationships with media outlets so these media outlets will provide coverage for major activities implemented by EMA and MWECS, and other food policy partners.		# of rounds	3			
Total Material Products/Outputs						
Direct/Indirect Beneficiaries Reached						

Table 11: Action Plan for the Livelihood Project for the Year 2023

Objectives & Activities	Strategy	Unit	Targeted Output	Five Years' Plan (2023-2027)	Plan for Year 2023	Remarks
Project Title: Enhancing Livelihood Opportunities for Youth and Women						
Objective 1: Unemployment and migration rate of youth reduced in targeted areas						
Youth trained in job creation and business management skills		No.		5,000	1,500	
Provide Vocational skill building on alternative livelihood opportunities		No.		5,000	2,000	
Training on leadership development Activity		No.		1,500	500	
Training on accounts and bookkeeping		No.		5,000	1,500	
Objective 2: Sustainable opportunities for lending to generate income are in place in the communities						
Conducting community level assessment including baseline survey and PRA exercises to collect detailed demographic and socio-economic information in selected sites and communities.		No.		3	1	
Formation & orientation on SHG; initial meetings with community members to form new SHGs will be organized in all the communities.		Groups		1,500	100	
Training on group dynamics to SHGs.		Activity		10	2	
Training on leadership development		Activity		10	2	
Training on accounts and bookkeeping.		Activity		10	2	
SHG exposure visits to other NGOs.		Activity		5	1	
Refresher trainings to SHGs		Activity		10	2	
Workshop on government livelihood entitlements to increase knowledge on the existing schemes		Workshop		10	2	
Networking with financial institutions to establish and increase micro-credit linkages for SHG. Apart from financial institutions, the project will coordinate with national entities		No.		10	1	
Organizing Cluster level meetings		Meeting		10	-	
Training on organization development and management to provide basic understanding about the organizational dynamics, development and management.		Activity		5	1	

Training on financial procedures and management to provide basic understanding on the financial management of the society.		Activity		5	1	
Networking for building marketing/business linkages.		Activity		10	1	
Objective 3: Poor families/households are able to control and influence their situation and change their household economy						
Identify families for support		Households		5,000	500	
Provide business skill training for representatives from the families		No.		5,000	500	
Selected families identify business ideas		No.		5,000	500	
Prepare business plan		Plan		5,000	500	
Families received capital support to launch a business.		Households		5,000	5000	

11.FINANCIAL AND HUMAN RESOURCE PLANNING AND MANAGEMENT

HDAMA understands the critical needs in strengthening and sustaining resources that are keys for achieving its mission. Hence it has aligned the financial and human resources plan during its five-year strategic plan, as presented below.

11.1. Budget Planning and Financial Resources Management

Three years' income (2021-2022) of HDAMA preceding this strategic plan has been reviewed. Trend of income showed a positive result that budget steadily increased in positive direction over the past three years. In 2022 a remarkable increment was observed in the organization's revenue. This means that HDAMA's operating budget is in the 2022 was in the range of 35,502,896.29 (Thirty five million five hundred two thousand eight hundred ninety six and twenty nine cents). Compared to the 2020 and 2021annual organizational income which was birr 21,447,103.10 and 24,679,579.84 respectively, there is considerable difference in terms of growth of revenue.

Taking the above scenario as a reference and taking the 2022 total annual organizational income (i.e. Birr 35,502,896.29) as a benchmark, HDAMA's five years' income is forecasted. To this effect, HDAMA needs to strengthen its internal capacity to mobilize funds and generate income in order to raise its budget by 15% in the first year (2023); 10% in the rest of the strategic plan period (2024-2027) and reach at least birr 59,776,759.0 for the final year (5^{th} year) of this strategic plan. The total estimated budget for this strategic plan is birr **249,261,041.90 (Birr Two hundred forty nine million two hundred sixty one thousand forty one and ninety cents)** (See Table 12 for details). This will help the organization achieve its planned targets and put itself in a better shape towards achieving its mission. This will also set a fine start to the next strategic period, improving the organization's budget more than 2 times after five years.

The HDAMA will strive to achieve financial sustainability by implementing three fundamental activities. One is diversifying budget/income sources which guarantees wider resources base and puts the organization in strong position by avoiding risks associated with financial and budget shortages. The second is revamping membership schemes and boosting membership contributions. Finally, HDAMA may introduce innovative income generating and fund raising schemes. A business development and resource mobilization manager position is included in the new organizational

structure that operates throughput this SP period and/or beyond. The main purpose of this position is to plan, design and implement viable business and fundraising activities which ensures financial and program sustainability, hence building a strong and transformed organization.

Table 12: HDAMA's Income History and Five Years' Financial Resource Forecast (2023-2027)

I. HDAMA's Income History			
S/No	**Year**	**Organization's Income for the Past three consecutive years (Birr)**	**Remarks**
1	2020	21,447,103.10	
2	2021	24,679,579.84	
3	2022	35,502,896,29	
Total		**81,629,579.23**	
II. Financial Resource Forecast (2023-2027)			
S/No	**Year**	**Forecasted/Projected Amount for the SP Period (Birr)**	**Remarks**
1	2023	40,828,330.7	Projected at 15% increment
2	2024	44,911,163.8	Projected at 10% increment
3	2025	49,402,280.2	
4	2026	54,342,508.2	
5	2027	59,776,759.0	
Total		**249,261,041.90**	

11.2. Assumptions

The fact that HDAMA mobilizes resources from donors in different currencies through times entails exchange rate gains or losses. Anticipating that HDAMA gains some amount of money through exchange rate gains throughout the strategic plan period, it is not worth mentioning or elucidating this as part of the budget for the strategic plan period. On the other hand, it is also important to anticipate rise of inflation during the strategic plan period which could be a risk. It is, thus, necessary to say that gains from exchange rate may be consumed by the rising inflations and hence, HDAMA may be alert in this regard.

11.3. Organizational Setup and Management

The current offices and organizational leadership remains during the implementation of this strategic plan. As per the organizational bylaw approved by the Authority for Civil Society Organizations – (ACSO), the boards of directors, backed by the general assembly, and with the assistance of the

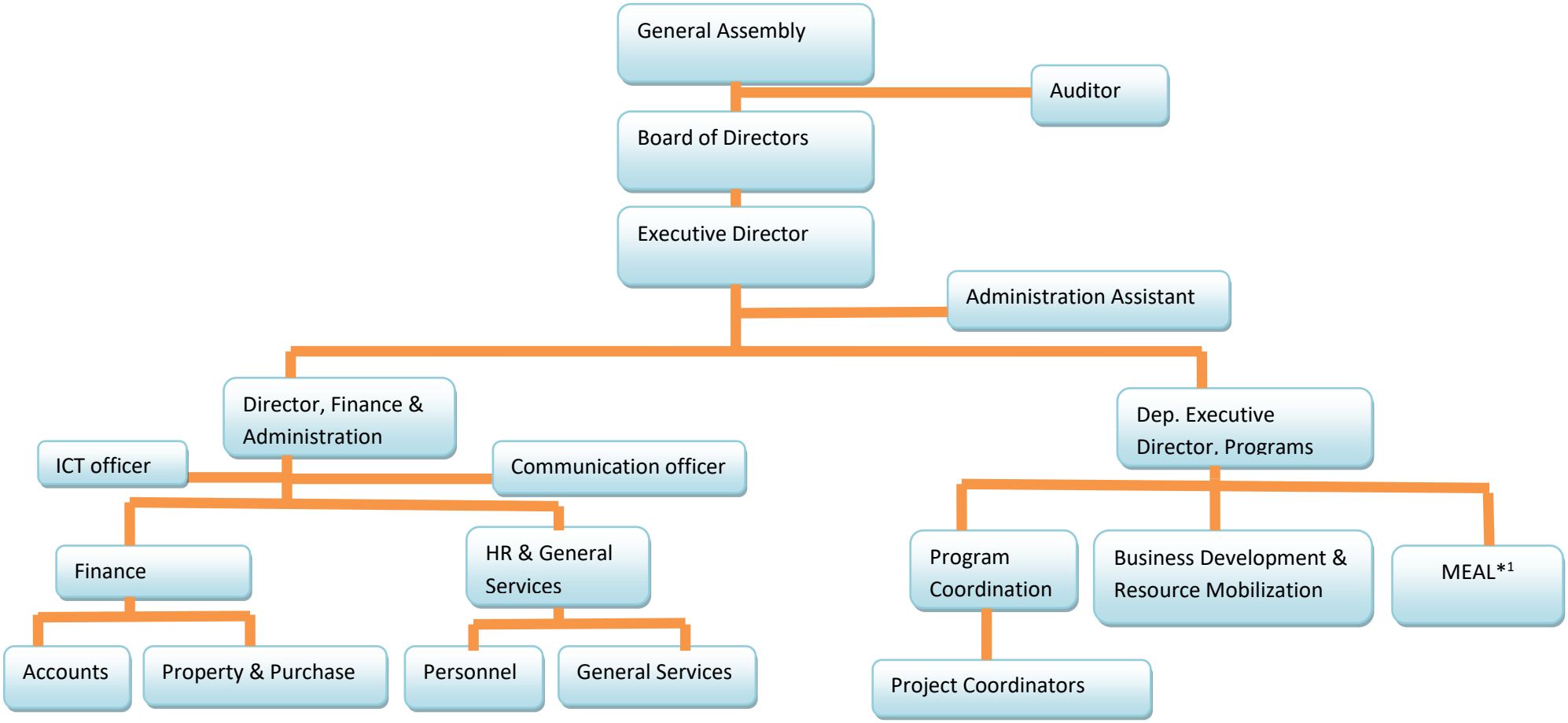
Executive Director, will execute strategic actions supportive to the organizations technical and operational effectiveness. As illustrated in the organogram annexed to this document, HDAMA clearly reflected the organizational setup and management such that the highest constituency is the general assembly –which elects the board.

The organization's board oversees the organization's operation and takes key decisions –including approving the annual reports and plans. The Executive Director, as a fulltime designate, and also serving the board as a secretary, manages overall organizational efficiency and effectiveness human resources and budget, while the Deputy Executive Director also takes the direct and primary leadership roles in program management, organizational development and resource mobilization, partnerships and networking, in addition to deputizing the role of the Executive Director at all times. Similarly, the Finance and Administration director leads the overall financial and administration issues of the organization.

Program, Organizational Development and Resource Mobilization and Branch Office managers will line manage overall program and field operations –under the leadership of the Deputy Executive Directors.

In line with the need, the organization will review the current staffing and staff roles, reporting lines and recruit and fill more positions. When expansion to other geographical locations becomes evident, pursuant to the availability of funds and needs, Branch Offices and other essential staff will be accordingly deployed. In addition to this, depending on the nature of the projects and needs of the donors, professionals in specific professions may be needed.

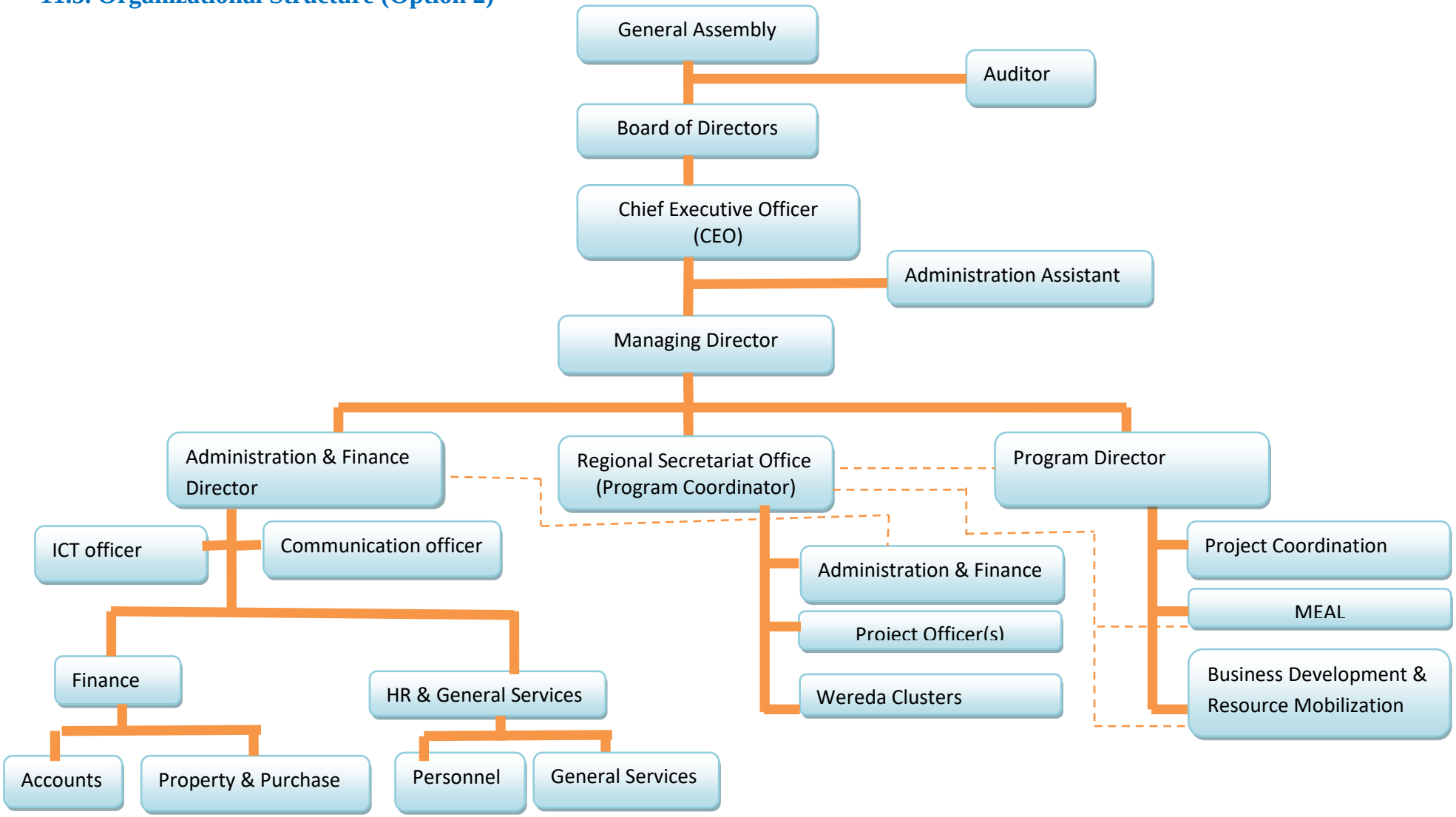
11.4. Organizational Structure (Option 1)



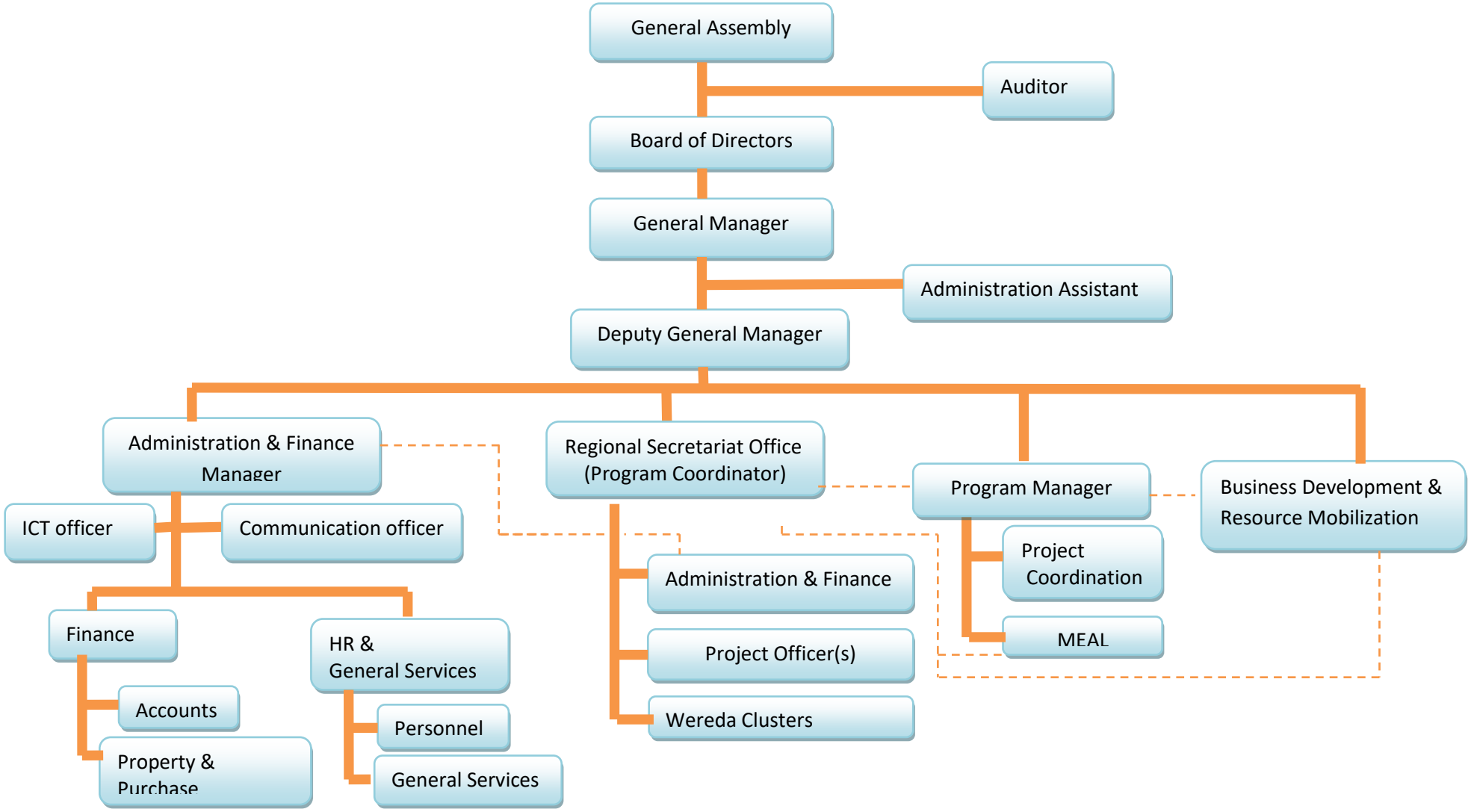
∗1=Monitoring, Evaluation, Accountancy and Learning

Figure 7: HDAMA's Organogram

11.5. Organizational Structure (Option 2)



11.6. Organizational Structure (Option 3)



12. MEASUREMENT OF SUCCESS/MONITORING PLAN

12.1. Measurement of Success

The aim is to specify clearly how the organization will measure the success of its activities. This will be a measurement of its services; details of what to measure and how to measure the various achievements of the organization is explained; what to measure will generally be based on goals and tasks set by the organization to be achieved during the plan period. How to measure success will be a methodology used to measure the actual performance of the organization compared to the targets set for each goal. In this regard, the organization revises and updates its existing monitoring and evaluation guideline to fit in to the current SP and indicators set in the SP.

12.2. Financial Projections

The strategic plan will be quantified to monitor performance and evaluate the results achieved; draw up revenues and expenses for the current period and the plan period; for the immediate current period, the annual plan is broken down into monthly or quarterly plan for effective monitoring of actual performance and timely correction of deviations; while key performance indicators (KPIs) measure the efficiency of individual activities that constitute an organization's overall operations, Financial Projections (targets) monitors the overall health of the organization.

In non-for-profit organizations where profit is not the motive, financial projections fix expense budgets to be within allocated resources for various activities; an organization can spend only what it raises as grants and funds from its beneficiaries and hence everyone in the organization should know how much they can spend on various activities to be within the available funds' position.

Where expenses go beyond the projected limits, the organization management takes corrective action to bring down such expenses; an organization financial projection also forecasts grants to be received and funds to be raised during the plan period. The staff team entrusted with this activity should ensure that the targeted grants and funds are raised to meet the expenses planned during the plan period. Where it is found that the planned fund-raising is falling below targeted values, the organization management should increase its efforts in this regard to raise the shortfall grants and fund.