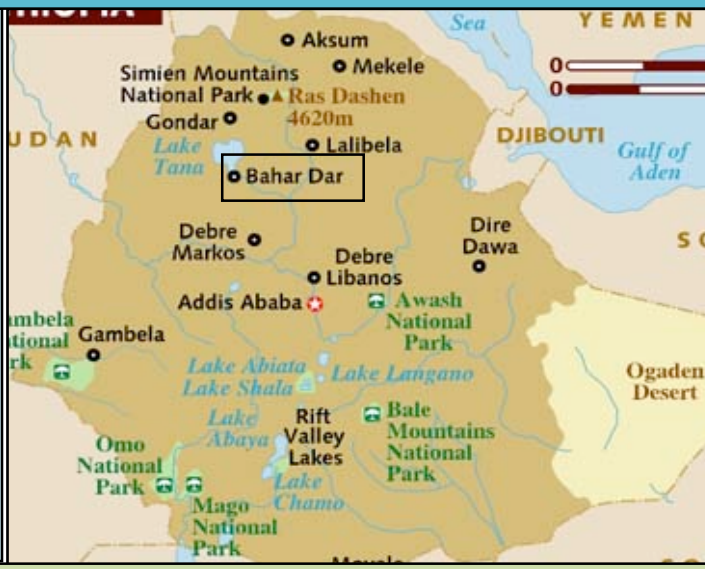
Springboard: Ethiopia

ONTEXT: The HIV/AIDS epidemic in Ethiopia has placed considerable stress on both the state and traditional communit sed safety net mechanisms. In 2009, an estimated 1,162,216 adults and children were living with HIV and AIDS, wi omen disproportionately affected by infection (Federal Ministry of Health of Ethiopia). Infection rates were significant gher in urban areas, where prevalence reached over 12 percent compared 2.6 percent in the rural areas. In 2009, t mber of orphans due to AIDS alone stood at 855,720. North Western Bahir Dar has the highest prevalence of HIV/AIDS e country. The Ethiopian Government regards HIV/AIDS as a key challenge to socio-economic development, and h orked to implement a multi-sectoral approach to the prevention and control of the disease (Ethiopian Strategic Plan f tensifying Multi-Sectoral HIV/AIDS Response of 2004-2008). Springboard aimed to reduce the socio-economic impact V and AIDS among women and youth in the Bahir Dar region, through improving the quality of voluntary counselling ar sting service providers (VCTs) and strengthening community-level safety nets for affected households.

BJECTIVE: To generate, share and use information to advocate for improved in service delivery for marginalised wome and youth; to build CSO and community capacity to understand policy processes; and to empower marginalised communities to demand quality service provision.

PPROACH: Springboard took a **rights-based approach**, in at it employed the use of social accountability mechanisms as means of a) improving community members' awareness of eir rights and responsibilities in relation to service providers, d b) building confidence for community members to proach service providers on non-delivery of entitlements, d c) creating mechanisms to allow for service improvement rough dialogue with providers.

ringboard was particularly concerned with effecting **stitutional change** in terms of the provision of services, and **ehavioural change** in terms of the ability of community embers and local CSOs to confidently engage in informed alogue with service providers.



TERVENTION: The Springboard project ran from 2007 to 2011 with funding from CIDA. CARE Ethiopia worked rtnership with the Family Guidance Association of Ethiopia (FGAE) and the Organisation for Social Support for AII SSA) to benefit over 30,000 vulnerable women, children and youth in the Bahir Dar region of Ethiopia, where timated one in five people were infected with HIV/AIDS in 2008.

he CSC process was implemented in seven stages:

Building the capacity of CSC implementing partners: Staff and partners attended information sessions; these we particularly designed for staff and partners who were new to CSC and the governance component of the project.

Community and District level ground work: At the *kebele* level, staff and partners met several times to ensu familiarity with and commitment to the CSC process. Plans to implement the CSC were also presented to local leade and a workshop was held for higher-level municipal officials in order to build familiarity and support for the process.

Community-level capacity building: Project staff provided training to community-based trainers who would lat facilitate the CSC process. The tool was also tested with volunteer CBOs involved in providing care and support servic to women, vulnerable children and people living with HIV/AIDS.

Developing the Input Tracking Score Card: Community members and service providers each devised a list of k elements required in order to effectively evaluate service provision. This entailed detailed planning and allocation appropriate resources; identifying key user groups in target communities; developing a work plan; meeting wi community members and leaders; and meeting with service providers to ensure their cooperation.

Developing the Performance and Self-Evaluation Score Cards: With the guidance of community facilitators, servi users developed indicators for individual services and allocated scores for each service identified. Service use participated in a similar process of self-evaluation.

Interface meeting: Service users and providers were brought together to discuss their respective results and to wo together to develop future action plans. Key decision-makers from local government participated in these meetings;

NABLING FACTORS

Motivation of service providers: Springboard found that service providers often gained confidence and a sense of pride on scoring highly on particular indicators; as a result, providers appeared to be motivated to improve service delivery in order to achieve and maintain higher scores in the future.

National decentralisation policy: Although the Ethiopian government is traditionally centralized and hierarchical, the state's decentralisation policy has provided a promising legal framework to lower government levels on which GAP was able to build.

Local government responsibilities: As part of the decentralisation process, *Kebeles* have been given responsibility for organising and mobilizing communities around HIV and AIDS-related issues; local government actors proved highly supportive of the CSC process and its outcomes. Thus, in spite of common issues of limited local government capacity, GAP was nevertheless aligned with existing local governance trends relating to HIV and AIDS.

DISABLING FACTORS

- **Resistance from service providers**: In the projec early stages, service providers appeared unwilling engage in the CSC process. This was ascribed to a la of appropriate orientation, which was subsequent addressed through more comprehensive ar explanatory CSC meetings.
- **Lack of community understanding:** The relati novelty of social accountability mechanisms such as th CSC at community level resulted in some cases in a la of community understanding and subsequently delaye implementation. This can be combated in three way ensuring quality facilitation through appropriate ar ongoing training; ensuring policies are careful explained using the local language; and providing we planned, comprehensive orientation on the CSC proce for both service providers and users to create a secu and comfortable environment for participation.

UCCESSES:

CSC adoption by service providers: Service providers have benefited from improved communication with, and awareness of the needs of, service users, and as a result have shown considerable support for the CSC process. Some service providers – for example, the *Shumabu Kebele* Administration's Department of Women's Affairs – have now institutionalised the CSC process.

Government support: Government officials have shown interest in adopting the CSC, with some offices developing terms of reference to initiate the use of the CSC with CARE's guidance.

EY LESSONS

Further stakeholder analysis: Although not an official CSC step, a thorough stakeholder analysis would impro understanding as to who has interests vested in different services and who has the authority to effect change

Deeper impact measurement: Current emphasis on capacity building and measurement should be balanced with more rigorous monitoring and evaluation system that works with service providers to collect robust data ar demonstrate improvement in service provision. In addition, mechanisms should be developed to capture unexpecte intangible or anecdotal change – for example, the fact that women CSC participants in Springboard consequent demonstrated greater empowerment and agency in their homes and with neighbours.

Wider facilitation skills: In order to provide facilitators with a transferable skill set, training should be provided o general facilitation and 'policy translation', rather than focusing exclusively on the CSC facilitation process.

Implementation ownership: The implementation plan should utilize the capacity of the service providers, as well a the users, and not be based on actions that require the sole input of NGOs. This should involve the facilitators identifying what capacity exists and how it might be best utilised.

NTACT: