MERQ Consultancy PLC in collaboration with New Partnerships Initiative (NPI EXPAND) Project and United States Agency for International Development (USAID)

October 2021
Addis Ababa, Ethiopia

MAPPING AND PROSPECTING COMMUNITY STRUCTURES AND CIVIL SOCIETY ORGANIZATIONS TO INCREASE DEMAND FOR AND DELIVERY OF HIGH-QUALITY, HIGH-IMPACT HEALTH SERVICES IN AMHARA, SNNP, AND SIDAMA REGIONS, ETHIOPIA

Final Report

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EXECUTIVE SUMMARY

BACKGROUND

Community engagement is the process of working collaboratively with and through groups of people, often in a given locality or affiliated by interest or living condition, so as to address the issues of these groups of people. Community engagement is becoming mainstream in both practice and research in interventions of various sectors and fields. There is supporting evidence of its effectiveness in maximizing achievements by promoting community ownership. Community participation is especially crucial in the provision of primary health care, particularly for low-income countries where the health system is significantly compromised owing to diverse challenges. Thus, a lot is expected from communities in filling this gap by complementing facility-based service delivery through health promotion and disease prevention activities and contributing to enhancing social accountability. One of the perspectives of the Health Sector Transformation Plan (HSTP, 2015/16-2019/20) is community engagement aimed at two of the strategic objectives of the HSTP, i.e., to improve health status and enhance community ownership.

With this understanding, the current study is designed to map prospecting community structures and CSOs to increase demand for health service, enhance quality health service delivery, and promote social accountability in service provision. Thus, the key purpose of this study is to elicit information to identify promising, sustainable model(s) for engaging communities in RMNCH and social accountability at woreda and kebele levels in Amhara; Southern Nations, Nationalities, and Peoples (SNNP) and Sidama regions to inform USAID and NPI EXPAND project planning efforts. The central study questions are:

- Which civil society organizations / community structures may be best suited to improve the reach and quality of FP/RH/MNCH services?
- Which civil society organizations / community structures may be best suited to engage in activities to improve accountability for improved FP/RH/MNCH services?
- What are the most promising and potentially sustainable models for community engagement or

accountability in primary health care?

METHODS

The study is primarily qualitative with some quantitative support for assessing the capacity of CSOs. First, literature review on models of community engagement and consultative meetings were used to identify an initial list of key informants and the topic guides for key informant interviews. Second, key informant interviews with government organizations, funding agencies, and NGOs were used to identify a list of community structures (CSs) and CSOs, recommended CSs and CSOs, reasons for recommending CSOs and CSs, and to identify the criteria that should be considered to identify CSOs and CSs. Third, follow-up interviews were used to describe characteristics of community structures. Fourth, basic organizational capacity assessment (OCA) was conducted on selected CSOs using a standard tool prepared for this purpose. Accordingly, sixty-five KIIs were held to identify CSOs and CSs, which were followed by thirty follow-up interviews and OCAs conducted for twenty-four CSOs. Data collectors were trained on the purpose of the study and the topic guides prepared to collect data.

Qualitative research assistants were also trained and a codebook with 70 codes was developed to support data analysis. Using version twelve of NVivo, ninety-two transcripts were analyzed, and code reports were produced. Three steps were followed in the final analysis. First, synthesizing the code reports, general description of CSOs and CSs, including their categorizations, was provided. Second, definition of criteria for prospecting CSOs and CSs was done, leading to the identification of six major dimensions with some sub-dimensions identified to map the prospecting CSs and CSOs. Third, assessment of the categories of CSs and CSOs was done based on the dimensions and sub-dimensions so as to select and recommend those CSs and CSOs suitable to work with to increase demand and

improve RMNCH service delivery and promote social accountability. Based on this, a draft report was produced and presented to the NPI and USAID to refine it. The final report is produced by incorporating comments from reviewers.

FINDINGS

The first data analysis phase produced ninety-four CSs and sixty-six CSOs. The ninety-four CSs were categorized into eleven clusters based on target groups they serve, nature of their activity, their affiliation, setting they are working in, and related issues. These were Development Army, Women Groups and Associations, Youths Groups and Associations, School-based clubs, Clubs, Leagues and Volunteer Groups, Local Government (LG) Structures and LG-initiated Community Structures, Traditional and Religious Institutions and leaders, Accountability Groups / Citizens Monitoring Groups, Associations with economic interests, Patients Associations, and others. The second phase of the analysis led to the identification of six major dimensions of criteria used to identify the prospecting CSs and CSOs. These dimensions are *technical capacity and motivation of members, reach and coverage, institutional features, power to influence, value compatible with RMNCH outcomes, and relevant experience.*

Using these criteria, six CSs were prospected for engagement under selected CSOs, namely: *Women Development Army, School Clubs, Sidama Cultural and Judiciary System, Women Associations, Women St Mary's Association, Youth Associations, and Water Committee*. For social accountability, three CSs were selected, namely: *community score card, social accountability councils, and community care coalitions*. Apart from the general description across

cluster and particular CSs, specific reasons for recommending each CS and CSO is provided. Finally, challenges and gaps of prospecting CSs—such as limited capability, poor coordination, vulnerability to manipulation, lack of accommodative space, lack of motivation and commitment, and geographic limitations—were noted.

CONCLUSION AND RECOMMENDATION

Conclusion

Although an initial study to identify tentative criteria for recommending a CS or CSO and then evaluating identified CSs and CSOs could have been advantageous, concurrently identifying existing CSs and CSOs as well as describing them across CSs and CSOs helped to authentically capture the CSs' and CSOs' attributes. In addition, no CS or CSO was found to fulfill all the criteria (six dimensions or twenty-three sub-dimensions). Rather, selections were based on relative fulfillment of some essential criteria. This implies the need to use two or more CSs by the CSOs. Each CS identified as prospective were found to have their own gaps, implying the need to fill their gaps before engaging them.

Recommendations

The recommendation is provided in two broad categories with details under each category: **Capacity building to the prospective CSs and CSOs:**

- Providing integrated, comprehensive, process-oriented, and needs-based capacity development intervention that may include training, experience sharing, material provision, advisory, simplified management systems, strategic plan development, etc.;
- Help CSs define or redefine their governance and bylaws and support them to develop their internal constitution and establish systems and procedures;
- Provide technical training (e.g., on social accountability tools and mechanisms), coaching, and technical support; this is specifically useful for those recommended for social accountability as experience in this area is much more limited.

Approach/System rethinking:

- The need to consider different community structures for different segments of target populations, e.g., women to women, youth to youth, etc.;
- Co-creation of structures;
- The need to build upon the existing practices and systems but with critical scrutiny towards strategically aligning them with the envisaged program;
- Better to plan to unleash the long-existed experience, practice, social capital, cohesion, etc. of the community structures and build upon that for the intended purpose;
- The possibility of initiating coalitions, networks, and forums of CSs in order to coordinate their efforts, share experiences and resources among each other, pool resources, and to have a collective voice.

ACKNOWLEDGEMENT

This landscaping assessment was made possible with the support of USAID through the NPI Expand Project of the Palladium Group. The MERQ team is thankful to the technical and financial support that allowed us to engage in and effectively accomplish this research activity. NPI Expand conducted a literature review and developed a draft key informant interview guide with inputs from USAID. Experts from NPI Expand also reviewed the assessment proposal, participated in data quality assurance activities, and reviewed the draft report. The MERQ team is thankful for these essential contributions. We are also grateful for our data collection team who demonstrated utmost efforts and professionalism in the collection of quantitative and qualitative data. Last but not least, we would like to forward our heartfelt appreciations and thanks to respondents of this study from USAID, International and Local NGOs, Government Organizations, and communities who took substantial amount of their time and provided their perspectives which are the sources for all the information generated through this study.

TABLE OF CONTENTS

Contributors and recommended citation Ili
Executive Summary iV
Acknowledgement.. VII
Table of contents.. VIII
Acronyms and abbreviations.. X

1 Introduction............. 1
1.1 Background............. 2
1.2 The New Partnerships Initiative (NPI EXPAND) Project............. 2

2 Objectives of the mapping/prospecting exercise............. 4
2.1 Purpose............. 5
2.2 Study questions............. 5
2.3 Objectives............. 5

3 Methods............. 6
3.1 General approach............. 7
3.2 Fieldwork............. 7
3.2.1 Preparation for the fieldwork............. 8
3.2.2 Key informant interviews............. 8
3.2.3 Follow-up interviews about community structures............. 9
3.2.4 Basic organizational capacity assessment............. 9
3.3 Data analysis and synthesis............. 10
3.3.1 Data management............. 10
3.3.2 Data analysis............. 10
3.4 Quality assurance processes............. 10
3.4.1 Quality assurance activities prior to data collection fieldwork............. 10
3.4.2 Quality assurance activities during data collection fieldwork............. 11
3.4.3 Quality assurance activities after data collection fieldwork............. 11
3.5 Report writing and dissemination............. 11
3.6 Ethical considerations............. 11

4 Findings............. 12
4.1 Community structures.............13
4.1.1 Characteristics of CSs identified and recommended by key informants.............13
4.1.2 Criteria for selecting prospective CSs.............14
4.1.3 Description of CSs

against prospecting criteria...17 4.1.4 Prospecting Community Structures...32 4.1.5 Community Engagement Approaches Employed in Engaging Community Structures ....34 4.1.6 Challenges and Gaps of Prospective Community Structures ....35 4.2 Civil Society Organizations...35
4.2.1 Civil Society Organizations Identified by Key Informants ....35 4.2.2 Profile and Basic Organizational Capacity of CSOs – Findings
from a Quantitative Assessment..36 4.2.3
Criteria for selecting CSOs fit for engagement in RMNCH
....38

4.2.4 Description of CSOs against prospecting criteria...40 4.2.5 Local Development Associations ....41 4.2.6 Professional Associations ....42 4.2.7 Local NGOs...42 4.2.8 Religion-affiliated organizations..43 4.2.9 Umbrella Organizations ....44 4.2.10 Summary of CSO Categories Description ....45 4.2.11 Prospecting CSOs 46

5 Discussion and conclusive remarks 48

6 Annexes 51
Annex 1: KII Guide and Questions .... 52 **Annex 2:** Guide for describing community structures .... 57 **Annex 3:** CSO profile and basic capacity assessment tool .... 61 **Annex 4:** List of community structures identified by key informants by categories .... 68 **Annex 5:** List of Civil Society Organizations Identified 71

ACRONYMS AND

ABBREVIATIONS

CS Community structure

CSO Civil society organization

ECBH Empowered Communities for Better Health (project)

FP Family planning

INGO International NGO

J2SR Journey to Self-Reliance

KI Key informant

KII Key informant interview

MNCH Maternal, newborn, and child health

MDA Men Development Army

MoH Ministry of Health

NPI New Partnerships Initiative (project)

NUP New and underutilized local partner

NUPAS Non-U.S. Organization Pre-Award Survey

RH Reproductive health

RHB Regional Health Bureau

SA Social accountability

SAC Social accountability committee

SNNP Southern Nations, Nationalities, and Peoples (region)

USAID United States Agency for International Development

WDA Women's Development Army

WoHO Woreda Health Office

ZoHO Zonal Health Office

1. INTRODUCTION

1.1 BACKGROUND

Community participation is a key principle in primary health care (1). In developing countries, where the health system is constrained by multifaceted challenges, communities are expected to play vital roles in terms of complementing facility-based service delivery, health promotion and disease prevention activities, and enhancing social accountability. The fourth and the seventh articles of the Alma Ata declaration clearly state that community participation in the planning and evaluation of healthcare is both a right and an effective strategy in primary healthcare (1, 2).

Developing a set of meaningful practices to forge community participation has been a priority for policymakers and researchers ever since the Alma Ata declaration. Ensuring social accountability has also been discerned as one of the principles of the Paris Declaration to improve aid effectiveness (3, 4). As a result, countries and multilateral organizations have developed and implemented a multitude of approaches to enhance community participation in health care (5, 6).

A USAID-supported systematic review on the role of civil society in family planning in low- and middle income countries identified a wide range of roles that civil society organizations (CSOs) played in piloting and scaling up evidence-based interventions. These roles include but are not limited to service delivery, financing, human rights, quality of care, behavior change, advocacy, and accountability (7). Despite these immense potentials of CSOs, their capacity to meaningfully engage in family planning (FP), reproductive health (RH), and maternal, newborn, and child health (MNCH) programs in Ethiopia is not adequately documented.

In Ethiopia, the ratification of the Charities and Societies Proclamation in 2009 brought several restrictions in the registration, operation, and funding of CSOs until recently (8). The 2019 revision of the law relaxed these restrictions, allowing more CSOs to engage in policy dialogue and advocacy. As a result, the number of CSOs with roles in advocacy and social accountability has been increasing (9). The role of CSOs and community structures in increasing demand for and utilization of FP, RH, and MNCH services and the government's self-reliance to deliver these services can be further accentuated by building the capacity of CSOs and CSs.

1.2 THE NEW PARTNERSHIPS INITIATIVE (NPI EXPAND) PROJECT

The New Partnerships Initiative (NPI) Expanding Health Partnerships—NPI EXPAND Project—aims to support missions with increasing the availability and utilization of quality health services across all priority health areas of the USAID. USAID is committed to expanding its range of implementing partners by investing in new and underutilized local partners (NUPs)[1] and strengthening their capacity to strategize, plan, and implement health sector programs with USAID funds. Enhanced participation of capable local partners to increase demand for and deliver high-quality, high-impact health services will enable the government to meet crucial health goals equitably and sustainably.

The NPI EXPAND project has three areas of results:

1. Organizational sustainability of new/underutilized local entities or locally established partners strengthened;

2. Utilization of high-quality, high-impact health services, information, and supplies expanded; and

1 New Partner: An individual or organization that has not received any funding from USAID as a prime partner over the last five years. Underutilized Partner: An organization that has received less than $25 million in direct or indirect awards from USAID over the past five years. For more details, see: https://www.usaid.gov/npi/npi-key-definitions

3. Scaling-up of promising and innovative health approaches through new and underutilized partnerships for increased sustainability.

The USAID Ethiopia Mission is engaging the NPI EXPAND project to support their Empowered Communities for Better Health (ECBH) project appraisal document. Moving away from a supply/demand model of health systems development, the ECBH emphasizes the need to engage communities toward improved health services and outcomes. This involves tapping civil society organizations, networks (e.g., women, men, youth), professional associations (e.g., midwives), religious institutions, and community elders and other community structures (e.g., Idirs) toward better health. The potential of these actors in community health systems has not been fully leveraged in part due to an overdependence on Women's Development Army (WDA) structures and gaps in the accountability framework, which needs to be expanded and strengthened to cover all levels of the health system.

Given these factors, ECBH aims to include communities more fully as a part of the health system and to include accountability as the core nexus between an empowered community and a quality service delivery point. This is a new approach for Ethiopia and a relatively new approach within USAID, so USAID/Ethiopia is investing in NPI EXPAND to explore approaches to strengthen community engagement and accountability within the health system by both building on existing models (e.g., community score cards and Health Development Armies) and experimenting with new models or those tried in other countries.

2. OBJECTIVES OF THE MAPPING/ PROSPECTING EXERCISE

2.1 PURPOSE

The primary aim of this work is to identify promising, sustainable community structures and civil society organizations that are better suited and positioned to engage in improving RMNCH service delivery and promoting. Towards this aim, the assessment entails eliciting information about the community engagement practices of leading civil society organizations and community structures/platforms working in FP, RH, and MNCH and/or social accountability at the woreda and kebele levels in Amhara; Southern Nations, Nationalities, and Peoples (SNNP); and Sidama regions. Findings from this exercise will inform USAID and NPI EXPAND project planning efforts.

2.2 STUDY QUESTIONS

The mapping and prospecting effort addresses the following guiding questions:

- What are the leading community structures currently working in FP/RH/MNCH and/or social

accountability in the three regions?

- What are the leading civil society organizations currently working in FP/RH/MNCH and/or social accountability in the three regions?
- Which civil society organizations / community structures may be best suited to improve the reach and quality of FP/RH/MNCH services?
- Which civil society organizations / community structures may be best suited to engage in activities to improve accountability for improved FP/RH/MNCH services?
- What are the most promising and potentially sustainable models for community engagement or accountability in primary health care?

2.3 OBJECTIVES

The mapping and prospecting exercise will meet the following objectives in the regions of Amhara, SNNP, and Sidama:

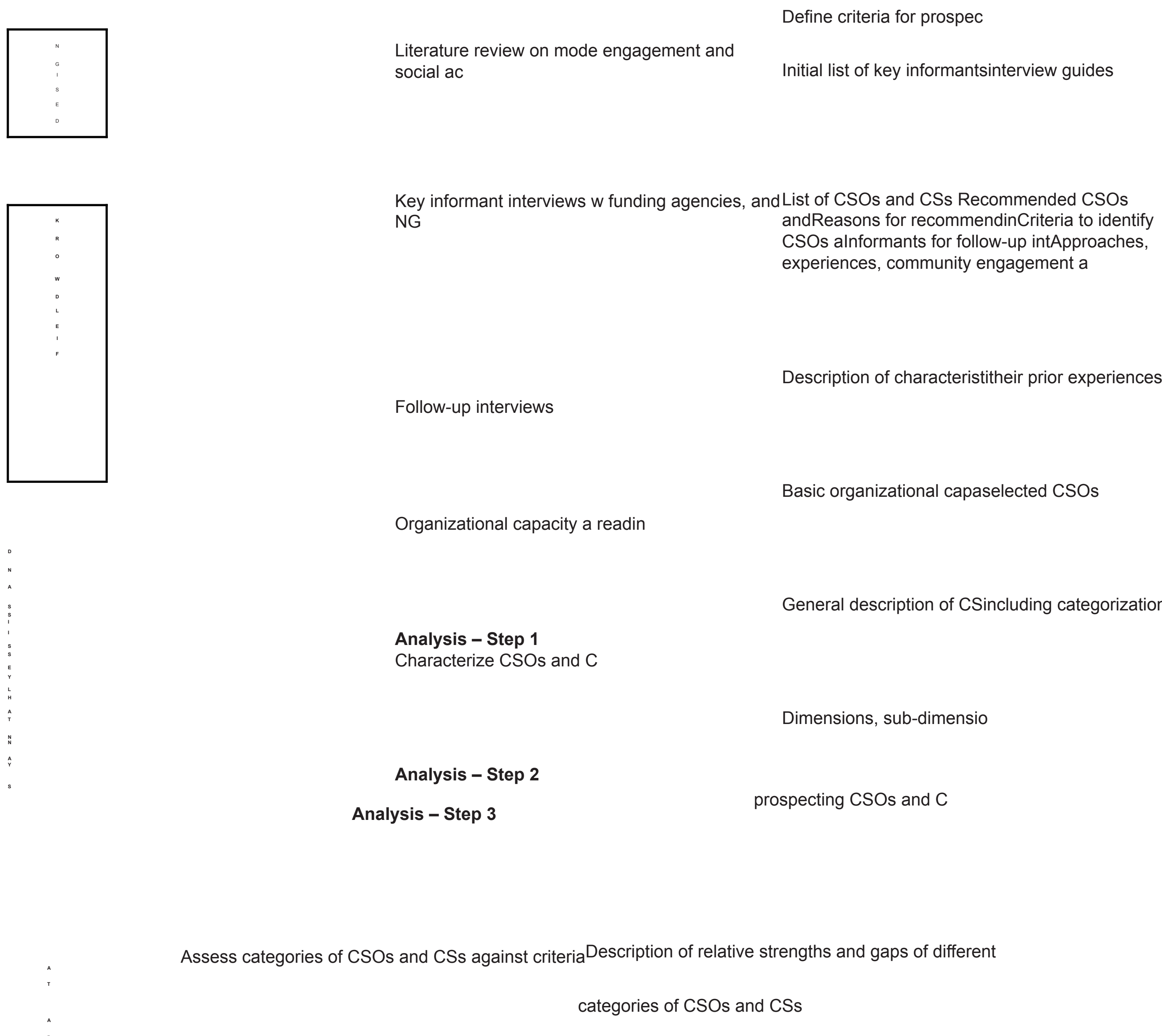
- Identify and describe the profiles of major CSOs and CSs currently working in FP/RH/MNCH and/ or social accountability;
- Assess organizational capacities of major CSOs specifically in terms of their readiness for community engagement to improve;
- Identify CSOs and CSs that are best suited to promote social accountability for improved FP/RH/ MNCH services.

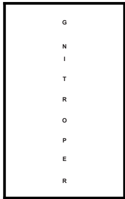
3. METHODS

3.1 GENERAL APPROACH

As a continuation to a rapid desk review of major community engagement and accountability models in health, both in Ethiopia and other countries, we pursued a multi-step process to identify, assess, describe, and select CSOs and CSs that are working in the areas of FP, RH, and MNCH and/or social accountability from the regions of Amhara, SNNP, and Sidama. Data needed to identify potential CSOs and CSs, refine criteria for selection, and assess the characteristics of recommended CSOs and CSs were collected through key informant interviews with relevant stakeholders, follow-up interviews about CSs, and basic organizational capacity assessments[2]in terms of readiness for community engagement to improve health service and enhancing social accountability on CSOs. Steps followed are summarized in *Figure 1.*

Figure 1. Flow of steps in mapping/prospecting





Inputs for refining the asseDraft and final report

3.2 FIELDWORK

Consultations with NPI Ex Report writing

MERQ collected the data from the fourth week of May to the second week of June. Data was collected from three regions and federal government sectors. Participants include regional health bureaus, zonal health departments, woreda health offices, donors, UN Agencies, NGOs, local implementing partners, MOH etc. Data was collected through key informant interviews, follow-up interviews, and organizational readiness assessments by using experienced research assistants who were provided intensive training

2 Basic organizational capacity assessment refers to an assessment of CSOs that intends to describe their profiles and document high level indicators of grant readiness. This is different from the widely known Organizational Capacity Assessment (OCA) as it includes only selected capacity items and lacks a participatory approach, an important feature of OCA.

on the purpose of the study and qualitative data collection including interviewing and record keeping prior to deployment. A total of sixty-five KIIs, thirty follow-up interviews, and twenty-four organizational readiness and capacity assessments were conducted (Table 1).

Table 1. Number of key informants from the public sector by category and region

Plan Amhara SNNPR Sidama Federal Total

KIIs for Identifying and Mapping CSs and CSOs 63 16 12 5 32 65 Government Organizations – MoH 4 6 6 Government

Organizations - Regional, Woreda

Health (RHB, ZHD, WoHO) 21 8 7 3 0 18 Other Sectors 8 4 2 1 0 7 Donors, UN Agencies, INGOs 15 10 10 Local

NGOs/Associations 15 4 3 1 16 24 Follow-Up Interviews 16 7 7 0 30 Inputs for Community Structure Description 16 7 7 0 30 Basic

Capacity Assessment 15 4 3 1 16 24 Local NGOs/Associations 15 4 3 1 16 24

3.2.1. Preparation for the fieldwork

Three teams of research assistants each consisting three members were set for data collection. The research assistants were selected based on relevance of their educational background to community engagement and/or social accountability in health and experiences in collecting qualitative data. The field teams were provided a comprehensive training for four days before their deployment to the field. Following the training, the key informant interview guide was pre-tested at the Ministry of Health. As part of the pre-test, two key informant interviews were held. A reflection session was also held based on data collectors' and trainers' observations from the pre-test.

3.2.2. Key informant interviews

Key informant interviews (KIIs) were conducted to obtain critical inputs on the most promising models and opportunities for community engagement to improve primary health care (FP/RH/MNCH) and for identifying or refining criteria to hone in on those CSOs and CSs best positioned to implement or scale up these interventions. Using the KIIs, we gathered information about community engagement models as well as formal organizations and informal structures or platforms that could be leveraged toward improved accountability, accessibility, and/or quality in primary health care.

Key informants were identified based on their knowledge and experience with community engagement models, including social accountability interventions; experienced with innovative approaches to improving the reach, quality, and/or accountability of primary health care at the community level; with local civil society organizations working with communities in FP/RH/MNCH; with local CSs that could play an important role in engaging community members in health efforts; and with experience in the relevant regions, service levels (woreda, kebele), and health areas of interest. We had identified some of the key informants based on an initial scoping exercise where we elicited suggestions from stakeholders. Key informants include public sector representatives, donors, and non-governmental

organizations. We used a semi-structured discussion guide that was prepared by the NPI Expand Team with inputs from USAID and MERQ to obtain information from respondents through interviews administered in person or virtually through video or call conferences.

We administered a consent process prior to any interview. Interviewers discussed consent with each key informant and answered any questions the respondents had. All participants interviewed provided oral consents.

Each interview was guided by a discussion guide that provided some structure to capture experiences and advice of key informants on community engagement models in primary health care systems as well as leading CSOs and CSs working in FP/RH/MNCH and/or social accountability (Annex 1).

3.2.3. Follow-up interviews about community structures

The field teams identified CSs that are currently working to create demand for or improve quality of care or promote social accountability in the delivery of FP/RH/MNCH services. In instances when key informants recommended engaging specific CSs but did not have full information about their profiles, field workers attempted to identify other informants through snowballing. We used CSs' description guide to shape follow-up interviews (Annex 2).

3.2.4. Basic organizational capacity assessment

Organizational capacity assessment was conducted on CSOs that were included in the initial list provided by NPI Expand and USAID based on prior discussions and literature review. Additional CSOs identified and recommended by key informants were also included in the assessment. We used an assessment tool adapted from USAID's Non-US Organization Pre-Award Survey (NUPAS) tool and CSO landscaping tools that the Palladium Group used for similar assessments in other settings with a focus on organizational profile and basic aspects of organizational capacity, including:

- Identification of the organization and contact details
- Registration status and year of establishment

- Scope of engagement
- Governance and management structures
- Plan and policies/standards
- Human resources
- Recent and current projects
- Experiences in FP/RH/MNCH activities/projects, community engagement, and social accountability • Does the organization have experience in promoting social accountability, policy advocacy, etc. • Financial management and internal control systems
- Source of income/revenue and expenditure
- Donor experiences
- Expressed needs for organizational capacity strengthening

Data was collected for twenty-four CSOs with the CSPro electronic data collection platform using the tool in Annex 3.

3.3 DATA ANALYSIS AND SYNTHESIS

3.3.1. Data management

Qualitative data collected through key informant interviews was audio recorded. Audio records were transcribed and translated to text files in English. Field teams summarized each interview while they were in the field in order to inform their subsequent sampling decisions (e.g., which CSOs, CSs, zones, and woredas to consider for subsequent interviews).

After completion of the fieldwork, the research team worked with team leaders from each of the three field teams to finalize a coding framework. The coding framework was developed based on 1) the objectives of the study, 2) contents of the key informant interview guide, and 3) data from sample transcripts. The three research assistants coded the data using NVIVO software. Necessary modifications were made to the coding framework as new insights emerged during the coding process. Code reports were then generated and synthesized based on their relevance to each step in the analysis process.

The quantitative data collected caters on the capacity and readiness of the CSO's. The data which was collected electronically, was exported and analyzed using STATA Version 16 Software for Windows. The data was later combined with summary findings from key informant interviews using an Excel spreadsheet.

3.3.2. Data analysis

We followed a step-by-step approach to analyze and synthesize data driven by the purpose of the study. In the first step, we characterized the CSOs and CSs identified and recommended by key informants. This allowed us to develop a typology relevant to the purpose of the study. In the second step, we synthesized relevant code reports to develop criteria for prospecting better off CSOs and CSs for the purpose of engaging in RMNCH service delivery and social accountability.

In the third step, we assessed each category of CSO and CS against criteria developed during the second step to select prospective CSOs and CSs. This step used data available from both the qualitative and quantitative datasets.

3.4 QUALITY ASSURANCE PROCESSES

MERQ's standard data quality assurance procedures were implemented to ensure the collection and use of high quality data in the study. Quality assurance procedures in this study included a set of activities that were implemented before, during, and after data collection fieldwork.

3.4.1. Quality assurance activities prior to data collection fieldwork

Data collection guides and tools: Experts with relevant experiences and expertise developed the data collection guides and tools. As the study is predominantly qualitative, we emphasized the need to give adequate flexibility and openness in the tool but simultaneously ensured the inclusion of key probing items that can be used to check the comprehensiveness of responses from interviewees. The data collection guide is translated to Amharic to facilitate easy understanding. For the CSO organizational capacity assessment tool, we used selected items from USAID's NUPS tool that have been widely used for similar purposes.

Recruitment of data collectors: We established data collection teams with complementary sets of skills and experiences. All the data collectors have at least master's-level training in public health and social sciences and have experience in collecting qualitative data. Most of them were recruited based on their previous performance on qualitative data collection.

Training of data collectors and pre-testing of data collection tools: We organized four-day field workers training on the study objectives, methods, and data collection tools. The training was facilitated by experts (research team members) with rich experiences in the areas of community engagement, social accountability, organizational capacity assessment, and qualitative research. On the fourth day of the

training, we conducted a pre-test of the key Informant Interview with experts at the Ministry of Health. A discussion was held following the pre-test interviews. The pre-test largely proved the appropriateness and feasibility of our plans; however, it also identified a few areas that needed modifications. Our tools and data collection plans were adjusted based on our observations.

3.4.2. Quality assurance activities during data collection fieldwork

Monitoring of data collection fieldwork: A central team monitored the progress and quality of data collected from the field daily. Data collectors submitted audio records of their interviews and a text summary of key findings from the field. The central team reviewed the submitted materials and provided timely feedback on the completeness and depth of interviews.

Field visits: In addition to data collection monitoring based on submissions from the field, an expert from NPI Expand did physical visits to the field teams.

Participation of the research team in data collection: For selected key informants from government and donor agencies, interviews were led by members of the core research team. This approach increased both the quality of the interviews and allowed direct interactions between the research team and data sources.

Virtual discussions on challenges of fieldwork: A Telegram group was created to facilitate the sharing of experiences from the field between data collection teams. Teams shared their experiences, challenges, and lessons from their fieldwork. The central team followed discussions and provided inputs in addressing key issues raised during discussions.

3.4.3. Quality assurance activities after data collection fieldwork

Debriefing sessions: Once data collection fieldwork was completed, we organized a debriefing session, bringing the data collectors together and the core research team. We held discussions on key findings/ observations, any data-quality-related issue, and recommendations. Notes from the debriefing sessions were used as inputs during the analysis phase.

Continued engagement of data collectors: Involving some of the data collectors was considered as a mechanism to maintain grassroots observations during the analysis phase. The data collection team leads (three research assistants) were involved in coding qualitative data, and one of them was involved in synthesizing selected code reports.

3.5 REPORT WRITING AND DISSEMINATION

Preliminary findings of the study were shared with the NPI Expand team through a virtual presentation. Criteria for identifying top prospects were discussed and agreed upon during this session. Subsequently, preliminary findings were presented with NPI Expand and the USAID Ethiopia mission. Comments and reflections from these sessions were used to refine the structure and presentation of findings from the mapping and prospecting study.

3.6 ETHICAL CONSIDERATIONS

This study focuses on mapping and prospecting CSOs and CSs. Data collected through document reviews and key informant interviews was targeted at understanding the organizational capacities of CSOs and the potential of existing CSs instead of exploring private information about respondents. For this reason, we believed that the study has below minimal risk. Therefore, we requested an expedited review and obtained exemption from full-board review from the Institutional Review Board (IRB) of the Ethiopian Public Health Association. Data collection at the institution level always followed obtaining permission from relevant officials of the target organizations. We also obtained informed verbal consent from all key informants. Data collected as part of this study will be used only for purposes mentioned to data sources during the consent process. Sharing or using the data for any other purpose will be considered only after obtaining permission from the sources.

4. FINDINGS

As a landscape assessment aimed at engaging communities toward improved health services and outcomes, this mapping and prospecting study intends to identify CSOs and CSs currently working in FP/RH/MNCH and/or social accountability. This section provides a description of profiles of the CSs and basic capacities of CSOs, criteria for assessing the potentials of CSs and CSOs, and recommendations based on assessment of the CSs and CSOs against these criteria.

The section is organized into two major subsections, community structures and civil society organizations. In the first subsection, we described CSs identified and recommended by key informants, criteria that should be considered in selecting CSs for future engagement, and a list of prospective CSs for engagement to improve demand creation and social accountability in RMNCH. This subsection also provides a summary of approaches that were employed by RMNCH stakeholders in engaging these CSs. In the second subsection, we describe CSOs identified and recommended by key informants, criteria that should be considered while selecting CSOs to support community engagement in RMNCH, and a list of CSOs recommended based on these criteria.

4.1 COMMUNITY STRUCTURES

CSs are structures (associations, institutio0ns, organizations, coalitions, networks, unions, etc.) that have often organically evolved and have existed as long as their respective communities. In some cases they have been, however, they may have been externally induced and initiated for designated purposes. Either way, the structures are meant for serving their respective constituencies and communities at large. Stakeholders interviewed in this study identified ninety-four CSs engaged in one or another way in RMNCH service delivery and/or social accountability. We developed a typology of these CSs and clustered them based on their common characteristics. The clusters of CSs were evaluated against a set of criteria that emerged from the views of key informants to identify prospective CSs that best suit the community engagement needs of RMNCH programs in the three study regions.

4.1.1. Characteristics of CSs identified and recommended by key informants

In total, some ninety-four CSs were mentioned by the key informants. The whereabouts (geographic location) and identity (at least in terms of purpose) of many of them were well traced, but either the geographic locations or indicative identity or both of some CSs was missed mainly because the KIs (particularly federal-level KIs) had limited information about CSs beyond their names. Those CSs that were enumerated by the key informants were further clustered into eleven categories. The CSs that share similar attributes were grouped in ten clusters while the CSs which could not one way or another fall into those categories were drawn up in one category by the name “Others” (Table 2). The list of CSs under each cluster is presented in Annex 4.

Table 2. Numbers of community structures identified by cluster

CLUSTER	NAME OF CLUSTER	NUMBER OF CSS
Cluster 1	Development Army	2
Cluster 2	Women Groups and Associations	12
Cluster 3	Youths Groups and Associations	5
Cluster 4	School-Based Clubs	7
Cluster 5	Clubs, Leagues, and Volunteer Groups	15
Cluster 6	Local Government (LG) Structures and LG-Initiated Community Structures	14
Cluster 7	Traditional and Religious Institutions and Leaders	15
Cluster 8	Accountability Groups / Citizens Monitoring Groups	5
Cluster 9	Associations with Economic Interests	8
Cluster 10	Patients' Associations	4
Cluster 11	Others	7
Total number of CSs identified		**94**

The first category consists of government-initiated networks of community members, including WDA and MDA, both of which focus on priority development issues that include health, education, and agriculture. The second and third clusters of CSs, women groups and associations and youth groups associations, represent CSs that deal with socioeconomic matters of mainly women and youth respectively. The fourth cluster includes the CSs that are based in schools (secondary and tertiary schools). The CSs that are most focused on voluntary activities in areas of HIV/AIDs, sports, social work, community health promotion, etc. constitute the fifth cluster. The sixth cluster encompasses CSs initiated by their respective local governments. These include structures like community care coalitions, water committees, health committees, sector-specific and multi-sectoral committees, and kebele command posts, among others. Further, traditional and religious institutions were brought together in a cluster that denotes CSs that are predominantly social, religious, rituals, and traditional justice groups. The other key cluster implicates community structures aimed at monitoring basic services in general and health services in particular. *The tenth cluster entails those CSs more engrossed with economic activities. The classification was then knotted with a collection of CSs that do not belong to nor share the same attributes as the other clusters.*

4.1.2. Criteria for selecting prospective CSs

While analyzing the qualitative data, eight of the codes that emerged from the data were found to be essential to identify qualities that a CS has to manifest to be considered a good platform to

enhance demand creation and improve service delivery related to RMNCH as well as increase social accountability in providing services. These codes are:

1) Characteristics of effective CSs,
2) CS recommended for demand creation,
3) Reasons for recommending a given CS for demand creation,
4) CS recommended for social accountability,
5) Reasons for recommending a given CS for social accountability,
6) Suggestions for better use of CSs for RMNCH service and social accountability, 7) Effective CS, and
8) CSs evaluated to be ineffective.

Examining and synthesizing these codes produced a set of criteria relevant for selecting CSs that best suit the community engagement needs of RMNCH in the three regions. Reorganizing these criteria produced six major dimensions, each consisting of two to five sub-dimensions. Table 3 presents the list of dimensions, sub-dimensions, and defining criteria that emerged from analysis of relevant codes.

Table 3. Dimensions, sub-dimensions, and criteria for prospecting community structures

DIMENSION SUB-DIMENSION DEFINING CRITERIA

Technical capacity and motivation of members Members serve as example to others
Literacy Members should have at least some education
Motivated members Eagerness to take assignments
(read and write) Health literacy They knowledge Model behavior
should have appropriate health/RMNCH related to promoting RMNCH

Composition Involve large majority of the community and yet have manageable size and involve relevant groups (youth and women for RMNCH)

Reach and and women
Constituency Constituting of diverse members or nearly every serve diverse interest groups
coverage Presence Grass-roots presence reaching large segments of target beneficiaries, e.g., youth segment of the population (male, female, youth, adults, people with disabilities, etc.) consequently enabling them to
Accessibility Being accessible to the community in time, place, and social and economic convenience

features System Having a well-established structure at the community level Institutional

Affiliation & Independence Integration and alignment/harmonization with government systems and the community, including being backed by government bodies on the one hand and being autonomous to decide by itself is also essential for independence on the other hand

Predictable behavior Having rules and laws that guide their function

Clarity of roles and responsibilities Members of the CS have clear division and mandated roles and responsibilities (could be formal/written or informal/tacit)

Self-sufficiency Originating organically in the community and enduring so that its sustainability is more likely

Power to influence Resource mobilization CS's ability to mobilize resources from the community, CSOs, and government

Trust and credibility A CS that is acceptable, well heard, and respected by the community and the local administration for various reasons

organization and practice

Value compatible with RMNCH outcomes

Impartiality Serves all community members equally and equitably, preferably not being tied to a single ethnic, political, or social class.

Volunteerism Being engaged on voluntary bases without waiting for incentives Alignment of purpose Willingness to work on RMNCH issues

Transparency and accountability Being transparent and accountable to the community and the local government in their

Community concern Being responsive to community needs and priorities

Relevant experience Experience in RMNCH and other health services Meaningful prior engagement in RMNCH-like health messaging and service delivery

Track record in previous engagements Known for its work on RMNCH for a pretty good time and has a good reputation in the community for this work; and having a good track record in working with CSOs and other partners

Quality of Engagement Provide quality service that benefits and brings satisfaction to the community it serves

Criteria that emerged for prospecting CSs for engagement in service delivery largely overlapped with those for engagement in social accountability. However, we have observed that members' individual characteristics were more important for engagement in service delivery while group characteristic of CSs were more important for social accountability. In addition, we have also found that working hand in

hand with service delivery institutions was more important for CSs to engage in service delivery whereas independence was emphasized as a criterion for engagement in social accountability.

Overall, as these dimensions are the basis for the selection of a given CS, we elaborate what each of these six dimensions entail, including the essence of the sub-dimensions each of them contains.

A. *Technical capacity and motivation of members*

For a community structure to be useful at enhancing health service provision, its members should have the required technical capacity to understand and communicate what they are expected to do. Apart from the capacity, the willingness and enthusiasm of individual members is vital. This includes demonstration of model behaviors. As a marker of capacity, literacy generally and health-specifically is crucial. If possible, advanced education is vital for an informed engagement, but at least being able to read and write is essential, as most functionality requires reading written messages and guides and writing reports, letters, meetings/discussions, agendas and notes, etc. To be more precise, the CS members need to have some knowledge on RMNCH-related issues. This means generic knowledge, not technical knowledge. The latter is an added advantage while the former is essential if they are to be selected to contribute to enhancing demand, improving service delivery, or promoting social accountability. As a behavioral dimension, since the engagement of these CSs is going to be voluntary, having motivated members is crucial. Another behavioral quality is the demonstration of a model behavior. A CS having many of its members who can serve as models in terms of exemplary behavior, like hard work, good leadership to better socio-economic status, and specifically

modeling positive RMNCH behavior related practices within his/her family, will teach by example. This enhances their likely contribution through acceptability.

B. *Reach and coverage*

For a community structure to have a visible contribution in either demand creation and service improvement or to enhance social accountability, its reach and coverage within its community or neighborhood or kebele is a crucial parameter. Reach and coverage can be operationalized by such measures as presence—where it is available in the community—to serve a large proportion of the community along with the community's diverse segments like youth, adults, men, women, children, etc. Relatedly, the composition of members of the CS matters. Particularly, being composed of the most affected groups—in this case youth and women, since the issue is RMNCH—is critical. Ability to reach people with disabilities, people living with HIV/AIDS, and other disadvantaged population sub groups also has to be considered. Finally, accessibility of the CS to the local community is paramount, as successfully serving in terms of time, place and, socio-economic convenience is an essential marker of reach and coverage.

C. *Institutional features*

This entails considering how the CS is strong as an institution to engage in enhancing demands and improving RMNCH service delivery or increasing social accountability. The sub-dimensions in this block are system, affiliation, predictable behavior, clarity of roles and responsibilities, and self-sufficiency. System refers to the presence of an established structure at the community level. Affiliation and backup is related to the vertical and horizontal connection a given CS has for a sound alignment, harmony, and relationship, and integration of these connections at the community level or beyond. By predictable behavior, we mean the presence of rules and laws that govern the functioning of the CS; this also includes norms, values, guidelines, and procedures. A fourth attribute under this dimension is the clarity of roles and responsibilities in the CS. Role confusion, role ambiguity, and role conflict are detrimental to a group's functionality. CSs as a group have to specify and clarify the roles of members. The final sub-dimension here is self-sufficiency, which refers to an enduring existence in the community, hence being well rooted for sustainability.

D. *Power to influence*

For a CS to serve as an effective platform for community engagement in primary healthcare, it has to be able to exercise influence. This requires having two essential attributes, the first being the ability to mobilize resources within the CS itself or in the local community or from other sources like government and NGOS and the second being gaining trust and credibility from the community, leading to being well heard and respected. Meaningful engagement and increasing demand for services and enhancing social accountability by and large depends on how influential the CS is.

E. *Compatibility in values with RMNCH outcomes*

In any service and engagement effort, values are essential to adhere to. In light of this, if a CS is to play a meaningful role in terms of increased demand creation, improved service provision, and enhanced social accountability related to RMNCH, there has to be congruence between the specific values the CS adheres to and the values that RMNCH service requires. To be specific,

the CS must be impartial by serving community members equally and equitably regardless of differences in socio-demographic and economic conditions of beneficiaries. A CS that is tied to an ethnic or religious or political group may face challenges in remaining impartial, although this depends on the personal and group values of the CS members. The CS should also remain transparent and accountable to its own members, the local community, and the local government. A third sub-dimension worth noting in value compatibility is volunteerism. Although the literature is divided on the effectiveness of non-incentivized engagement, it is difficult to fully incentivize local CSs, as this is financially demanding and logically less sound. Why should one have to be incentivized for serving his/her own families, relatives, neighbors, etc.? Incentivizing also encourages dependency and minimizes future possibility for volunteering. The fourth sub-dimension is aligning one's own purpose (CS level) with RMNCH values. Finally, being concerned with the problems of the community is essential. This last sub-dimension entails the need to know and internalize the community's problems and be responsive to the community's health, including prioritizing the community's needs under any circumstance.

F. ***Relevant Experience***

The final major dimension used as criteria to assess and evaluate CSs is having relevant experience, which in this case refers to RMNCH and/or social accountability. Three sub-dimensions illuminate this dimension. First, the CS should have experience or engagement related to RMNCH; that is, prior engagement in communicating health message or serving in health-related committees. The second is having a good track record in serving the community on RMNCH and other related health services. This includes a strong reputation from the community on such services and positive track record in working with CSOs and other partners. The final sub-dimension centers on the quality of the engagement. It is not the mere engagement that counts but also the effectiveness of the engagement, which can be manifested by the satisfaction of the beneficiary community.

4.1.3. Description of CSs against prospecting criteria

In this section, CSs that were most frequently mentioned and recommended by KIs and hence were further explored in each cluster are described against the criteria that emerged in the analysis process. Table 4 presents a synopsis of the clusters and the corresponding key merits.

Table 4. Synopsis of clusters of CSs and corresponding key merits

CLUSTERS	KEY PECULIAR MERITS
Cluster I: Development Armies	▪ Both have a wide range of reach and coverage ▪ WDAs are a good avenue to access women ▪ MDA can reach men. In both cases ▪ Both have the experience, values, and expertise suited to their respectively designated tasks
Cluster II: Women's Groups and Associations	▪ Strong in terms of reach and coverage, particularly to women, although the purpose is more economic and social than health.

- The women associations have good standing in terms of influence, both in mobilizing resources and in terms of being acceptable by the community.
- Reported to have a huge potential for RMNCH service promotion and improved service provision.

Cluster III: Youths Groups and Associations

- The youth associations are viable platforms to reach young people
- Some of them are reported to constitute “well trained and educated members”
- The youth associations have a strong working relationship with their respective government structures
- Their roles and contribution in FP and MCH service delivery were learned to be immense, particularly in reaching the younger generation

Cluster IV: School-Based Clubs

- Have designated and defines places
- Target school communities

Cluster V: Clubs, Leagues, …

- Their relevance to either RMNCH or social accountability was upheld by the key informants.
- No details were provided by the KIs except passive mentions

Cluster VI: Local Government (LG) Structures and LG-Initiated Community Structures

- CCCs seem essential for community engagement in RMNCH in terms of their accessibility, diversity, capacity, independence, influence in mobilizing resources, acceptance, transparency, sensitivity to community problems, working as check-and-balance systems, and having relevant experience in RMNCH as well as social accountability
- The water committees seem like one relevant platform for improving hygiene.
- *Idirs* have some exposure and experience in areas like nutrition and other health-related activities.
- *Idirs* were learned to have involvement in HIV-related work and CBHI programs.
- Reports also demonstrated that quite a lot of *Idirs* and their coalitions were involved in social accountability initiatives.
- The elderly associations were also found to have some experiences in promoting health issues, mainly to their members.

Cluster VII: Traditional and Religious Institutions

Cluster VIII: Accountability Groups / Citizens Monitoring Groups

- Have particular experience of engaging communities with the respective health sector office and health facilities towards provision of improved and equitable RMNCH services

Clusters IX, X, and XI: Associations with Economic Interests, Patients Associations, and Others:

- Economic-focused CSs such as economic associations, income generation groups, loan groups, saving groups, consumers associations, *equib*; patients-related structures such as diabetics’ patients associations, heart disease associations, associations of people living with HIV/AIDS, civil servants HIV/AIDS care and support associations; and others like farmers’ unions, *debo*, community elders, communities of people with disability, etc. were grouped in these clusters respectively.
- The KIs did not recommend them as effective platforms for community engagement to increase RMNCH service delivery and social accountability, though.

In this section, CSs that were most frequently mentioned and recommended by KIs and hence were further explored in each cluster are described against the criteria that emerged in the analysis process.

Cluster I: Development Armies

The development army cluster of CSs constitutes the women’s development army and men’s

development army. Both structures have long existed at the grassroots level (kebele and sub-kebele levels). WDAs and MDAs were founded to facilitate development activities with a special focus on different sectors, including but not limited to health, education, and agriculture. These structures are aligned with the government initiatives including Health Sector Transformation Plan (HSTP) and are the key avenue to reach and increase access and awareness of the people residing at rural parts of the country. Both Men and Women Development Armies are organized as one-to-five and one-to-thirty networks of households and widely considered as a primary platform for reaching grassroots communities for government initiatives. While MDAs focus on agriculture and other economic activities, WDAs usually focus on health and other social issues.

a. Technical Capacity and Motivation of Members:

The findings show that, in most of the rural areas, members of WDAs and MDAs have literacy constraints (48% cannot read and write). Many of them (particularly members of the rural platforms) are not well educated. But in some cases, the study shows that some members of the development armies are educated to the extent that they can equally play the roles of HEWs in relation to some of the HEP packages. Particularly, most members of the WDA are perceived by their respective communities as models in their behavior. Further, most of the members of the WDA may have the right knowledge on each of the health service areas, and most of them have good health literacy about the eighteen packages of the HEP. Nevertheless, it was reported that some members of the WDAs and MDAs lack the initiation to steer and discharge designated duties and responsibilities, mainly because they are working on a voluntary basis and do not receive sufficient financial compensations.

b. Reach and Coverage:

As far as WDAs and MDAs are concerned, in the study areas, almost no kebele is without these community structures. Apart from their geographic presence, both structures serve their communities in social, economic, legal and health issues., mostly women and men respectively, regardless of any differences involving ethnicity, religion, physical impairment, etc. Members of these CSs live together with the respective communities they serve and know these communities intimately.

c. Institutional Features:

WDAs and MDAs have been organized with twenty-five to thirty members each, which are further sub grouped into “one-to-five” networks. Five best performers are selected out of the thirty members, and each of them is assigned to be the leader of five women or five men of the respective groups. The WDAs use this arrangement mainly to discuss and share life experiences about health issues, like family planning and child immunization, while the MDAs optimally use it for facilitating agricultural activities, such as water and soil management work, fertilizer, and seeds distribution. These CSs do not have bylaws, but they have guidelines to which they adhere while they practice their vested responsibilities. Notably, a KI from the Amhara region (Machakel) remarked that “there are some irregularities in assuming and practicing their responsibilities due mainly to a lack of a consistent and uniform operational manual and bylaws.”

d. Power to Influence:

The acceptance and power of influence of the development armies was learned to have depended on the quality of services that the structures accord to their respective communities. In this regard, KIs mentioned that the more a WDA becomes model in practicing the required health behavior, the more the tendency to be taken as exemplary and be accepted by the respective

community members, while the opposite is true for those WDAs that perform poorly. It was also noted that WDA leaders' influence is mostly limited to women in their networks, and those of MDA is similarly limited to men in their networks.

e. Compatibility of values with RMNCH Outcomes:

The WDAs claim to work for the entire community equally and equitably. They are also attested to be transparent and accountable for the services they are providing. In that regard, it was mentioned by key informants from SNNPR (KTZ-Kecha-Bira) that "the heads of the WDA are often evaluated by health extension workers based on a set of criteria. They are thus provided with feedback for improvement. Further, WDAs are trained and sensitized to work with due respect to the values and dignity of the community they serve." Despite some trends of fading volunteerism, most WDA members are working on a voluntary basis and are keenly interested to serve their community. Consequently, many of the WDAs are motivated to understand the problems of their respective communities.

f. Relevant experience:

WDAs are recognized by almost all KIs for their profound contribution and experiences in issues like maternal and child health, promotion of child immunization, family planning promotion, etc. KIs in the

Amhara region (Machakel) commented that "WDAs are really active in the health sector. Had they not been as active as they are currently, the health extension workers wouldn't have been able to be effective in raising mothers' awareness and thereby reaching them for vaccination. For instance, whenever there is an expecting mother in our areas, the WDA leader of that area provides the necessary awareness-raising services and summons the mothers to the health centers. If an ambulance is required, again, it is the WDAs that inform the HEWs about the situation and urge them to facilitate the process. As a result, the number of mothers giving birth at home has significantly reduced, which in turn contributed to the observable reduction in maternal deaths." One of the informants in Machakel further underlined that "WDAs are known for their tracks in working on RMNCH and other health services. WDAs have good reputation among the community. Consequently, WDAs have been an entry point for CSOs and other development partners." *Aligned to the views of the key informants in Machakel, the KIs in SNNPR (KTZ-Kecha-Bira) stated that* "the [WDA] groups go to the places where the health extension workers are not able to reach." *In SNNPR, the WDAs are identified to be responsible for the inspection of the health of community members two times every month. In this regard, it was learned that the WDAs closely follow up with pregnant mothers in the kebele to ensure the mothers are receiving health care services. Further, it was mentioned that the* "WDAs are also responsible for environmental sanitation".

On the other hand, the MDAs have limited experience on health-related issues. Nevertheless, the MDAs in places like Machakel (Amhara region) play some role in mobilizing their constituents and community members in health-related actions, like construction of model communal latrines. In the same place, it was learned that "the health sector had been using the men groups in order to promote the health status of the community. These men groups used to make house-to house visits and even distribute family planning pills" (KI, Machakel Woreda, Amhara Region).

The other relevant experience of these CSs is their "community score card." The WDA in SNNPR and WDAs and MDAs in the Amhara region were all stated to have applied community score cards to ensure greater accountability. In this regard, some KIs in the SNNP region narrated the roles played by these CSs in making service providers accountable. One example that was provided by was a role played by development armies in solving an acute problem of the proper use of ambulances. "There was a long

prevailing problem in using ambulances where some woredas put them at woreda level, and political cadres unlawfully use them for political purposes. Even in some places, some drivers were discovered collecting charges from patients." *It was thus learned that development armies mobilize the community to demand proper use of ambulances, as a result, control of the ambulances shifted to health offices and or the health center.*

In Eastern Gojam, one of the ambulance drivers was confronted by community members for not answering his cell phone. In response, the driver claimed that he could not be obliged to pick his phone up because "it is his own cell phone." To that end, community members joined together to buy a cell phone and gave both to the driver, instructing him, "Here after it is our phone, and you should respond at all times. Unsurprisingly, the number of clients who received ambulance service after that was reported to double" (KI, Walana Health Post, Kecha Bira WoHO, SNNPR)

Similarly, WDAs in Dembecha (Amhara region) were found to be determined to ask for their rights. "They don't hesitate to ask, even at the woreda level, and face the problem head on, and thereby report to the concerned government counterparts the fact that they are not getting appropriate service and response from the health care facilities. WDAs are responsive to community needs" (KI, Dembecha Woreda, East Gojam Zone).

In Summary: WDAs are a good avenue to access women while MDA can reach men. In both cases, they have a wide range of reach and coverage. Both have the experience, values, and expertise suited to their respectively designated tasks.

Cluster II: Women's Groups and Associations

This cluster includes CSs involving and/or serving only women. These include but are not limited to women's associations, women's saving unions, women St Mary Associations, women's Idirs, and merchant women's associations.

a. Technical capacity and motivation of members:

Informants reflected that women association members are mixed in their literacy. Related to health literacy, they have limited experiences in providing health-related services. Women Idirs were described as capable of doing things by themselves. Overall, CSs in this category do not seem strong in technical capacity and motivation to serve, as they have limited exposure in the area of RMNCH.

b. Reach and coverage:

In terms of presence, women' associations have good regional, zonal, woreda, and kebele level representation. Their constituency are adult women. The women's saving union was mentioned as a CS composed of a large number of women coming together as an economic support group whereby women help one another. About 901 women's saving unions are available in the Amhara region, with 21,154 women are involved. They discuss issues related to agriculture and health.

The Women's St Mary Associations are also cited as having a huge presence (several of these associations in each kebele). They are accessible and their leaders are known. However, their discussion is limited to religious celebration rather than economic, health, or social issues. The women's Idir is notable for its organization, like having a chairperson, cashier, and weekly meeting date. It also has both Muslim and Christian members, and thus it is religiously inclusive. The leader of the women merchant association key informant at South Wollo articulated the inclusiveness in terms of constituency of the merchant women's associations as follows:

“Any woman who has a trade license can be a member of this association. It involves any merchant woman from lower level to higher level … It involves Muslims, Christians, and all … And it is a big backbone for women. It aims to empower women through capacity building and support them so that they can form a business. The association has a saving and lending institution, so a merchant woman can save and can expand her business by borrowing triple the amount of money as what she has saved without any collateral” (KI, South Wollo Zone, Amhara Region).

In terms of accessibility, the above informant added that they are making their association accessible and mobilizing more female merchants to become members of this association. But there are some challenges; women, for instance, sometimes don’t come to meetings and fail to be alert for many calls.

c. Institutional features:

With regard to independence, women’s associations are not affiliated religiously or politically. They are also somehow predictable, with well-stated bylaws. As a rule, the women’s association and its members do activities that help to improve women’s decision-making power, to increase the number of women in decision-making positions, and to promote gender equality. The Merchant Women’s Association is also described as free from political and religious dependence. This association has tasks such as enhancing acceptance of women in the business sector, helping women get training and support to improve their business.

In terms of their system, Women Saving Unions have a program to meet weekly or biweekly, and some of them have a monthly program. They have a secretary and cashier. They also have what they call yetimret hibret, which is formed from different kebeles, and this is an organized structure; for example, between roughly four and eleven kebele form one yetimret hibret, which has a chairperson, a cashier, and a committee. This means that, if they get a fund, they will receive it through the timret hibret, and the timret hibret further distributes to the union. The union is found at the kebele level, and there is a chain. In sum, the saving union is very organized.

Speaking of predictable behavior, among the women’s saving union, the chair of one of the unions mentioned its strong financial capability mobilized through adherence to its rule and regulations. Rules and regulations dictate how they deposit, how they withdraw, how they take loans, how they return them, and how default can be treated. This local CS has recognition by woreda union. In terms of certification, it is known up to the regional level. Women’s saving unions are recognized at regional as well as federal levels.

d. Power to influence:

Women associations are actively involved in income-generating activities and take a role in facilitating support for low income women in partnership with different stakeholders, which contributes to their enhanced capacity to influence. They are also highly accepted by the community.

Women’s saving unions are also strong economically, as they have a lot of savings and thus are thought to be able to effect change if they work on women’s health. The chair of one of the women’s saving association who was interviewed reflected that “Nearly every community member, including men, could give you information about the women saving union, as it is familiar in the community. It is embedded in the community, and thus young girls, males, and household heads also contribute and help the union, showing its credibility and acceptance and the consequent influence” (KI, Women Saving Union, Amhara Region).

"Women Idir deposit a fixed amount every month mainly for medical expenses of sick persons, to help people with grief, and for weddings. Due to this, they are widely accepted. The women Idir is independent and yet able to influence the government. The government encourages and accepts their activities. Far from governmental opposition, there is motivation from the government for this CSs" (KI, Women Idir, Amhara Region).

Power and influence for the merchant women's association is operationalized in terms of their relations with government and other sectors. The chair of the merchant women association expressed her view as follows: "They have very good relations with government bodies, especially with the trade bureau, and it gives them good support. Other sectors also have positive responses for their questions, although there might be some bureaucratic things that take time" (KI, Women Merchant Association, South Wollo Zone, Amhara Region).

e. Value compatibility with RMNCH:

Women's associations are in general willing to work on RMNCH if they are requested to do so. The chair of the women saving union articulated the existing engagement value compatibility as follows: "The HEW uses this saving union to implement packages and postnatal care. Health extension workers use the saving union by adjusting their program and forming links with them, and, in addition, they are also the part of development team structure. Since they have high importance … they use them at large. So, one of the structures that the HEP uses to transmit information is saving unions" (KI, Women Saving Union, Amhara Region).

f. Relevant experience:

With regard to relevant experience, women associations do not have structured engagement with health in the past. Some experiences reported include one related to fistula screening in which women associations contributed to spreading health awareness and knowledge through their structure. Their engagement focused on prevention activities, like awareness creation, promotion of healthy behavior and behavior change, and communication. There are also reports that women associations were involved in the implementation of ESAP (Ethiopian social accountability program).

In relation to relevant experiences, in some places self-motivated HEWs managed to use women St Mary Associations as a platform to promote the implementation of the HEP even though there is no formal guidance on how to use these structures. As reported by the health office head of Machakel woreda in the Amhara region:

> *"While St Mary's association members gather for celebration every month, the HEW, and WDA leaders join them and discuss about health and health related issues. The host of the ceremony will be the focus of their discussion,... The HEW will discuss everything based on the condition of that house, the toilet structure, use of safe water, and the like. If everything is not good, that mother will be educated about all the gaps, and the religious father will also encourage her to do so, and all the members who attended the ceremony will be told to practice what that specific mother is told to do, and this is all about the mission of the association for the health*

> *sector, and finally all members will compete for a better achievement of their household … As we have said, Women's Development Armies are our bases, and members of this association will greatly support the works of the WDA. What makes the St Mary Association special from Idir is that all the members are women, and they compete with one another and for better achievements in order to get rewards from their religious father. For instance, if the mother who prepares the ceremony of the St Mary memorial has good*

achievements of the health care packages when she is assessed for it, she will be rewarded a certificate with a heading called 'Jegnit' (Amhraic to say brilliant) and that will be posted on that woman's wall, and hence it will motivate the next mother for a better performance and implementation of the health care packages, and this is the way we proceed. By the way, this is not simply talk; we already started it and we have got good results from it. Therefore, mothers compete with each other in order to get recognition from their religious father and from their friends. So, she will work harder to prepare her housing and every health-related activity in her house so as not to disappoint her father. We have started it, but to make it formal it needs a manual, since that is a good way of addressing the society's health-related problems, and it has to be part of the government agenda" (KI, Machakel Woreda, Amhara Region).

One of the women Idir chair mentioned that, until now, they don't have any relationship with health service providers, yet they still engage in environmental hygiene and encourage the community to wash their hands. Since at the time of interview the COVID-19 was a concern, their focus was on how to prevent infection and how to improve their community's health. They also discussed how they can reduce their children's vulnerability to COVID-19.

Chairperson of one of the women's associations also shared the view that, although they didn't usually engage much, as they didn't get the opportunity for participatory projects, they have done a lot on relation to COVID-19 prevention. The informant added that, though they have low engagement currently in health activities, they have a strong potential for the future with proper support. She added, "I think we will be effective if we do it for the future, because most women are responsible for a family, and they are the ones who suffer from many problems. So, if we train them, I am sure there will be big change, and if we do it together, we can bring big change." (KI, Machakel Woreda, Amhara Region)

The women merchant association has a very strong impact in improving the economic situation of women, but they have also expressed interest in working in the health sector if they get the opportunity to participate.

In Summary: This cluster is found to be strong in terms of reach and coverage, particularly to women, although the purpose is more economic and social than health. In general, it seems that the different kinds of women associations have good standing in terms of influence, both in mobilizing resources and in terms of being acceptable by the community. In sum, although there are mixed reports in relation to relevant experience, this cluster demonstrated a huge potential for RMNCH service promotion and improved service provision. For example, the Women's St Mary's Association was effective in Machakel woreda of the Amhara region. There is a high level of willingness to participate in health-related activities.

Cluster III: Youths Groups and Associations

This cluster of CSs comprises associations either owned by or affiliated with youths. These include youth associations, SRH volunteers, female youth or adolescent associations, youth leagues, youth women associations, and youth health teams. Nonetheless, only the youth associations were further discussed by the key informants, and the others were simply passively mentioned by the informants.

a. Technical capacity and motivation of members:

Youth associations were mentioned to have "well trained and educated members." Members were also recognized as committed and energetic. Their energy emanates from their age level, government support for such associations and their achievement of goals.

b. Reach and coverage:

Many of them are associated with youth centers which, in turn, are widely distributed in most of the kebeles. Youth associations include members from both sex. Members represent a younger population. They are well organized and well situated at all levels; at the grassroots, community level, there are members with more informal ties, while, at higher levels, they tend to be more structured.

c. Institutional features:

Kis reported that youth associations have a strong working relationship with their respective government structures. Many of the youth associations have been legally registered by the respective regional government offices. They claim to be unaffiliated with the government but there are complains that they are being manipulated by the regional government structures, often for political purposes.

d. Power to influence:

Many of the youth associations were found to be trustworthy and acceptable by the respective community, particularly their members, unless they were found to be affiliated with government offices for the purposes beyond their establishment. Youth associations collect membership fees from their members.

e. Compatibility of values with RMNCH outcomes:

Legally registered by the regional government offices, youth associations are understood to play vital roles in health promotion in general and in family planning and reproductive health in particular.

f. Relevant experience:

Their roles and contribution in FP and MCH service delivery were learned to be immense, particularly in reaching the younger generation. They were also depicted as a structure that strong links with the health sector to offer services at youth centers.

In Summary: Youth associations are viable platforms to reach

young people. ***Cluster IV: School-Based Clubs***

This cluster includes self-organized interest clubs established and run by school communities, particularly by students. These take several forms with different names, including school clubs, gender clubs / girls-only clubs, music & entertainment clubs, uncircumcised girls' clubs, peer-to-peer groups in school, university youth associations, and reproductive health clubs.

a. Technical capacity and motivation of members:

This is one of the CSs with the most literate members, comprised of teachers and students. There is also evidence that shows some schools are serving as models for sound health practices. If they are well-coordinated, young students can be motivated to engage in impactful health promotion activities.

b. Reach and coverage:

In terms of presence, since this CS is school based, it can be found in almost every school.

Moreover, its members emanate from the surrounding community, thus it is well rooted. It can reach large populations when students influence their parents, their peers, and their neighbors. With regard to composition, most members of school clubs are students led by the school directors and teachers who serve as focal persons for health and health-related issues in their respective schools. Its major constituency is the school community. Its availability in each school makes it highly accessible.

c. Institutional features:

Obviously, these groups are school affiliated and hence under more government influence, as schools

exist under government mandate, and only few private schools are available. Since members of this group are more informed citizens, they are relatively predictable. In terms of roles and responsibilities, school clubs have variable levels of clarity.

d. Power to influence:

Schools and school clubs are accepted by society, as they are considered relatively

enlightened.

e. Compatibility of values with RMNCH outcomes:

There are various school clubs, like HIV/AIDS, reproductive health, and related ones, whose values are compatible with RMNCH. In general, school clubs tend to have more positive attitudes towards the provision of RMNCH services to young people as compared to other CSs comprising adults.

f. Relevant experience:

School health promotion takes place at schools, even though the frequency, content, and dose of interventions varies across schools. In recent years, there has been increasing provision of and exposure to health messages in school communities as part of curricula and through health cadres from surrounding health facilities, and children can bring these health messages home.

In Summary: school communities can be accessed in a defined place. Interventions targeting school communities can not only benefit students, but they can also be used as messengers and agents of change for their parents and communities.

Cluster V: Clubs, Leagues, and Volunteer Groups

Some fourteen CSs enumerated by the KIs fall under this cluster. These include anti-HIV/AIDS clubs, community volunteers, family health groups, sport clubs, volunteers coalitions, community advisory groups, community resource persons' committees, informal youth volunteers, peer-to-peer groups out of school youth, and rotary clubs, social service workers, volunteer youth associations, volunteers and community health promoters, and yebego tena meliketegnoch. However, their relevance to either RMNCH or social accountability was upheld by the key informants. Pertinently, Kis provided no details except passing mentions of these types of CSs in their interviews.

Cluster VI: Local Government (LG) Structures and LG-Initiated Community Structures

There are fifteen structures under this cluster. This cluster includes CSs that are initiated and/or managed by local government structures established mostly with the purpose of addressing specific needs of their communities. These include but are not limited to community care coalitions (CCC), water committees, village health leaders (VHL), health committees, HTP platforms, multi-sectoral committees, and parents, students, and teachers' associations (PTSA).

Adequate descriptions were available for community care coalitions, water committees, and village health leaders (VHL). VHL is a newly designed option for community engagement that MoH is currently piloting to assess its feasibility and effectiveness.

a. Technical capacity and motivation of members

Members of CSs under this category are mostly selected for specific purposes. That, by default, selects community members with a relatively better understanding of the subject under inquiry to become members and leaders of the structures. For example, KIs described members of the CCC as representing themselves capably since most of them are literate. In relation to health literacy, some CCCs are already working to improve the community's health service utilization. They are specifically considered models for social accountability for what they are doing in their community care activities for various vulnerable groups. Village health leaders and voluntary community representatives receive capacity building on health-related topics by health officers coming from the nearby health centers as part of the health sector's pilot program to identify alternative community engagement mechanisms (data obtained from

Silte Zone in SNNP region). They are selected based on their prior capacity but also receive additional orientations and trainings on health-related topics.

b. Reach and coverage:

CCCs are mainly engaged in providing support to vulnerable members in a community. CCCs are present in most kebeles. Their composition is diverse, as they are formed from different stakeholders that can be influential in that specific kebele. Their constituency contains organizations and community members in the kebele where they reside. They are also accessible to all segments of the community.

The other issue-focused CS widely available in the three regions is the WASH committees. Water sources are built and protected by government as well as nongovernmental organizations in different places. Based on the water sector structure, there is a WASH committee which includes seven members for each water source. Members include female and male community members; they have a chairman, secretary, supervisor, property keeper, and finance section. The committees are responsible for their community's use of water, meet monthly, and contribute money for the maintenance of the water. These structures are widely available in the three regions; however, their availability depends on the existence of a water source constructed or protected by government or non-government actors who also facilitate the creation of the committees. These committees do not exist in areas where such water sources are not available.

c. Institutional features:

From the institutional perspective CCCs have established structures at the community level. As they are not government affiliated, they are relatively independent in their practices. In addition, CCCs are sustainable, as they stem from and work for the community.

d. Power to influence:

CCCs are basically known for their effectiveness in mobilizing resources. They mobilize resources for maternal waiting homes, ambulances, and sometimes to support health facilities in their community. They are also highly accepted by the community, leading to elevated trust and credibility to enhance demand creation or to ensure social accountability.

e. Compatibility of values with RMNCH outcomes:

CCCs are considered exemplary in their transparency, as they practice transparency in using the

resources, they mobilize to support vulnerable groups. Members of the CCC work on a voluntary basis without a salary. Though their engagement is not specific to health, they also are contributing to the improvement of RMNCH services, as there are several occasions in which their goals will be aligned with RMNCH (health of vulnerable groups). In terms of community concern, their sole purpose derives from the community's needs and problems, making them sensitive and responsive to these.

Members of WASH committees are selected from the community. When these committees are invited for training, the WASH committee provides trainings for five to seven days, with the last two focusing on hygiene practices. One of the trainers is specifically from the health sector. The water sector organizes the training, and the health sector avails experts and provides training on healthcare packages. Therefore, the water committees have good awareness and knowledge not only on how they can manage the water schemes but also on how to prevent water-related diseases.

f. Relevant experience

Experiences of CSs under this cluster are largely related to the issues of their primary interest. Overlap between their primary purposes and RMNCH usually creates opportunities for them to engage in the promotion and improvement of RMNCH services and/or social accountability. For example, CCCs have engagements related to RMNCH. They have improved RMNCH by contributing to the reduction of home delivery, improved child nutrition, and by contributing their share in making the maternal waiting homes functional. Participants also reported that, in some areas, CCCs have been used as a check-and-balance mechanism for the services, which clearly marks them as socially accountable.

Similarly, water committees, established with the primary purpose of managing water sources at the village level, contribute to improved child health by promoting hygiene and sanitation in their communities.

In terms of the track record in promoting hygiene, the water sector establishes the water committees and the health sector uses this committee for promoting hygiene. The committee minimizes the work of health extension workers, since they are not expected to go house to house to educate the community about how to keep water clean at a household level. They rather will use the monthly committee meetings for information dissemination about how to keep water clean, proper hand-washing practices, and latrine use. This committee is seen as an important platform to work with HEWs in improving communal latrine construction.

In Summary: CSs under this cluster seem to have strengths in the areas of their primary purposes of establishment. Because of their multi-disciplinary role that largely overlaps with RMNCH, CCCs seem essential for community engagement in RMNCH in terms of their accessibility, diversity, capacity, independence, influence in mobilizing resources, acceptance, transparency, sensitivity to community problems, working as check-and-balance systems, and having relevant experience in RMNCH as well as social accountability. They are depicted as important for both RMNCH service and social accountability. Particular to RMNCH, the water committees seem like one relevant platform for improving hygiene.

Cluster VII: Traditional and Religious Institutions

This cluster consists of CSs that are indigenous to the communities and serve primary purposes related to religion and other social issues. These include structures that are involved in handling conflicts, funerals, and religious services. *Idirs, coalitions of Idirs, Sidama cultural judiciary*

systems, religious leaders, zewold/abegar, associations of elders, faith, women and youth associations, local churches, senbete, tsewa mahiber, customary justice leaders, abbaa gaddaa / gadda leaders, clan leaders, fiche, and haadha siinqqee are CSs identified under this cluster.

a. Technical capacity and motivation of members:

Kis reported that most of the Idirs were found to be led by educated (often retired) and culturally or religiously enlightened individuals. Kis also reported that most of the members have attended various health-related trainings. However, it was also reported that most of them, do not have practical experience in promoting health service delivery. Almost all the leaders of the CSs under this category are voluntary and hence are likely to be motivated and committed to serve their respective constituents. Leaders are also known for their model behaviors in various aspects of life.

b. Reach and coverage:

Songo, the Sidama judiciary system, operates down to the lowest structure level in the region. However, "only males lead the cultural judiciary system, and it is hereditary based. Women do not get a chance to be part of it even, if there is no male from the family" (KI, Sidama Region).

Idirs are there in every community. Coalition of Idirs are often at a higher level, from Woreda and above. The way Idirs are organized favors them to reach all segments of a community and a broad geography. The religious institutions are more relevant to the respective worshippers. Further, associations of elderly exist both in kebeles and woredas. People aged sixty and above, regardless of their religion, gender, ethnic group, disabilities, or other identities, can make up the association.

"ZEWOLD" or Abegar is a specific group to the Kobo area (Amhara region). This group focuses on assigning the wisest, most exemplary, trustworthy, and articulate people to represent and speak for the community.

c. Institutional features:

The Sidamas are reported to have long-existing institutionalized cultural systems. "Sidama believes in three things. First it believes in Kalika, which means God. Secondly, it believes in Halale, which means

truth. and truth is God. They also say, 'admit or respect the wisdom of someone.' Thirdly, people of Sidama believe elderly men have the Spirit of God, so they advise not to refuse their orders because they believe that their blessing may reach and curse too. They also make decisions fairly by sticking to the truth" (KI, Sidma Region).

For instance, AydiSongo is a congregation of clan leaders. Any individual-based conflicts do not go beyond this level, and AydiSongo is the last judicial system that resolves such conflicts. On the other hand, murderers cannot be judged at woreda level. Rather, they are adjourned at the Zonal level cultural judiciary system. The decision passed by Mote or Garo is almost always accepted. Anyone rejecting the decision will be punished/sanctioned for that. Sanctions may include isolating the person from any social matters, not allowing him/her to share materials, not helping him/her during mourning, etc.

The other community structures, Idirs, are independent structures constituted by community members for a designated social purpose. They are not influenced by any government structure. They have well written bylaws with clearly articulated roles and responsibilities. Likewise, the elders' association and Abegar have democratically elected leaders, defined roles and responsibilities, and some working systems. On the other hand, Zewold has a formal structure

that resembles the local government structure. The association has a CEO, chairman, vice chairman, cashier, and internal auditor.

d. Power to influence:

Community structures in this category, in general, have the strongest informal power to influence their communities. Their power arises from their reputations (as individuals and as a system), the belief that they are messengers of supernatural forces in the case of religious leaders, and fear of being excluded from valued social services such as in the case of Idirs. For example, the Sidama Cultural Judiciary System is an overarching and influential system of the Sidama people. As a result, the elders remain committed to maintain the system from generation to generation. Subsequently, when they meet for Songo, they intentionally bring children to watch the process. As a KI mentioned, the elders note to the children "respecting elders and knowing your culture makes you love people, love your neighbors, and live in peace. The Sidama people have a due regard to the cultural system" (KI, Sidama Region).

Idirs are especially influential/powerful in the communities they serve. They are known for their effective resource mobilization practices in support of needy people. They sometimes support the health facilities in their community too. Religious leaders are also strongly trusted and accepted by their respective constituents. Similarly, Zewold is a reputable structure both within the community and local government. It is known for its truthfulness, fairness, and equitability. They participate in conflict resolution.

e. Compatibility of values with RMNCH outcomes:

The Sidama people have the valuable practice of responding to health issues, particularly epidemics and other natural and human disasters. For instance, if an epidemic occurs, they discuss how it occurred and how to prevent it. Again, if war or larger conflicts happen, they also discuss how to avoid it if possible. If famine occurs, mothers pray by handling a stick. There are mothers who are wives of Motes (like first ladies); they are called Kerichos, and they lead other elderly mothers and facilitate prayers. Therefore, Mote discusses social issues, health issues, natural occurrences, etc.. On the other hand, Idirs provide services to all who need them, regardless of any differences. Similarly, they serve health purposes mainly in raising the awareness of community members. Regarding the Kobo area community structure, Zewold, people ready to accept whatever is prescribed by the structure. It is a highly valued, value-oriented structure. People tend to prefer it for social services to other formal structures.

f. Relevant experience:

Despite their potential, the experiences of CSs under this structure in RMNCH services is limited. For example, the Sidama judiciary system is highly influential; however, it is not known for its direct involvement in health issues in general and RMNCH in particular. One KI noted that:

"Songo members are influential. People respect their decisions. So it is possible to deal with them, and much can be done through them. They can decide and pass their decision to the

community in every health issue, like maternal, child health, and epidemics. For instance, I have worked in the health sector, and I know how latrine utilization used to be promoted. It has gained acceptance only when elders adopted and promote it. Likewise, maternal and child health care can also be promoted by working with elders. For instance, they can promote immunizations. It would be good if they tell people about its importance. Rather than you tell them a thousand times, one word from elders gets automatic acceptance by the community. So it is possible to promote every

health issue, whether latrine construction or immunization or anything else, through them." (KI, Sidama Region)

Unlike the judiciary system (Songo), Idirs have some exposure and experience in areas like nutrition and other health-related activities. Idirs were learned to have involvement in HIV-related work and CBHI programs. Reports also demonstrated that quite a lot of Idirs and their coalitions were involved in social accountability initiatives. The elderly associations were also found to have some experiences in promoting health issues, mainly to their members. On top of that, the associations "have carried out different development activities that include building and offering shelter to the elders, maintenance of old shelters, comprehensive support to the elderly people, etc." (KI, North Wollo Zone, Amhara Region).

Cluster VIII: Accountability Groups / Citizens Monitoring Groups

This cluster specifically deals with CSs focused on soliciting community feedback. It includes mainly the two structures that exclusively work on accountability mechanisms: the community score card (CSC) and social accountability councils *(SACs)*. The community score card (CSC), which itself is a social accountability tool, is a citizen feedback / citizen engagement mechanism implemented by the health sector by the name CSC, whereas social accountability councils are institutionalization efforts of CSOs that had been involved in the Ethiopian social accountability program (ESAP). The community scorecard, which Clients' Councils established at local community levels, appeared to be the most common platform for engaging communities in social accountability in the health sector.

a. Technical capacity and motivation of members:

CSC is learned to "have been structured and cascaded by the health sector to ensure woreda transformation and quality services" (KI, MCH Expert, North Worllo Zone, Amhara Region). It's composed of a range of actors that include teachers and other professionals apart from the health sector exerts. Despite some fading practices of the CSC, most members are reported to be "working responsibly and with energy" (KI, Machakel Woreda, Amhara Region). Social accountability councils, on the other hand, were initiated mainly as a mechanism to sustain social accountability initiatives targeting multiple sectors and had been fostered by selected CSOs. SACs are composed of diverse professionals, mainly from the services side and sectoral offices.

b. Reach and coverage:

The CSC is executed at the woreda level on the health care facility but extends to the kebele level too. The CSC involves, at the community level, clients' councils that are composed of religious fathers, women representatives, youth representatives, influential persons (opinion leaders), and health care representatives. The SAC also constituted with representatives from religious people, Idirs, government sector offices , some thematic structures such as PTAs for education, etc. The SAC has also extended itself to the lowest level of administrative structures. For instance, in Hawassa, the SAC was mandated to reach seven out of eight sub-cities. But it was later learned that it has a sub-committee at the eighth sub-city, trying to reach the entire community of the city. Sectorally, the CSC deals with the health sector while the SAC is engaged in multple-sectors.

c. Institutional features:

The CSC initiatives are reported to be often managed by designated managers (most often teachers) but are derided for ineffectiveness mainly due to their respective mandates and roles in their respective working places. The CSC initiated is associated with the health sector. The SAC is led by community volunteers. It is not a budget-allocated structure and is owned and run mostly by the community. The

SAC in Hawassa has bylaws and working guidelines. It has also signed a memorandum of understanding (with clear roles and responsibilities of each party) with the respective sector offices of the government.

d. Power to influence:

Members of the CSC are reported to be acceptable and dependable. But informants underlined that, as the role of the CSC is facilitating feedbacks on the health services provided by health facilities and cannot solve problems by themselves, thus they are considered less influential. A KI noted that "the health center leader may accept the feedback voiced by the service users and facilitated by the CSC structures, but if s/he doesn't have the power to curve the situations mainly due to lack of inputs (which are often allocated by structures above that), it is hard to assimilate the roles that the CSC initiatives are playing. Of course, corrective measures related with discipline and ethics are taken at facility level. But decisions related to inputs like medicine, equipment, etc. are not often solved there, and hence the CSC is perceived as not influential by the community" (KI, Machakel Woreda, Amhara REgion).

> ***"The social accountability council members, on the other hand, are viewed as well-respected members of the community. Reports show that many of them are opinion leaders. They have a say in the community. They have the power to become a bridge between the government and the community. Their expertise is also knowledge based and so they have the ability to fill existing gaps" (KI, JeCCDO, Sidama Region)***.

"The SAC is well known both by the community and the local government. Both recognize that the SAC is benefits of government as well as the community. Perhaps because of the lengthy trainings conducted with regards to social accountability, government officials easily became aware of the concept and thereby their roles and responsibilities in getting it grounded. The government bodies didn't pose us any problem. We easily reached an agreement and implemented it successfully. As I told you before, the fact that we conducted extended trainings on social accountability has benefited us a lot. The Hawassa city administration is really positive and supportive of the whole thing" (KI, JeCCDO, Sidama Region).

e. Compatibility of values with RMNCH outcomes:

SAC and structures for CSC values completely align with RMNCH service delivery and social accountability because their very existence is to improve services. The CSC structures are composed of people drawn from religious leaders, famous individuals, teachers, leader of the WDA, the kebele chairman, and the community at large. The CSC assesses health facilities based on pre-set indicators. Information/
feedbacks are thus collected in a non-judgmental and unbiased way. The feedback is then relayed to the health centers. The health centers in turn reflect on the feedbacks and develop further action plans based on it. Plans of actions will be presented to and discussed with the community. The consultative sessions are meant to ensure that a plan of action aligns with service standards of the health facilities. Therefore, it is important that feedback is in line with the values of the community and the health sector, and also that the process is transparent.

The SAC in Hawassa has been reported to have applied CSC as a social accountability tool to assess the quality, accessibility, affordability, etc. of services provided in WASH and education. To that end, they organized numerous focus group discussions where the service providers and service users separately rated the aforementioned services. After these discussions they organized an interface meeting where the service provider and representative of service users came together and reviewed and discussed the compiled feedback that was separately provided

by both. They developed a joint action plan in response to identified gaps. The SAC plays a pivotal role all through these processes and serves as a way of institutionalizing the entire initiative. That entire process was executed with due blessings, recognition, and keen participation of the target communities. The process has also been learned to have adhered to the rules, norms, and values of the respective government offices.

f. Relevant experience:

The CSC is an integral structure in the health sector. Pertinently, despite some irregularities and challenges, KIs applaud its relevance, significance, and feasibility. The practice of CSC is applauded by

the staff of health centers, mainly because feedbacks from service users helped them improve the way they provided services. A KI noted that the CSC helps the community and the professionals (health staff): "When community members file complaints and when we receive such feedback, we get ashamed of our services and become more encouraged to do things differently and try to satisfy clients" (KI, Machakel Woreda, Amhara Region). The informant further commented that "it would be better if the trainings are be provided both for health facility workers and the community. It would also be belter to be considerate of budgets for such monitoring and evaluation exercises" (KI, Machakel Woreda, Amhara Region). Because of the application of CSC, the KIs noted that the practice of accountability was enhanced. A KI reckoned citing one such example:

> *"Let us take the typical example of ambulance services. We were on field work yesterday and the day before yesterday. We were checking the CSC and its results of one health center. The health center scored forty-eight out of 100 (as evaluated by the community). We were a bit confused by the score. But later we found out that it was because of the broken ambulance. The ambulance of the health center has long stopped providing services to the community due to a mechanical problem. The health center had to be responsive and thus reported the matter to the woreda health office, which in turn relayed the case to the woreda administration for budget allocation to get the vehicle maintained. Eventually, the ambulance was successfully maintained and resumed services. Therefore, I attest that CSC is a practical means to solve problems of the health facilities and it essential. However, it needs regular orientation, as the head of the health center and some member of CSC often changed" (KI, MCH Expert, North Wollo Zone, Amhara Region).*

The SAC (in Hawassa) employs community score cards and collates feedbacks, and then the SAC organizes interface meetings with the respective government counter parts. A KI exemplified that as follows:

> *"There was an interface meeting with all the representatives from the mayor's office, health, education, water, and finance offices on one side and representatives of the community who were drawn from Idirs of the seven sub-cities. In that meeting, along with other problems, the fact that particularly the poorest of the poor (yedehadeha) were found to be not treated well in the health centers was disclosed. Further, the relationship of the community and record officers and security staff of the health center was announced to be worse and tense. On top of the compiled reports of the CSC, the community representatives underlined health center workers are not welcoming and are disrespectful. To add to that, the staff, instead of providing the service at the center, directs patients to private clinics, which in turn incurs costs to*

them. Having attended the interface meeting, the service providers fixed all the problems promptly. With this, what I assure you is that, as long as social accountability is implemented properly with the keen ownership of the community, services will be perfect" (KI, JeCCDO, Sidama Region).

SACs were reported to have done work more than CSCs. In addition to the feedbacks they receive through the CSC, SAC members make periodic visits to the services areas (e.g., health centers, hospitals, schools) to observe and gather feedback. The SACs would subsequently organize the feedback and present it to the relevant government offices for action. Henceforth, the SACs prepare joint action plans with government counterparts with a clear distinction of roles and responsibilities for each party. The action plan is thus integrated into the government budgeting and planning documents. Afterwards, the SAC closely follows up and monitors the execution of the plans and completion of the designated tasks.

In Summary: CSC initiatives of the health sector and social accountability practices of the social accountability programs seem to be feasible mechanisms to engage communities with the respective health sector office and health facilities towards provision of improved and equitable RMNCH services.

Clusters IX, X, and XI: Associations with Economic Interests, Patients Associations, and Others:

In these clusters, economic-focused CSs such as economic associations, income generation groups, loan groups, saving groups, consumers associations, *equib;* patients-related structures such as

diabetics' patients associations, heart disease associations, associations of people living with HIV/ AIDS, civil servants HIV/AIDS care and support associations; and others like farmers' unions, debo, community elders, communities of people with disability, etc. were grouped respectively. None of them however, were further discussed, mainly because the KIs did not recommend them as effective platforms for community engagement to increase RMNCH service delivery and social accountability. A further explanation provided for not recommending them is that these structures do not have visible health related engagement.

4.1.4. Prospecting Community Structures

The study shows that no single CS or cluster of CSs meets criteria under all the dimensions. No sole evaluation criterion shall also help exhaustively explain a CS or cluster of the CSs. Multiple criteria shall help us determine the commendable CSs, both for service delivery and social accountability. Therefore, given the above descriptions, the study team proposes prospective CSs along with foremost reasons for selection as follows.

A. Community structures for RMNCH service delivery

Although many CSs were mentioned, only a few were found to be highly relevant to be engaged in RMNCH demand creation or improvement of service delivery. From the ninety-four CSs and eleven clusters, six CSs from six categories emerged as potentially helpful for engagement. This recommendation stemmed from the evaluation of these CSs along the six dimensions and twenty-four defining criteria.

While recommending them, two essential considerations were also raised: first, for what kind of target group or setting are they recommended? Second, a recommended CS may differ from geography to geography whereby some could be useful everywhere and some could only be useful in a specific region. Below is a list of the recommended CSs along with a brief description

of reasons for their recommendation.

Women's Development Army: Although most of the Women's Development Army leaders have a limited level of general literacy, their health literacy is very good compared to the general public. Because of their engagement in the health extension program, they have good knowledge about the eighteen health packages, which are largely related to RMNCH. WDAs are available in every kebele and thus have an extensive reach. Their institutional features are also found to be suitable for engagement, as they can use the 1-5 structure to discuss health issues. The evidence also demonstrated that WDAs are serving fairly and equally. In sum, WDAs are recommended for their tremendous contribution in the health sector by participating in the health extension program. Their contribution in relation to maternal and child health issues is immense. They work closely with health extension workers. Sometimes, in their absence, they even replace health extension workers. As such, they have gained sufficient experience.

School Clubs: School clubs are recommended because they are primarily good to reach young people, particularly those at school. Some schools serve as models for health practices. Thus, if they are well coordinated, young students can be motivated to engage in game-changing health promotion activities. Since school clubs are found in almost every school and they come from the surrounding community, they have good reach to enhance health service delivery. They are the most literate group. As they are informed citizens, they are relatively predictable. There is a reasonably high level of societal acceptance of school clubs, as they are considered relatively enlightened. There is also value compatibility in that various school clubs like HIV/AIDS, reproductive health, and related ones exist, making them a good fit for the promotion of RMNCH service delivery. In terms of direct engagement, school health promotion is taking place at schools.

Sidama Cultural and Judiciary System: Although it is concerned with only males and acts only on hereditary bases, this structure extends to the lowest structure level in the region making, it a potential candidate for health service delivery. The Sidama Cultrual Judiciary System is an overarching and influential system of the Sidama people. This structure is reported to have high levels of acceptance

among the Sidama people and has long-existing institutionalized cultural systems, making it predictable. With regard to value compatibility, the Sidama people have valuable practice in responding to health issues, particularly epidemics and other natural and human disasters. For instance, if an epidemic occurs, they discuss how it occurred and how to prevent it. As the Songo members are influential people whose decisions are respected, and it is possible to deal with them to promote health issues in general and RMNCH in particular. They can decide and pass their decision to the community in every health issue, like maternal, child health, and epidemics. This CS thus offers an opportunity to promote RMNCH service delivery.

Women Associations: Women's associations are widely available, with somewhat loose structures at lower levels and more organized ones at higher levels. In terms of technical capacity, women association members have some level of health literacy acquired through their experience in either giving or receiving health service. It is somewhat predictable due to its clearly stated bylaws. Women associations are involved as well in income-generating activities and take a role in facilitating situations to support the poor women in kind and cash in partnership with different stakeholders. This helped them build capacity and power to influence the local community and hence gain acceptance. This makes women associations a relevant platform. They have done a lot regarding COVID-19, including mobilizing women for home-to-home visits and educating them to save themselves and prevent the disease. It is mentioned that they work on fistula screening, contributing to health awareness and knowledge through their structure, focusing on the health extension program. Given this evidence, by bringing them together with

WDAs, they can meaningfully contribute in promoting RMNH service delivery.

Women St Mary's Association: Women St Mary's Associations are reported to have a huge presence (several of these associations in each kebele of the reporting area). They are accessible and their leaders are known. The Women St Mary's Association at Machakel is excellent, with commendable experience. While celebrating St Mary's holiday, HEWs and WDAs participate in the celebration and, in collaboration with the religious fathers, discuss the health care packages. In some selected geographic areas, this practice is extremely useful (e.g., Amhara) and scalable. This platform is also specific to women.

Youth Associations: Since members of youth associations were mentioned to be relatively trained and educated, they are a good platform to reach other young people, particularly those who are out of school. Another positive attribute to recommend youth associations is their members' commitment and enthusiasm. Their coverage is also good, as they are available in youth centers widely distributed in several places in most kebeles, particularly in urban settings. Another good feature of youth associations is their gender inclusion. As compared to other CSs, they are better organized and well situated at grassroots levels, enabling them access to all segments of the population. Youth associations' working relationship with the respective government structures and their legally registered status by the respective regional government offices also make them a preferred platform. Evidence shows that many of the youth associations were found to be trustworthy and acceptable by their respective community, making them a good platform to promote RMNCH service delivery among young people, particularly out-of-school youth.

B. Community structures to promote social accountability

Social accountability (SA) is an approach towards building accountability that relies on civic engagement. SA mechanisms are hence demand driven and operate from the bottom up. SA can also be understood as a particular form of civic engagement in which citizens engage with the state for the purpose of holding government officials and bureaucrats accountable. Within social accountability, citizens, communities, and their structures play important roles to facilitate serious engagement between communities and service-providing agencies.

SA mechanisms are useful in strengthening links between citizens and local-level governments and assisting local authorities and service-providers to become more responsive and effective. It is the participation of citizens that distinguishes SA from conventional mechanisms of accountability. In this regard, the findings show that some of the community structures that were identified in this study are commendable. These are:

Community score card: Findings show that CSC is a citizen feedback mechanism introduced to the health sector to facilitate citizens to periodically rate the performance of their respective local health posts, health centers, or primary hospitals. Equipped with technically capable people, the structure functions at the grassroots level. The CSC was also claimed to have been effective when it enabled actors to be reflective and collaboratively solve local administrative, procedural, attitudinal, bureaucratic, and other non-input processes. Complementary with the findings of this study, reports of the MoH show that "many improvements in healthcare delivery have been recorded, including improved cleanliness, more respectful care, and better ambulance management as a result of CSC," The same report indicates that "the CSC has led to infrastructural improvements, often with financial or in-kind contributions from the community." Therefore, despite some concerns (which are discussed in the subsequent section of this report), CSC would stand as one of the mechanisms of promoting social accountability in the health

sector.

Social accountability councils: The Hawassa SAC was learned to have been initiated in an effort to institutionalize and sustain the social accountability initiatives that had been run through the support of the Ethiopian social accountability program. Evidence shows that the Hawassa SAC is a monitoring group that evaluates the performances of the service providers in the city of Hawassa. Their roles consist of collating feedback through CSC as a tool and initiating and facilitating dialogues and meetings between the concerned government authorities and the citizens at sub-city and entire-city levels. Relatedly, the literature shows that similar structures were ventured by CSOs that had been implementing social accountability programs across all Woredas. Those structures were meant to shoulder the responsibility of ensuring social accountability in a sustainable manner, even after the termination of the project. The Hawassa SAC has developed its own vision, mission, objectives, and values. It was also learned that the social accountability initiative that the SAC is running has resulted in a number of positive impacts which include citizen awareness and participation, encouraging influence of the SAC over decisions made in resource allocation, and improved government practices in responding to felt needs of the citizenry. Therefore, the SAC was found to be one of the recommendable avenues of promoting social accountability of the services provided in the health sector.

Community care coalition: The CCCs are often composed of people with diverse skills and technical knowledge. In relation to health literacy, some CCCs are already working to improve the community's health service utilization. Their constituency contains organizations and community members in the kebele where they reside. They are also accessible to all segments of the community. CCCs are basically known for their resource mobilization effectiveness. They mobilize resources for maternal waiting homes, ambulances, and sometimes to support the health facilities in their community. CCCs are considered exemplary in their transparency, as they emphasize transparency in their resource utilization. They are also specifically considered models for social accountability for what they are doing in their community care activities for various vulnerable groups. They are also highly accepted by the community, leading to increased trust and credibility to enhance demand creation or to ensure social accountability. Reports show that CCCs have improved RMNCH by contributing to a reduction of home delivery, improved child nutrition, and by contributing their share in making the maternal waiting house functional. Participants also reported that, in some areas, CCCs have been used as a check-and-balance mechanism for the services, which marks them as socially accountable. Pertinently, the CCC is recommended for promoting social accountability.

Yet, despite their immense potentials to increase demand for RMNCH and promote social accountability in the health sector, the study illustrates that almost all the prospective CSs are constrained by some challenges. These challenges and gaps are briefly discussed in the following sub-section.

4.1.5. Community Engagement Approaches Employed in Engaging Community Structures

KIs identified several CSs engaged with the health sector at different levels of the health system. They identified diverse community engagement models and approaches through which CSs supported service delivery and promoted social accountability in primary healthcare. The most frequently mentioned approaches include:

- Influencing social norms through community dialogues
- Mutual support and experience sharing

- Participation in dissemination of health messages
- Creating platforms to reach target communities
- Demonstrating model behaviors to the general public
- Provision of feedback to the health system

4.1.6. Challenges and Gaps of Prospective Community Structures

The most recurring challenges and gaps of community engagement identified during the inquiry process of this study are enumerated as follows:

- ***Limited capabilities of the CSs:*** CSs are seriously challenged by lack of capacity (institutional, organizational, and individual) in fulfilling their presumed role and responsibilities (RMNCH and social accountability). These include a lack of systematically developed organizational structure, a lack of proper planning and coordination for effective service delivery, a lack of systematically developed working guidelines, and inexpert leadership capacity.
- ***Poor coordination among the CSs:*** CSs were reported to (i) miss opportunities for joint gains and fail to recognize shared interests for undertaking collective action on influencing and participating in local development (e.g., associations that target same segment of populations) and (ii) be exposed to duplication of efforts and failure to coordinate lessons amongst themselves and even from others (e.g., accountability groups), leading to wasting resources.
- ***Vulnerability of CSs to manipulation:*** CSs become vulnerable to manipulation by resource providers and other partners with different agendas (e.g., WDAs, youth association, leagues, etc.). “WDAs, for instance, are perceived as a government structure, and some people consider it as an organization established for a political agenda”.
- ***Lack of accommodative space:*** Some of the CSs, such as the Sidama Cultural Judiciary System, are open only for specific groups. That in turn limits their reach and coverage.
- ***Lack of motivation and commitment among the leadership:*** Many of the CSs have voluntary leaders. Consequently, some of them were reported for their fading commitments and declining outputs mainly due to some reasons that include lack of incentives.
- ***Service, sector/theme, and geography specificity:*** Most of the CSs are confined to a specific service (e.g., water committee for WASH), particular theme (e.g., Women St Mary’s Association whose experience is limited to religious celebration rather than economic, health or social issues), and geographic boundary (e.g., the Sidama Cultural Judiciary System for peace and reconciliation for the Sidama people and school-based clubs for school communities).

4.2 CIVIL SOCIETY ORGANIZATIONS

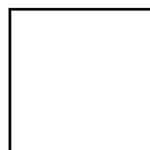
4.2.1. Civil Society Organizations Identified by Key Informants

A total of sixty-six CSOs were identified through interviews with KIs. These organizations fall under five major categories, namely: 1) local development associations, 2) professional associations, 3) local NGOs, 4) faith-based organizations, and 5) umbrella organizations (Table 4). From these, key informants prioritized and recommended 31 of them. Even though our plan was to conduct basic organizational capacity assessment for all CSOs prioritized and

recommended by key informants, we were able to conduct the basic organizational capacity assessment only for 24 CSOs. The 24 CSOs were either those identified in the initial list of CSOs developed by NPI Expand and USAID teams or additional CSOs included in the list during fieldwork because of strong recommendations from key informants. The list of CSOs under each category is attached in Annex 5.

Table 5. Number of CSOs by categories

Category	Number
Local NGOs	39
Professional Associations	12
Religion-Affiliated Organizations	6
Local Development Associations	5
Umbrella Organizations	4
Total	**66**



4.2.2. Profile and Basic Organizational Capacity of CSOs – Findings from a Quantitative Assessment

The profiles and basic organizational capacities of twenty-four CSOs was assessed during the landscaping field visit. In general, we found that a large majority of the CSOs (almost 100% of them) have the basic capacities included in the basic capacity assessment tool. However, it should be noted that this part of the assessment partly relied on the mere presence or absence of organizational features expected from an organized system without a rigorous process of verification and quality assessment which would be expected from a full organizational capacity assessment exercise. We believe findings should be interpreted cautiously, and identification of gaps in organizational capacity for these organizations should follow a self-assessment process that explicitly purposes identification of areas for improvement, not for the purpose of prospecting partners.

Governance and leadership

All CSOs have written mission statements and an organogram displaying the organizational structure. Moreover, all CSOs are governed by elected board members with defined roles and responsibilities (Table 5).

Table 6. Governance structures of CSOs

Governance structure
Have a written mission statement
Articles of incorporation, or charter, or by-laws supporting its mission available
Have organogram
Have a governance board
Have defined roles and responsibilities for its board
Have a written requirement of integrity, ethical behavior, and transparency of its board members
Board has clear terms of reference and a clear understanding of its key functions
Board limits defined
Board's power limits reasonable

Board members and officers elected/appointed/removed in accordance with applicable laws and approved, written procedures

Board members meet regularly and monitor the function of the organization **Availability of plan and policy documents**

23	95.8
24	100
24	100
24	100
21	87.5
22	91.7
24	100
24	100
24	100
23	95.8

24	100

Most CSOs have a strategic plan covering the current budget year and all have an action plan, financial management, and human resource management manual (Table 6).

Table 7. Availability of plan and policy documents

Availability of documents

24	100

Strategic plan

Updated strategic plan which covers the current fiscal year An action plan for the current fiscal year

Financial and logistics management manual

Human resource management manual

Financial policy/guideline

24	100
23	96
24	100

Sources of Income and financial control system

24	100
24	100

Sources of income were grant/donations from international NGOs for 88% of CSOs and membership fees for 75% of CSOs. About 38% of CSOs generate income selling products and services. All CSOs have electronic double-entry accounting systems and have annual external

audit reports for the past budget year. All the CSOs have a history of receiving funds from donors, and most, 96%, also have past experience receiving funds from USAID (Table 7).

Table 8. Major sources of income and financial management and control

Income and financial control		
Sources of income		
Grants/donations from local organizations	17	70.8
Funding agencies	16	66.7
Grants/donations from INGOs	21	87.5
Contracts or subcontracts	14	58.3
Membership fees	18	75.0
Products and/or services/service fees	9	37.5
Others	4	16.7
USAID funding		
Ever received funds from USAID	23	96
Financial management and control		
Have double-entry accounting system	24	100
Have electronic accounting system	24	100
Perform annual external audits of their accounting records	24	100

RMNCH project experiences

The majority, 96%, of CSOs implemented reproductive health programs, and 92% implemented family planning and 87% maternal, newborn, and child health programs. All the CSOs claimed that they have experience promoting social accountability and engaging communities (Table 8).

Table 9. FP/RMNCH projects implementation and community engagement experience of CSOs

Implement FP projects	22	92
Implement reproductive health projects	23	96
Implement maternal, newborn, and child health projects	20	87
Experience promoting social accountability	24	100
Experience engaging or leveraging communities	24	100

Capacity-building needs of CSOs

All CSOs have interest in participating in a capacity-building intervention. Most CSOs reported their interest to participate in capacity building in technical areas of RMNCH and social

accountability. The majority, 75%, of CSOs were also interested in capacity building in the areas of monitoring, evaluation, and learning (Table 9).

Table 10. Capacity-building needs of CSOs

Capacity-building needs		
Interest to participate in capacity strengthening interventions	24	100
Areas of capacity-building needs		
Governance and leadership	14	58
Financial management and internal controls systems	14	58
Human resource management systems, including trainings	16	67
U.S. government rules and regulations	17	71
Project management	13	54
Data management and reporting	14	58
Monitoring, evaluation, and learning	18	75
Technical capacity in areas of RMNCH	22	92
Technical capacity in areas of social accountability	20	83
Others	5	21

4.2.3. Criteria for selecting CSOs fit for engagement in RMNCH

Following procedures described in the subsection for identifying criteria for prospecting CSs, we also identified some thirteen aspects and corresponding criteria that could serve as the basis for prospecting CSOs based on synthesis of both quantitative and qualitative data. The corresponding criteria were bunched in seven dimensions and presented in *Table 10*, followed by a brief description and elaboration of each of the dimensions. The dimensions and sub-dimensions largely overlapped with criteria we identified for prospecting CSs, with some differences in their defining criteria.

Table 11. Dimensions, sub-dimensions, and criteria for prospecting CSOs

Organizational Capacity	Governance and leadership Functions with clear mission and vision, organizational structure, legislation, and policies; obeys its own and the country's rules and regulations
	Financial management and control system Uses financial guidelines and policies; strong follow-up system; conducts regular audits
	Human capacity Has adequate technical and supportive human power
	Legal status Legally registered to operate in its geographic target areas
Reach and coverage	Transparency and accountability Shares its plans, performance, and financial information to the government and the public Presence at lower level Has offices or branches at zonal and woreda levels; has a structure that extends to the community level
	Proximity to service delivery Runs RMNCH service-providing facilities or has affiliation with such facilities, allowing linkage between demand creation and service delivery
Relationships	Community Acceptance CSO should be trusted by the community; community feels that the CSO is working for them Large size of members (for membership-based CSOs) Encompasses a large size of members or affiliates
	Cultural competence Respects the culture and social norms of the community it serves
	Community Affiliation Considers communities as its members; communities voluntarily contribute to the CSO

1

2

3

Institutional strengths	Efficient utilization of resources Uses project resources appropriately and for the intended purposes
	Commitment to ensure equity Benefits the community without discrimination; uses formal procedures and criteria for beneficiary or target identification; targets disadvantaged community members
	Capacity to mobilize local resources Can mobilize local communities to generate resources for their own programs
Relevant experience	Experience in CE and/or RMNCH Previously supported grassroots community structures for purposes related to RMNCH; a culture of engaging community representatives in planning, implementation, and M&E of the organization's activities.
	Experience in social accountability Previously engaged in supporting social accountability processes
	Technical expertise in RMNCH Organization and its staff have expertise and experience in RMNCH
	Track record in project implementation History of effective implementation of projects

4

5

Additional Criteria for Service Delivery

Collaboration	Collaboration with government Has smooth relationship with government; works with the government; supports government initiatives; existing working relationship with relevant government offices

6

Additional Criteria for Social Accountability

Independence	Independence from health authorities responsible for delivery of health services	Ability to function independent from local health service providers and local health authorities

7

ORGANIZATIONAL CAPACITY:

This key dimension entails issues like governance and leadership, financial management and control systems, human resource capacity, verification of legal registration, operational transparency, and accountability. It is a core dimension that was used to ensure availability of clearly articulated organizational identity (vision, mission, values, etc.), leadership (board and/or management) organizational structure, policies, guidelines, manuals, etc.

Reach and coverage:

The reach and coverage aspect of the CSOs is to ensure presence of the CSOs at the grassroots level (through branching and partnership), look into how a CSO runs RMNCH service-providing facilities allowing linkage between demand creation and service delivery, and inquires who the CSOs are reaching (target population).

Relationships:

This block of the dimensions is used to determine whether a CSO encompasses a large number of members or affiliates, respects the culture and social norms of the community it serves, considers communities as its members and—in return—communities voluntarily contribute to the CSO, and uses project resources appropriately and for the intended purposes. Further, the dimension inquires if a CSO is seen as credible and a valuable resource to its constituency and networks, shares resources with national and international partners, has diversified contacts within the donor community, is regarded as a credible and valuable resource to donor(s), and engages in open and frank dialogue with donors and other partners.

Institutional strengths:

The institutional strength portrays the CSO's commitment to ensure equity, capacity to mobilize local resources, ability to benefit the community without discrimination, and trends of applying formal procedures and clear criteria for the beneficiary or target section. The other criteria entailed in this dimension probe to (i) ensure if a CSO consciously targets disadvantaged community members, (ii) can mobilize local communities to generate resources for programs, (iii) has previously supported grassroots community structures for purposes related to RMNCH, (iv) has an observable culture of engaging community representatives in planning, implementation, and M&E of programs, (v) is able to attract volunteer support, and (vi) warrants sustainability (program-benefit sustainability, organizational sustainability, financial sustainability, and resource-base sustainability).

Relevant experience:

This dimension scrutinizes the CSO's relevant sectoral expertise, experience, and visible outcomes. It examines the CSO's technical expertise in RMNCH, experience in social accountability, track record in project implementation, and capability of adapting the envisaged program.

Collaboration:

With this dimension, the CSO is assessed for how it is collaboratively working with donors, the community, and government counterparts. The dimension helps examine whether a CSO has a smooth relationship with the government (federal and regional), closely works with the government, supports government initiatives, has contacts with decision makers, and is able to engage policy makers in dialogue towards integration of plans and activities into regional and national plans. The extent to which a CSO is exchanging resources (training, TA, material resources, etc.) with other CSOs and the government is also determined by the defining criteria of this dimension.

Independence:

Independence, in this context, refers to the functional, operational, and institutional sovereignty of a CSO. The criteria in this dimension shall gauge prospective CSO's independence from health authorities that responsible for delivery of health services and also the CSO's ability to function independently from local health service providers and local health authorities. In this regard, the social accountability initiatives in particular require the CSO's independence and neutrality.

4.2.4. Description of CSOs against prospecting criteria

In this section, CSO categories identified by KIs are described against the identified dimensions. Since the dimensions emerged during the analysis, information about some dimensions/criteria (for example, institutional strength) is limited, and, as a result, the description focuses on dimensions for which

adequate information is available.

4.2.5. Local Development Associations

Local development associations are nonprofit, nongovernmental organizations. These organizations are typically established at the regional or zonal level (in line with the political administrative structure) with the aim of addressing the developmental needs of people in living in that particular region or zone. Their establishment was mainly initiated and/or supported by local government structures. A total of five local development associations were identified (Amhara Development Association, Wolaita Development Association, Sidama Development Association, South Ethiopia Development Association, and Kembata-Tenbaro Development Association), and basic capacity assessment was conducted for four of them (see the list in Annex 5). The associations are membership based, where the members are largely people born or who live in that particular region or zone.

a. Organizational capacity

Local development associations have relatively strong organizational capacity. Most are administered by an elected board and have sufficient human resources (including members and volunteers). In general, local development associations are characterized by having many members and volunteers who participate in different tasks. For instance, Amhara Development

Association, which operates in the Amhara region, has more than four million members and over 90,000 volunteers. Their income mainly comes from members contributions, provision of services, and donors.

b. Reach and coverage

Local development associations typically have their headquarters at regional or zonal capitals and branch offices in each woreda. In some instances, their structures extend to the kebele level. For instance, Sidama Development Association, Wolaita Development Association, and Amhara Development Association have offices in each woreda in their respective constituencies. These organizations can also use their members in government structures at different levels to reach the wider community.

c. Community acceptance/relationship

Members of these associations, staff, and volunteers are from the community. This increases their acceptance and cultural competence. Most associations have extensive experience with engaging the local community for different activities, making them ideal for projects that require community engagement. The associations have excellent working relationships with the local government structures, with most local development associations enjoy the support of local government structures. In fact, a substantial number of civil servants working at different local government sector offices are also members of these organizations, potentially increasing their acceptance and influence.

d. Experience implementing FP/RMNCH services

Most local development associations have experience implementing FP/RMNCH services, engaging existing community structures, and creating new community structures for their specific needs. For instance, Amhara Development Association has established a forum in each woreda where three to five members representing each kebele and institutional stakeholders are represented. The forum approves the association's plan, reviews and approves its performance, and audits its report. They have also a robust capacity to generate resources, including labor and materials from the community. For instance, some associations mobilize labor and materials from the community to construct health facilities.

e. Experience in social accountability

Although some associations reported their familiarity using some social accountability tools, including implementing awareness creation, and community empowerment activities, their overall experience in social accountability activities seems minimal. Implementing social accountability tools may require some degree of independence/autonomy from government influence/ However, there is substantial

overlap between local government structures and local development associations, as indicated earlier; local government staff are likely to be members of the local development associations. As a result, these associations may not be independent from local health authorities to implement social accountability.

When asked which CSOs they recommend for FP/RMNCH and/or SA activities, a substantial number of KIs mainly working in government offices, including the MoH, RHBs, ZHDs, and WoHOs, recommended local development organizations. The main reasons for their recommendation include widespread presence of local development organizations at the community level, close collaboration of these organizations with government structures at different levels, and strong community acceptance.

4.2.6. Professional Associations

Professional associations are organizations established by professionals working in the same or similar fields that define and develop their profession, set professional standards, and build capacity of their members. Professional associations participate in policy dialogue, advocacy, and develop guides and principles for professional ethics and standards. A total of twelve professionals associations were identified. Of these, a capacity assessment was conducted for two of them. Professional associations identified include the Ethiopian Midwifery Association, Ethiopian Public Health Association, Ethiopian Society of Sociologists, Social Workers & Anthropologists, among others (see Annex 5 for a complete list). Some professional associations have a sizable member base. For instance, the Ethiopian Public Health Association, Ethiopia Medical Association, and Ethiopian Nurses and Midwives Associations have more than 3,000 members. In addition to serving their core mission, some professional associations have been involved in implementing different health programs and have experience implementing FP/RMNCH projects, including social accountability.

a. Organizational capacity

Some professional associations have relatively good organizational capacity at the federal level. Most are administered by an executive board elected by the general assembly, but only some associations have branches or chapters at regional capitals, which could limit their capacity to implement FP/ RMNCH services to remote, underserved rural communities. Although professional associations have a limited number of permanent staff, their members are found throughout the country and can be an asset for implementing any FP/RMNCH program. Moreover, the association's members have technical expertise that can give capacity-building and technical support to other implementing organizations.

b. Experience implementing FP/RMNCH services

Some professional associations reported their experience of engaging communities through existing CSs to implement different health projects, including FP/RMNCH services. For instance, the Ethiopian Public Health Association and Ethiopian Midwives Associations have been implementing RMNCH projects in different parts of the country. However, professional associations have a limited presence at the community level, potentially limiting their capacity to implement FP/RMNCH services to remote and rural areas.

c. Experience in social accountability

Professional associations have autonomy/independence from government influence while also maintaining good working relationships with the appropriate government structures. This could make professional associations ideal candidates to implement social accountability projects. In this regard, some professional associations have rich experience implementing different social accountability projects. For example, the Ethiopian Society of Sociologists, Social Workers, and Anthropologists (ESSAWA) has rich experience implementing social accountability tools using CSs and social workers (for example, it is involved in establishing community care coalitions (3C) that promote women empowerment).

4.2.7. Local NGOs

Organizations categorized as local NGOs are non-state, nonprofit entities established, legally

registered, and based in the country with a specific mission that includes promoting development and citizen participation. A total of thirty-eight local NGOs were identified, and a basic organizational capacity assessment was conducted for fourteen (see the list of local NGOs Annex 5). In addition to health, the identified local NGOs are engaged in a variety of relief and development activities. Some NGOs operate nationally (in all regions of Ethiopia) and have widespread coverage, while others are operating in specific localities.

a. Organizational capacity

Local NGOs have a varying level of organizational capacity; some are relatively large, with well established organizational structure and many decades of experience, while others are small, operating in limited geographic area. Most are administered by elected executive board members. A majority of the local NGOs have few permanent staff and depend on the availability of projects. Most are donor dependent, as their income mainly comes from external donors. Some NGOs are membership based and have many volunteers involved in different tasks. For instance, FGAE and Beza Development Association have a sizable number of volunteers working in different parts of the country.

b. Reach and coverage

The capacity of NGOs to reach lower-level administrations and kebeles greatly varies. A majority of local NGOs are small to medium sized with a narrow operational area. Despite their small size, there are NGOs that meaningfully engage communities at the grassroots level. Most local NGOs are based in Addis Ababa, and some have branch offices in regional/zonal capitals. For example, the Family Guidance Association has branch offices in different parts of the country, youth centers and clinics that serve communities. But most do not have branch offices in woredas, potentially limiting their capacity to reach remote, rural communities. A small fraction of the NGOs (Beza Development Association, Netsebrak Reproductive Health, and Social Development Organization) are based near their operational areas.

c. Experience in FP/RMNCH service delivery

Most local NGOs have experience implementing FP/RMNCH projects, including service delivery. They also have good experience using existing CSs to meaningfully engage communities. There are also NGOs which use innovative approaches to establish their own CSs that fit their specific needs. Most of the projects that have been implemented by local NGOs are small scale, with limited scope, and they are donor dependent when it comes to a lasting positive impact. Potentially sustainable projects including establishing reproductive health clinics,. Youth centers that provide different health services have been established by some local NGOs.

d. Experience in Social Accountability

Most local NGOs reported their experience using social accountability tools. A majority of them have been involved in awareness creation and community empowerment, and some even have ongoing projects promoting social accountability. However, their experience and engagement in social accountability appears limited, mainly because of the previous restrictive CSO law, which prohibited CSOs that received external funding from engaging in some community empowerment activities.

KIs were asked to recommend local NGOs that have the potential to implement FP/RMNCH and/or SA activities. A substantial number of KIs recommended FGAE for FP/RMNCH service provision. The main reasons for their recommendations include strong organizational capacity, efficiency, and national level coverage.

4.2.8. Religion-affiliated organizations

FBOs include those that are established by a particular faith or religious group that are engaged in different relief and development activities, including health. In this assessment, nine

religion-affiliated

organizations were identified, and basic organizational capacity assessment was conducted on one of them. The identified organizations in this category are engaged in numerous relief and development activities, including health, education, and agriculture. One of the organizations (Inter-Religious Counsel of Ethiopia) is unique in that it is established by different religious groups as a discussion platform to promote inter-religious harmony in the country.

a. Organizational capacity

FBOs have a medium level of organizational capacity; some operate throughout the country, and others focus on a particular area where a large number of the faithful are present. Although FBOs are affiliated with a particular religion, they usually provide services to all community members irrespective of religious affiliation. Their income largely comes from contributions from the faithful, service provisions, and external donors.

b. Reach and coverage

FBOs have great potential to reach the community, as a large segment of the Ethiopian population considers themselves religious. Some FBOs have branch offices in regional/zonal capitals. In addition, religious leaders are respected and influential in their community and can thus play vital role in engaging communities. FBOs have also established and operate health facilities and schools in different parts of the country.

c. Experience in FP/RMNCH service delivery

Some FBOs have experience providing health services, including FP/RMNCH services in their health facilities. Some operate different projects targeting youth and women. They also have a rich experience of community engagement using different CSs, including Idirs, youth, and women associations. Even though religion-affiliated organizations implement RMNCH services, some may not actively promote programs such as FP and reproductive rights.

d. Experience in social accountability

The experience of FBOs in promoting social accountability seems minimal. However, FBOs are independent of government influence and are trusted by the community. Therefore, FBOs have the potential to engage in promoting social accountability by creating awareness and empowering the community.

4.2.9. Umbrella Organizations

Umbrella organizations are a network or coalition of different nongovernmental organizations that have a shared/similar mission or geographic focus. Four umbrella organizations were identified, and basic capacity assessment was done for three of them (see Annex 5 for a complete list). Umbrella organizations are established to collaborate and coordinate efforts among member NGOs, mobilize resources, and share experiences among member organizations. They are also involved in need-based capacity building of member organizations. These organizations function as a platform for policy dialogue among members and represent its member organizations in high-level consultative forums. In some instances, umbrella organizations are involved in direct project implementation, including service provision. For instance, the Network of Charitable Association of HIV Positive for Health and Development (NAPHAD) has been involved in health education on HIV prevention and defaulter tracing activities.

a. Organizational capacity

Most umbrella organizations have a single office at the central level and no branch offices at the regional or zonal level. However, the capacity of their member organizations can also be considered one of their assets. Most are characterized by a limited permanent staff, since they are not involved in direct service provision.

b. Experience in FP/RMNCH services

Some umbrella organizations have been engaged in advocacy, policy dialogue on reproductive health rights, and ensuring integrated and sustainable sexual and reproductive health information and services in the country. Moreover, they have been involved in capacity-building activities of the member organizations. However, there is limited evidence regarding their involvement in direct FP/RMNCH service provision.

c. Experience in social accountability

Some umbrella organizations have been involved in promoting social accountability. For instance, the Consortium of Reproductive Health Association (CORHA) has been involved in a social accountability project which seeks to empower citizens, promote citizen engagement in public venues, and improve service delivery.

4.2.10. Summary of CSO Categories Description

In summary, CSOs have varying strengths regarding the criteria set. Local development associations were found to have strong organizational capacity, reach and coverage, smooth relationships with the community and local government structures; however, they lack independence. Professional associations are independent/autonomous and have strong organizational capacity at the federal level, but they have limited reach and coverage except through their members who live and work throughout the country. Local NGOs also have strong organizational capacity, relevant experience, and good relationships within community, and they are also relatively more independent from government influences; however, most of them function in limited geographic areas.

Assessing and comparing the identified CSOs against all the previously described criteria was challenging due to the sparsity of data as a result of the parallel collection of data used to define the criteria and to assess the CSOs. Assessment of the relative strengths of the five categories of CSOs based on available quantitative and qualitative data produced a summary presented in Table 11.

Table 12. Status of CSOs categories against the selection criteria (rating of relative strengths based on available data)

CSO categories

Local Development Associations

Professional Associations

Local NGOs

Faith-Based Organizations

Network of NGOs

Key

Criteria for selectio

Organizational Capacity	Reach & Coverage	Relationships		

High Inadequate evidence
Medium
Low

4.2.11. Prospecting CSOs

The identified CSOs were evaluated against the identified criteria to come up with a potential/ recommended list of CSOs for FP/RH/MNCH service provision and/or social accountability. It was found that different categories of CSOs have varying areas of strengths, and no single organization or category of CSOs fulfilled all the prospecting criteria. Moreover, data is limited on some of the selection criteria. Hence, additional information, particularly on criteria for which data was sparce, could be necessary for further screening of CSOs in the future. Based on available evidence, the following CSOs are identified as top prospects for the purpose of facilitating community engagement in RMNCH service delivery and social accountability in primary healthcare.

A. ***CSOs to support community engagement in service delivery***

It is apparent that no single CSO or category of CSOs fulfilled all the selection criteria. But some categories of CSOs are better suited for service provision than others. Accordingly, we propose the following CSO categories as having the potential to support community engagement in RMNCH service delivery.

a) Local development associations

b) Local NGOs
c) Professional associations

Local development associations:

Local development associations have strong organizational capacity and wider reach and presence at multiple levels, including the grassroots level. Moreover, their membership is large. Local development organizations have collaborate closely with government structures and were recommended by KIs from all the regions and all levels of the health system (RHBs, ZHDs, WoHOs). From the identified local development associations, the following are considered to have strong capacity to implement the proposed interventions:

- Amhara Development Association
- Wolayta Development Association
- Sidama Development Association

• Kambata Development Association

Local NGOs:

Some local NGOs have strong experience working with CSs (including volunteers), and some have their own SRH clinics (e.g., FGAE). Most of them, though, have limited reach. From the identified local NGOs, the following are considered to have the best capacity to implement the proposed interventions:

• Family Guidance Association (all regions)

• Beza Posterity Development Organization (BPDO) (Amhara)

Professional associations:

Professional associations have a strong technical capacity that can be used for capacity building of other organizations. They also have strong organizational capacity at the federal level. Some have relevant experiences engaging communities and implementing RMNCH services. From the identified professional associations, the following are considered to have the best capacity to implement the proposed interventions.:

• Ethiopian Public Health Association (all regions)

• Ethiopian Midwives Association (all regions)

As indicated above, the CSO categories have different areas of strength. Therefore, mixing CSOs from categories may be essential. For instance, local development organizations and NGOs are stronger in working with grassroots community structures and community mobilization, whereas professional associations tend to have the technical capacity to provide technical support.

B. ***CSOs to promote social accountability in RMNCH***

To identify potential CSOs for promoting social accountability, independence from local health service providers and local health authorities is essential. Therefore, independence was considered as an additional dimension to select CSOs for social accountability. Because of this criterion, we recommend that selection of CSOs to promote social accountability should partly rely on their engagement in service delivery. A CSO selected for directly supporting service delivery may not be an appropriate choice for promoting social accountability in the same area.

Local NGOs, professional associations, religion-affiliated, and umbrella organizations can be considered for social accountability projects. The experience of a majority of CSOs in this regard is minimal. Only a few organizations, including the Ethiopian Society of Sociologists, Social Workers & Anthropologists (ESSAWA) and Beza Posterity Development Organization (BPDO), have extensive experience implementing such projects.

5. DISCUSSION AND

CONCLUSIVE REMARKS

The qualitative inquiry of mapping prospective CSs produced a bulk of data. In the rigorous, meticulous, and extensive search, some ninety-four CSs and sixty-six CSOs were identified. The CSs are diverse in evolution, typology, purpose of origin, structure, composition, etc. Many of the CSs have organically evolved. They have long been there for social (e.g., all sort of Idirs), cultural (e.g., the Sidama Judiciary System), economic (e.g., Equib), etc. purposes. Others were externally instigated for various ends (e.g., CCC for social development, WDA for health services, clubs for respective institutional objectives, and accountability groups to serve as the citizens' voice). Similarly, CSOs had veracious primary purposes and target populations.

A majority of the CSs focus on specific segments of a population that include but may not be limited to women, youth, men, or patients, indicating that the use of a single CS in the promotion of RMNCH service delivery may not allow the health sector to reach all the needy.

The CSs, despite their peculiarities, have features that most, if not all, share in common. Unlike the formal organizations, CSs are uniquely attributed to working within and are owned by the community. CSs have a comprehensive understanding of the situations under which the community members live. They are grassroots platforms with firsthand knowledge about existing problems and can come up with indigenous solutions. Their setup enables them to provide services by being in closer contact with community members and a high sense of ownership. Many of them are made up of members (mostly volunteers) of their target community who are more often acknowledged and accepted by the community for their evolved capacity, model behavior, commitment, and determination to serve the community. Their membership is based on shared vision. Evidence (of this particular study) depicts that they are fairer, more equitable, and non-discriminatory in addressing the most needy. Their environment of operation is one of care and mutual support because they themselves are working to accomplish the same changes in their lives as the community they are working for. Some of the CSs are best for maximum mobilization and utilization of local resources and the use of existing social capital and social structure.

CSOs were also found to have substantial potential to mobilize and support CSs in areas where they are operational. Their formal organizational structures, technical capacities, and relationships with both service delivery points and potential funding sources make them appropriate as platforms through which the capacities of CSs can be built. Different CSOs possessed strengths in different dimensions.

In sum, the findings of this study showed that:

- If assisted to identify their problems and actively participate in development endeavors (social, economic, cultural, etc.) in general and primary health care services in particular, CSs and CSOs can play fundamental complementary roles in promoting community engagement in RMNCH service delivery and social accountability;
- Pertinently, some six CSs were proposed for service delivery / to increase demand for RMNCH, and another three CSs were recommended for promotion of social accountability in the health sector. Matching the constituencies and targets of CSs with population segments targeted for RMNCH services is critical (e.g., address in-school youth through school clubs, married women in rural communities through WDAs, etc.);
- Different categories of CSOs have different areas of strengths. It is important to consider working with multiple categories of CSOs because of this. Professional associations tend to have the capacity to provide technical support while local development organizations and NGOs are stronger in working with grassroots CSs.
- Data is available only about some of the criteria for success. Include remaining criteria as part

of subsequent appraisal processes.

Despite the invaluable importance of the CSs and CSOs to increase demand for RMNCH and promote social accountability in the health sector, findings show that the prospective CSs and CSOs are constrained with capacity gaps and strategic alignment of endeavors. Pertinently, the following recommendations were passed.

a. ***Capacity building to the prospective CSs:*** The findings show that there may be a need to enhance and empower the CSs to enable them to effectively articulate their needs, protect their interests, skillfully manage their resources, actively participate in the delivery of primary health care services, and demand the social, economic, and political rights of their constituents.

b. ***Approach/system rethinking:***

- The need to consider different CSs for different segments of target populations (e.g., women to women, youth to youth, etc.)
- Co-creation of structures where by the local community and stakeholders create, shape or restructure and existing structure. This allows adaptations to local needs and expectations to ensure relevance, feasibility, and effectiveness of capacity building and community engagement approaches
- The need to build upon the existing practices and systems but with critical scrutiny towards strategically aligning them with the envisaged program
- Better to plan to unleash the long-existed experience, practice, social capital, cohesion, etc. of the CSs and build upon them for the intended purpose
- The need to underline issues of linkages with the government's public service reform and good governance activities while planning for social accountability initiatives
- The possibility of initiating coalitions, networks, and forums of CSs in order to coordinate their efforts, share experiences and resources among each other, and to join their voices together
- The need to engage different CSOs for different activities aligned with their major capabilities (e.g., professional associations for technical capacity building and development associations and NGOs for mobilizing grassroots community structures in areas where they function)

6. ANNEXES

ANNEX 1:

KII GUIDE AND QUESTIONS

Part 1: Information sheet

INTRODUCTION:

Thank you so much for letting me talk to you and explain about a study that looked into the best ways of engaging community structures in primary healthcare. My name is _______. We are here to learn more about the experience and opinion of your organization and yourself about community engagement in primary healthcare. Do you have about 5 minutes for me to explain to

you about the study? If you agree to participate in the study, we will continue with the interview which will take about 30 minutes; if not we will stop there.

1. Yes, please. …. Continue
2. No. Do not have time …. Ask for an alternative time/day.
3. No. I do not want your explanation. Say “thank you” and leave the place.

Study title: Mapping/Prospecting community structures and civil society organizations. **Purpose of the study:**

The primary aim of this work is to identify promising, sustainable model/s for engaging communities in primary health care services. Toward this aim, the assessment entails eliciting information on promising intervention models as well as leading civil society organizations and community structures/platforms working in FP, RH, and MNCH; and/or social accountability at the woreda and kebele levels in Amhara; Southern Nations, Nationalities, and Peoples’ (SNNP); and Sidama regions. The study will identify the top prospects among CSOs and community structures found in the three regions. The exercise will describe the existing major CSOs and community structures with roles in FP/RH/MNCH or social accountability to hold the government accountable for improved access to and quality of services. Based on findings of the mapping and prospecting work, we will identify the top prospects among civil society organizations and community structures/platforms for eligibility to test different models of community engagement in FP/RH/MNCH, including accountability interventions.

We are data collectors working for MERQ; MERQ is an independent consultancy firm legally registered in Ethiopia to conduct studies like this one. MERQ is collaborating with the New Partnerships Initiative (NPI) Expanding Health Partnerships—NPI EXPAND Project. The project is funded by the United States Agency for International Development (USAID).

Procedures and duration

We are planning to interview people from public sector organization (Ministry of Health, Regional Health Bureau, selected Zonal and Woreda Healtth Offices, Regional and Zonal level offices of Labor and Socail Affairs, Women, Youth and children Affairs) and non-governmental organizations (Donor agenises, International NGOs, Local NGO/Associations). These organizations and government offices were selected because of the role they have in community engagement.

You are selected to be involved in this study because we believe you have significant knowledge and experience in engaging communities in primary healthcare and/or social accountability. We’re interested in your perspectives on approaches for engaging communities in improving primary healthcare, particularly in family planning, reproductive health, and maternal, newborn and child health. If you

agree to participate in this study. I will ask you questions about the primary function of your organization, if your organization have sub-awardees working in the health system, and how you are involved in community health system strengthening. We will further discuss about your experiences in engaging communities in primary health care, the key challenges with efforts to strengthen community engagement, and if you have any success or failure stories that you can share with us regarding community engagement.

Voluntary participation

Your participation in this study is entirely voluntary. This means that you do not have to participate if you do not want to. If at any time and for any reason you would prefer not to answer any questions, please feel free to do so. If at any time you would like to stop participating, please tell me. There are no consequences if you decide to stop participation at any time. Although your participation in the study is highly encouraged, if it happens, your decision not to participate in the study will not disappoint us in any ways.

Benefits and risks

We should point out; however, that being involved in the research doesn't guarantee any direct benefit or it does have any risk to you or your organization. However, any information that we will get from you and other study participants will help us to understand the ideal ways of engaging community in primary healthcare. This information will help USAID to support Ministry of Health to be able to find sustainable means of engaging community in primary health care

Confidentiality

The information that you provide will be anonymous. This means that your name, telephone number, physical addresses or any other information that can be used to identify someone's identify will not be recorded in a way that links the information you will provide with your identities. The only people who will see the information that you share are the members of the study team. The study team members are trained and committed to keep the information we gather confidential. All the information will also be kept in a secure place with proper protection so that it can't be accessible to anyone.

Offer to Answer Questions: Do you have any questions about the survey before we proceed? Please let me know if anything I have stated is not clear; I will be happy to explain it further to ensure that you understand.

Contact information

In case you need more information about the survey, you may contact the PI(the person who is in charge) of the study, Dr. Alula Meressa through the following address:

PI's full name: Alula Meressa Teklu

Cell phone address: +251935409495

Email Address:ateklu72@gmail.com

You may also reach out to the Chair Person of the IRB at the Ethiopian Public Health Association, who granted ethical approval to this study, through the following address:

Full name of the chair person of the IRB: Dr. Alemayehu Bekele

Cell phone address: +251911179205

Email Address:alemayehubekele2002@yahoo.com

Part 2: Consent for Participation

This interview will take place only once. If you agree to participate in this study, we will do the

interview now. Are you happy to participate in this study?

1. Yes, …. Ask permission for audo-recoding
2. No … Stop the interview

With your permission, I would like to audio-record our conversation so that I can focus on the discussion and still have an accurate record. The audio-record will be destroyed once excerpts are put in texts.

1. Yes, …. Continue with audio recording
2. No … Continue without audio recording

Part 3: Key informant profile filled out in advance of interview

Interviewee name/s and title/s	
Organization name and contact	
Type of organization	1. Public Sector 2. Donor/ Foundation 3. International NGO 4. Local NGO 5. Other / specify
Primary functions of organization in the health system (please check all that apply)	1. FP 2. MNCH 3. Governance/Social Accountability 4. Health System strengthening 5. Quality assurance 6. Policy Development 7. Service Delivery 8. Training and Capacity Development Services 9. Community engagement/mobilization 10. TB/HIV and Malaria programs 11. Other (please specify):
Does the organization have sub-awardees or grantees working in the health system development particularly grantees implementing FP/RH and social accountability programs?	1. Yes --- list sub-awardees and describe projects 2. No

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How is KI involved in community health system strengthening and efforts to engage communities in primary health care?	1. Develops or oversees policies, guidance, community health systems programs 2. Funds community engagement, accountability or mobilization for health system strengthening 3. Provide technical assistance for grantees or sub-awardees doing community engagement, accountability or mobilization for health system strengthening 4. Do grass-roots community engagement, accountability or mobilization for health system strengthening 5. Community structure representative or expert 6. Other professional experience relevant to areas of interest 7. Other (please specify) ___________________________

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Part 4: Discussion Items

Note: *The questions below are intended as guides for discussion. Not every question will be relevant or appropriate for every stakeholder. The questions will be adapted as needed based on the person interviewed. Introductions and brief recap of the primary aims of the assessment exercise. If consent hasn't already been obtained, then this needs to be obtained before starting the interview. Consent provided based on description of assessment aims, data use, and confidentiality. Agreement to participate will be secured before the interview is scheduled if possible.*

Could you tell us about your experiences engaging communities in primary health care? These experiences might include efforts to engage communities in: • Strengthening accountability for health services • Enhancing the accessibility, responsiveness or quality of services	Where have these efforts taken place? Which groups or community structures have been involved? Have these efforts involved family planning or maternal, newborn, child health services and social accountability in health system?
In your experience, what types of community engagement interventions in health **have worked best**?	Why did you consider them so? Which groups or structures are involved in these interventions? How? Where? What are the major success factors?

In your experience, what types of community engagement interventions in health **didn't work well**? Based on your experiences, what are the key challenges with efforts to strengthen community engagement in health services? Any lessons to share?	Why did you consider them so? What are the major reasons for failure?

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In your opinion, what approaches to engaging communities to strengthen social accountability in health might be scalable and sustainable?	What specifically sets these apart as scalable and sustainable?
Do you know of any innovative approaches to community engagement in health care? If so, could you describe them further?	Social accountability? Accessibility of care? Quality and responsiveness of care? Who is implementing this work and where?
Do you know of any opportunities or openings for engaging communities in primary health care that are worthy of further investigation and testing?	Models for expanding the reach or quality of primary health care services? To improve accountability for performance/results?

Can you recommend any specific civil society organizations that are engaging communities effectively to strengthen responsiveness and accountability in health?	Family planning? Maternal, newborn, and child health? Social accountability in PHC system? If the KI's organization has sub-awardees, grantees or local affiliates, would the respondent be willing to share a list of their top CSOs?
What are your reasons for recommending these CSOs?	
Can you recommend any specific community structures that are engaging communities effectively to strengthen responsiveness and accountability in health? What are your reasons for recommending these community structures?	Family planning? Maternal, newborn, and child health? Social accountability in PHC system? If the KI's organization has local affiliates, would the respondent be willing to share a list of them?

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13	If we would like to know more about these community structures you recommended, who do you think are the most appropriate informants about each community structure?	Obtain contact details of identified informants.
14	In your opinion, what characteristics should a community structure fulfill in order to be an effective community engagement	
15	Before we close, do you have any other advice for us?	Recommendations for technical and/or organizational approach? Other people to interview?

Conclusion:

Identify any action items or follow-up after the interview.
Mention that we will be sharing a summary of top-line findings with KIs (but nothing that would be personally or organizationally identifiable). Provide contact information for any further queries or follow-up about the assessment.
Thank KI for her/his time and attention.

Part 5: Key points to summarize

Key findings on community structures

- List of community structures mentioned
- List of community structures recommended to increase access to quality RMNCH services
- Reasons for recommending specific community structures
- List of community structures recommended to promote social

accountability Reasons for recommending specific community structures

- What criteria does the key informant consider to assess the effectiveness of community structures?

Key findings on Civil Society Organizations

- List of CSOs mentioned
- List of CSOs recommended to increase access to quality RMNCH

  services Reasons for recommending specific CSOs

- List of CSOs recommended to promote social accountability

   Reasons for recommending specific CSOs

- What criteria does the key informant consider to assess the effectiveness of CSOs?

ANNEX 2:

GUIDE FOR DESCRIBING COMMUNITY STRUCTURES

Identification

Field Team ____ Region: ____

Part I: Brief description of the community structure (CS)

Name of the Community Structure: ____
____
____

Brief description of the community Structure (Describe the CS based on information you already obtained from previous KIIs: ____
____
____
____
____

Part II: Context and sources of information

Region:____ Who participated in describing the community structure?

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Part III: Interview guide for describing attributes of community structures

TOPIC/QUESTIONS	
Could you characterize the background of the community structure?	Probe: How is the CS formed/created (indigenous vs non-indigenous)? Legal status (legally registered) or informal? Who played roles in their

	establishment?
What are the primary roles/ purposes/ activities of the community structure?	Probe: Purpose of existence or mission of the CS The major activities of the CS
How formal are these structures in the region?	Probe: Are there processes for registration of these structures at different levels? Who are the registering bodies? If there is a registration system applicable for these structures, to what extent are currently existing structures registered? Are there structures that are already registered? What motivates them to do so? Are there structures that are not regis tered? What are the reasons for not registering?
Could you describe the composition of members, in terms of gender, religion, clan/ ethnic group, and age category? How are members selected/enrolled?	Probe: Any gender and age preference Clan, or religion preference Criteria for membership
Could you describe the power dynamics/ power relations of the community struc ture?	Probe: Who are the influential/powerful mem bers? Sources of power? Presence of formal organizational struc ture? Presence of written by-laws governing the community structure?

2

3

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TOPIC/QUESTIONS	

Could you describe the main sources of revenue of the community structure? How do the community structures cover the costs of activities that have financial costs?	Probe: How do these community structures generate revenue? How sustainable are the revenue sources? Experience of using formal financial man agement system?
How do the working relationship of the community structure with other stakehold ers look like?	Probe: With government With target groups With NGOs and other CBOs
How do you describe the affiliation of the community structure?	Probe: Government affiliation, how? Religious affiliation, how? Affiliation with a CSO, how? Any other affiliations, describe how?
How widespread is the community struc ture?	Probe: In which geographical areas do such structures exist? How many such structures exist in the region? Source of data? Which population segments are targeted by the CS?
How familiar are community members with this community structure?	Probe: To what extent do people know about the existence of the CS? To what extent do people know about the functions/roles/responsibilities of the CS?

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TOPIC/QUESTIONS	
Could you describe the level of trust and acceptance of the community structure in the localities they operate?	Probe: Acceptance of leaders of the CSs by mem bers of the CS Acceptance of leaders and members of the CS by the general population
Could you tell us the experience of the community structure in promoting/ imple menting health interventions?	Probe: In health promotion in general For family planning For maternal and child health For social accountability
What do you think are the opportunities to use the community structure in implement ing health interventions in the future? Strengths: What are the key strengths of this community structure in terms of using it for promotion of FP/RMNCH services and social accountability?	Probe: How can the CS be used in promoting FP/ RMNCH services? How can the CS be used in ensuring social accountability?
Limitations: What would be the key limita tions of this community structure in terms of using it for promotion of RMNCH services and social accountability?	
Before we conclude, are there other things that you would like to tell us about this community structure?	Any other attribute Additional persons to interview

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Thank you for your time!

ANNEX 3:

CSO PROFILE AND BASIC CAPACITY ASSESSMENT TOOL

QUESTION/ITEM		
IDENTIFICATION OF THE ORGANIZATION, INCLUDING GPS COORDINATES AND CONTACT DETAILS		
Name of the organization		
Address of the organization (Headquarters)		
Region		
Zone		

Woreda House Number GPS coordinate of the head office Website domain (if available) Telephone Number (Office)		
REGISTRATION AND YEAR OF ESTABLISHMENT		
Year of establishment in GC		

1

2

Name of registering organization (registered by)

Renewed registration for 2013 EC	Yes/No	Collect a copy of renewed license
Type of organization	1. Local NGO	
	2. Professional association	
	3. Labour union	
	4. Faith Based Organization	
	5. Consortium or network of NGOs	
	6. Local Community Structure	

7. Others, specify__________

3 ORGANIZATIONAL CONTACT PERSON

Primary contact person Name		
Position Office phone number		
Cell phone number Email address/s		
Secondary contact person		
Name		
Position		
Office phone number		
Cell phone number		
Email address/s		

QUESTION/ITEM		
SCOPE OF ENGAGEMENT		
Level of engagement	1. Federal	
	2. Regional	
	3. Zonal	
	4. Woreda	

4

5. Health facility (Hospital/HC/HP)

6. Community

7. Others, specify_________

operational? Tick/circle all that apply. 1. Federal In which regions is

the organizational currently

2. Tigray

3. Afar

4. Amhara

5. Oromia

6. Somali

7. Benishangul Gumuz

8. SNNP

9. Gambella

10. Harari

11. Sidama

12. Dire Dawa

13. Addis Ababa

offices? Tick/circle all that apply. 1. Federal In which of the regions do

the institution have

2. Tigray

3. Afar

4. Amhara

5. Oromia

6. Somali

7. Benishangul Gumuz

8. SNNP

9. Gambella

10. Harari

11. Sidama

12. Dire Dawa

13. Addis Ababa

Tick/circle all that apply. 1. Health

Which sectors is the organization working with?