USAID Empowered Communities Activity

Procurement Sensitive

PROGRAM DESCRIPTION (Draft)

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Addis Ababa, Ethiopia

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0. ACRONYMS

ADS	Automated Directive System
AOR	Agreement Officer Representative
CBHI	Community-Based Health Insurance
CBO	Community-Based Organization
CDCS	Country Development Cooperative Strategy
CLA	Collaborating, Learning and Adapting
CRC	Citizen Report Card
CSC	Community Score Card
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DO4	Development Objective Four
DO	Development Objective
ECBH	Empowered Communities for Better Health
FBO	Faith-Based Organization
FP	Family Planning
HC	Health Center
HEP	Health Extension Program
HEW	Health Extension Worker
HP	Health Post
HSS	Health Systems Strengthening
HSTP II	Health Sector Transformation Plan II
IR	Intermediate Result
J2SR	Journey to Self-Reliance
LCD	Local Capacity Development
MCH	Maternal and Child Health
MNCH	Maternal, Newborn and Child Health

NGO	Non-Governmental Organization
MOH	Ministry of Health
NPI	New Partners Initiative
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PHEM	Public Health Emergency Management
RMNCAH-N	Reproductive, maternal, newborn, child, and adolescent health and nutrition
SA	Social Accountability
SpO	Special Objective
SWOT	Strength, Weakness, Opportunity, and Threat
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene
WDA	Women Development Army
WHO	World Health Organization

1. TITLE

The title of this activity is USAID Empowered Communities.

2. SUMMARY

USAID/Ethiopia intends to award a five-year assistance activity entitled USAID Empowered Communities to support an organization or group of organizations, from here on, known as "Recipient" who share the expressed public purpose of improving healthcare outcomes through evidence-based and theory-grounded community[1] engagement and empowerment, social accountability, and local capacity-building interventions. The overall objective of this Activity is to achieve better health and nutrition outcomes through improved community ownership of health and strengthened social accountability systems.

USAID/Ethiopia expects to award one cooperative agreement based on a competitive Notice of Funding Opportunity (NOFO). Subject to the availability of funds, USAID/Ethiopia intends to allocate approximately $25-30 million USD over a five (5) year period. The activity will be funded with a majority of family planning funding and some maternal and child health funding; therefore, all expected results and proposed solutions should contribute to the betterment of the lives of women, children and men who access reproductive, newborn, maternal, newborn, adolescent, and child services, with a meaningful emphasis on family planning services. USAID/Ethiopia reserves the right to fund any or none of the applications submitted in response to the NOFO. The Empowered Communities Activity will operate in up to 50 selected woredas (hereafter referred to as 'district') in five agrarian regions of Ethiopia namely, Amhara, Oromia, Sidama, Southwest Ethiopia and Southern Nations, Nationalities and Peoples' (SNNP).

USAID/Ethiopia will support the successful Recipient in achieving the Recipients' public purpose of improving health and nutrition outcomes. This Activity will focus its support primarily at the community level to ensure communities can effectively act to improve their own health. In addition, the Activity will build the capacity of non-state actors (NSAs) including but not limited to private organizations, faith-based organizations, community-based organization (CBO)[2], civil society organizations (CSOs), and formal and informal community platforms to strengthen community voice and feedback in the delivery of essential health services for more transparent, responsive, and accountable health services.

This Activity supports USAID's effort to integrate development activities within certain geographic districts, including health, education, nutrition, youth and WASH programming. The Recipient will be expected to coordinate with other USAID-supported activities at district level, which will include sharing the annual work plans, reporting to district and regional government officials, and leveraging resources to facilitate cost-efficiencies in programming.

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[1] *Communities will be defined as: neighborhoods, towns, or kebeles where people live and work, and are commonly served by a common health post.*

[2] *Community based organizations is a general term, which could encompass any organization with a desire to equitably serve its community. The Empowered Communities Activity intends to work with existing, legally registered local organizations, and the type of organization engaged may vary. These organizations could be completely voluntary in membership or could be more formal with salaried staff. Examples could include Village Savings and Loans Associations, Mothers' Groups, Health Governance Boards, or Adolescent Youth Clubs.*

The Empowered Communities Activity will support health sector actors to increase utilization of quality health and nutrition services as stated in the Development Objective (DO) 4 of the USAID/Ethiopia Country Development Cooperation Strategy (CDCS) 2019-2024. The Activity will contribute to community engagement and empowerment and to social accountability efforts outlined by the Government of Ethiopia (GoE) and other sector actors to meet the ambitious goals outlined in the Health Sector Transformation Plan (HSTP II 2020-2025). The Activity also focuses on NSAs and community structure/platforms (e.g Idirs, community care coalition), capacity building to increase organizational capability (i.e., knowledge, skills, processes, systems, etc.) to engender effective, efficient and sustainable institutions.

3. OBJECTIVE

The purpose of the USAID Empowered Communities Activities is to achieve better health and nutrition outcomes through improved community engagement and ownership of health and strengthened social accountability[3] systems. Specifically, this Activity will:

1. Improve individual and community knowledge and understanding of their own health rights, available services, and fee and delivery structures to make informed decisions in managing their own health;
2. Build the capacity of non-state actors including but not limited to private sectors actors, CSOs,[4] community-based organizations, faith-based organizations (FBO), and or other community platforms, to collectively advocate for more transparent and responsive health services on behalf of individuals, families and communities accessing care (e.g., serving as a bridge between clients and health service providers).

It is assumed that with an explicit focus at the community level, with engagement of local NSAs that health system functionality will improve, community health seeking behaviors and care-seeking practices will improve, and contribute to higher-quality, more client-centered health services mainly at HP and HC levels.

Therefore, the specific objectives of this Activity are to:

- Improve community engagement, ownership, and ability to make informed decisions about its own health.
- Enhance CSO capacity to advocate for improved health system accountability, transparency, and responsiveness.
- Strengthen accountability systems and platforms to improve the health outcomes.

[3] ***Social accountability(SA)*** *is widely understood to be a way for citizens to hold state actors accountable for their actions.It is also refers to actions initiated by citizen groups to hold public officials, politicians, and service providers accountable for their conduct and performance in terms of delivering services, improving people's welfare and protecting people's rights.Moreover, it is also about governance relationships between citizens, as services' users, and the providers of public services. Social Accountability Program.*

[4] *The Ethiopian Organization of Civil Societies Proclamation (2019) defines CSO as a non-governmental, nonpartisan, not-for-profit entity established at least by two or more persons on a voluntary basis and registered to carry out any lawful purpose and, includes non-government organizations, professional associations, mass-based societies and consortiums. In addition, local organization means a civil society organization formed under the laws of Ethiopia by Ethiopians, foreigner's resident in Ethiopia, or both.*

It is expected that this activity will have deliberate and intentional overlap with USAID/Ethiopia's newly awarded Healthy Behaviors Activity award in all 50 woredas. The Healthy Behaviors Activity award will work directly with individuals, families and communities to spark change in knowledge, attitudes and practices related to RMANCH behaviors. This activity will not implement direct behavior change communication for RMANCH behavior, (i.e. benefit of delivery in a facility rather than community), but rather, this activity will them complement and ensure that once a client/patient seeks services at a health facility they are full informed about what services are available, quality of services they should expect and if they have any issues how to seek support and resolution of patient care issues.

4. BACKGROUND

4.1 Country Context

With more than 112 million people, Ethiopia is the second most populous country in Africa after Nigeria (World Bank, 2021). Ethiopia has eleven regional states and two city administrations, and is home to various ethnicities with diverse cultural, religious, and linguistic backgrounds with more than 80 different spoken languages[5].

Ethiopia is a low-income country with a per capita income of $936.30[6] in 2020 and aims to reach lower-middle-income status by 2025[7]. Ethiopia's economy experienced strong, broad-based growth averaging 9.4% a year from 2010/11 to 2019/20. However, the real gross domestic product (GDP) growth slowed down to 6.1% in 2019/20 due to COVID-19. Ethiopia is also characterized by rapid population growth (2.6%). In 2016, Ethiopia had a high total fertility rate of 4.6 births per woman (2.3 in urban areas and 5.2 in rural areas) and a corresponding crude birth rate of 32 per 1000[8].

Citizen engagement is crucial for sustainable local development and can be further supported to strengthen accountability mechanisms. Yet, the ability of individuals, communities and NSAs to advocate for more responsive health services has been constrained by past legal frameworks that undermined the ability of citizens to advocate for improvements in health services. Recently, such advocacy became possible with the March 2019 revision to the Civil Society Law[9] , which included provisions for CSOs to engage in advocacy and human rights monitoring. However, due to historical restrictions placed on CSO functionality and operations in Ethiopia technical and institutional capacity within organizations may have weakened to fully support implementation of these provisions.

[5] Health Sector Transformation plan II, 2020-2025

[6] GDP per capita (current US$) - Ethiopia

[7] Ethiopia Overview: Development news, research, data | World Bank

[8] Ethiopia: DHS, 2016 - Final Report

[9] The Ethiopian Organization of Civil Societies of Proclamation

4.2 Health Context in Ethiopia

Ethiopia's health sector aims to promote health and wellbeing with a high-quality, equitable comprehensive package of promotive, preventive, curative, and rehabilitative health services. Ethiopia outlined its priorities and goals through HSTP II 2020-2025. The overall objective of HSTP-II is to improve the population's health status by accelerating progress towards universal health coverage, increasing protections during health emergencies, transforming districts, and improving the health system's responsiveness.

Both the 2019 Mini-Demographic and Health Survey (EMDHS) and the 2016 DHS showed general positive trends in health outcomes, although results fell short of HSTP goals. Progress in newborn health and nutrition has stagnated. From 2005 to 2016, the maternal mortality rate declined by 39 percent to 412 per 100,000 live births. Per the 2019 EMDHS, the mortality rate for children under five dropped from 123 to 55 per 1,000; stunting decreased from 51 to 37 percent; and use of modern family planning (FP) methods increased from 14 to 41 percent. However, since 2007, issues related to poor sanitation, access to safe water, and malnutrition have continued to drive the burdens of morbidity and mortality. Newborn mortality increased from 29 per 1000 live births in 2016 to 30 per 1000 live births in 2019, indicating the need for priority focus on newborn health.

According to the Ministry of Health (MOH) annual performance report[10], utilization of maternal health services improved compared to the previous year. Contraceptive acceptance rate was 73%, a 4 percent point increment compared to the baseline. Seventy percent of pregnant women received four or more antenatal care (ANC) visits; 66% women delivered at health facilities; and 85% received early postnatal care (PNC) service. Ninety-seven (97%) percent of pregnant women were provided with iron and folic acid, but only 72% were screened for syphilis. The birth rate decreased from 14 per 1000 births in 2020 to 12 in 2021. Coverage of immunization services was high with 97%, and 93% of infants under age one received measles and full immunized services. Regarding child health service uptake, 74.2% of children under five with diarrhea received treatment, while 60.8 % of the same age group with acute respiratory infections received antibiotics. Moreover, more than 11 million (86%) children aged 6-59 months received vitamin A supplements, and more than 7.7 million (82%) children aged 24-59 months received deworming tablets.

Social and gender norms compounded by lack of community-lead feedback and advocacy has contributed to suboptimal health and health-seeking behavior with regard to FP, maternal, newborn, and child health (MNCH); nutrition, water, sanitation and hygiene (WASH); and malaria services.

Public health services in Ethiopia are delivered through a three-tier system of primary, secondary, and tertiary care (Figure 1 below). The primary level includes primary hospitals, health centers (HC), and health posts (HP). The primary health care units (PHCU) consist of 17,550 HPs and 3,735 HCs which form the main source of primary care services and particularly so, for rural communities.

The HPs are mostly staffed by two health extension workers (HEW) who deliver an 18 services package[11] addressing major causes of maternal and child morbidity and mortality within rural communities.

[10] MOH, Annual Performance Report,2021/2022

[11] *In 2018, the service packages for HEWs increased from 16 to 18, which included services across four themes:* ***Disease Prevention and Control*** *(HIV/AIDS and other STIs, tuberculosis, malaria prevention and control, first aid);* ***Family Health Service*** *(maternal and child health (MCH), family planning, immunization, adolescent reproductive health, nutrition);* ***Hygiene and Environmental Sanitation*** *(safety*

Ethiopia's MOH recently expanded this service package to also address non-communicable diseases and mental health.

Although rural-urban-disaggregated data on morbidity and mortality is limited, the burdens of communicable diseases, and of maternal, perinatal, and nutritional conditions are estimated to be higher in rural communities[12].

Health service delivery in Ethiopia is organized in a three-tier system providing primary, secondary, and tertiary level care. At the bottom of the tier system are Primary Health Care Units (PHCUs) supported by a Primary Hospital (PH). The community, families and clients/ patients associations are also part of the health system especially at woreda and below. For instance, the health-sector specific Woreda transformation mainly focuses on strengthening and transforming district health systems through improving key health system investments and implementing high-impact health interventions mainly at household and primary health care levels. It will focus on creating model households, model kebeles and high performing primary health units (PHCUs) through a meaningful community engagement and a transformed woreda leadership HSTP II 2020-2025. Hence, the community, households/model families and patients contribute to strengthening the health system and services delivery.

Ethiopia's health sector is well known for its strong community health program, the health extension program (HEP). Launched in 2003, the HEP delivers cost-effective basic health services to all Ethiopians but mainly to women and children and in rural communities. HEP is underpinned by the core principle of community ownership, which empowers communities to manage health problems specific to their communities, thus enabling them to safeguard their own health[13]. The Women Development Army (WDA) structure was added in 2011 to bolster the HEP.

The HEP is expected to involve women in decision-making processes and promote community ownership, empowerment, autonomy, and self-reliance as core principles in its theory of change. Community engagement strategies for the HEP include empowering women through model family training (MFTs) and engaging community structures[14].

During the early stage of the HEP, a model family was defined as a family that implements a minimum of 75% of the 16 packages after taking at least 75% of the 96 hours of model family training. These model families are households that: are trained in HEP-related topics, including maternal health, child health, malaria prevention and control, and hygiene and environmental sanitation packages; are able to implement these packages after the training; and are able to influence their relatives and neighbors to adopt similar practices. Before the introduction of the WDA, model families were expected to gather regularly for experience-sharing. Now, they work as part of the WDA to engage communities for health improvement[15]. The expected changes required to be a model household include making visible changes in behavior: for example, owning and using a latrine, washing hands properly, eligible mothers' and children's completing immunization schedule, and pregnant mothers' accessing antenatal care (ANC).

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excreta disposal, safety waste disposal, food hygiene, healthy home environment, arthropod and rodents, personal hygiene), ***Health education & communication- cross cutting****, non-communicable diseases and mental health.*

[12] *A Roadmap for Optimizing the Ethiopian Health Extension Program 2020 – 2035.*

[13] A Roadmap for Optimizing the Ethiopian HEP 2020-2035

[14] A Roadmap for Optimizing the Ethiopian HEP 2020-2035

[15] National Assessment of the Ethiopian Health Extension Program, 2019

A model family mainly implements all the HEP packages as instructed by HEWs, is involved in other development work, serves as an early adopter to help diffuse health messages leading to the community's adoption of desired practices and behavior, is part of the group network (which contains 6 household members), and has a household head (the mother) who shares her stories of success in implementing the HEP. Model family trainings were expected to transform households and communities, with model family 'graduations' serving as a key metric of whether the HEP was performing well in a community[16].

The 2019 national assessment of the HEP shows that exposure to HEWs in general and enrollment in model family training in particular has been very low. The assessment collected information on the awareness of women regarding model family training, enrollment, and the completion status of households. Findings reveal that MFT reached only a very small proportion of households. Only 14.9% of women in agrarian settings and 8.0% of women in pastoralist settings reported being aware of MFT. Enrollment and graduation rates were very small, with only 2.9% of agrarian and 2.1% of pastoralist households reporting having ever been enrolled in MFT. Low coverage of model family training, suboptimal functionality of WDA structures, and limited capacity of WDA leaders have created major challenges/gaps to community engagement and empowerment with the HEP. Hence, this activity should identify opportunities to leverage priorities in the HEP 2.0 Roadmap that are in alignment with the results of this award.

The HEP has been a massive investment in human resources for health with over 39,878 salaried HEWs distributed across the country (85% rural, 15% urban)[17]. Over several years, the HEP has been expanded to reach the majority of the agrarian rural communities and was later adapted for pastoralist communities and disadvantaged groups in urban settings[18].

4.3 Community Engagement and Empowerment Programming in Ethiopia

The World Health Organization (WHO)[19] defines community engagement as a process of developing relationships that enable stakeholders to collaboratively address health-related issues and promote wellbeing to achieve positive health impact and outcomes. At its core, community engagement stimulates changes in behavior, environments, policies, programs, and practices within communities. Different levels, depths, and breadths of community engagement determine the type and degree of involvement of community members. Community empowerment also refers to a higher level of engagement whereby community members develop influence and take ownership within decision-making processes that can improve their own health status.

The Alma-Ata Declaration 1978[20] indicates that health exists as a state of complete physical, mental, and social well-being and not as the mere absence of disease or infirmity. The WHO constitution also states that enjoyment of the highest attainable level of health is a fundamental right of every human being.[21] As a result, adopting a human rights-based approach to health is critical to achieving health for all.

[16] Health Sector Transformation Plan II, 2020-2025

[17] https://e-library.moh.gov.et/library/wp-content/uploads/2021/07/1.-HEP-Roadmap_Main-Document_Final.pdf

[18] National Assessment of the Ethiopian Health Extension Program, 2019

[19] WHO,2020.

[20] Declaration of Astana

[21] WHO,2017

The principle of health as the basic human right is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. The 2018[22] Global Conference on Primary Health Care also reaffirmed the importance of involving individuals, families, communities, and civil society to develop and implement health policies and plans. The Alma-Ata Declaration also outlined PHC as a path for countries to improve population-level health status and cited community engagement as key in highlighting people's right and duty to participate in planning and implementing health care.

Alignment to Country-Defined Priorities and Country-Established Strategies

Ethiopia's MOH views community engagement as a critical vehicle to improve health. Community engagement has been a primary principle and strategy for achieving the strategic objectives of HSTP-I. The WDA served as a primary community engagement platform at the grassroots level and has been scaled up to almost universal coverage in agrarian settings and to partial coverage in urban settings. The HEP is underpinned by the core principle of community ownership, which empowers communities to manage health problems specific to their communities, thus enabling them to safeguard their own health[23,24]. The initial HEP success was based on the model family training and household graduation approach that created strong community ownership of the platform[25].

At the facility level, high-performing HPs consistently demonstrate stronger community engagement than lower-performing ones[26]. While increased community knowledge has increased community expectations for HPs, this has not always translated into HPs to meeting the expectations of individual patients or communities notably for curative care. This area has been a chronic source of dissatisfaction, particularly with the expansion of community-based health insurance (CBHI). If the communities cannot have their needs met, they lose trust in providers and the broader PHC system. As a result, the national HEP assessment recommended that instead of relying solely on the WDA framework for community participation, community structures and engagement need to be improved. This could be improved by enhancing HEP leadership, devising community structures by involving all segments of the population (including youth, women, men, traditional leaders, religious leaders, and other influential individuals) and link HPs with all segments of the population within kebele[27].

Moreover, the MOH developed a 15-year roadmap to optimize the Ethiopian HEP (2020-2035) to guide the program's evolution to meet the current and future health needs of individuals, households, and communities through health service delivery, predominantly at the kebele level. There are five strategic pillars of this roadmap including:

1. Ensure equitable access to essential health services;

2. Improve the quality of health services provided through HEP;

3. Ensure sustainable financing and eliminate financial hardship from HEP services;

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[22] A Roadmap for Optimizing the Ethiopian HEP 2020-2035

[23] *Health Sector Transformation Plan II, 2020-2025*

[24] *A Roadmap for Optimizing the Ethiopian Health Extension Program 2020 - 2035*

[25] Health Sector Transformation Plan II, 2020-2025

[26] A Roadmap for Optimizing the Ethiopian HEP 2020-2035

[27] *The lowest administrative unit in Ethiopia*

4. Strengthen community engagement and empowerment; and

5. Ensure resilience by maintaining the provision of essential services during any health

This activity will directly contribute to objective four: *strengthen community engagement and empowerment by redesigning its current structures and functions*. The roadmap also focuses on nurturing platforms to expediently conduct health education and promotion activities at national scale; create an environment that encourages community participation in dialogues that impact health; and enable action to improve health and nutrition status[28]. This activity will also contribute to those priorities of the HEP 2.0 Roadmap.

Introduction of Social Accountability in Ethiopia

The social accountability concept was successfully introduced in Ethiopia in 2006 through a pilot program with World Bank funding. Ethiopian Social Accountability Program I (ESAP I) was a pilot program from 2006-2009 and it evolved into a broader program at second phase Ethiopia Social Accountability Program (ESAPII) that functioned between 2011-2018[29]. The third Phase Ethiopia Social Accountability Program (ESAP III) launched May 30/2019(Start 1 January 2019 till 31 December 2024). ESAP II supported three the three SA tools: community scorecards (CSC), citizen report cards (CRC), and participatory planning and budgeting (PPB).

The Ethiopia Social Accountability Program (ESAP) seeks to empower citizens, strengthen civil society, promote citizen engagement in public venues, modify how public officials engage citizens, and improve service delivery. ESAP's programmatic features were designed to produce supply-side and demand-side change, both independently and interactively. ESAP brought community leaders and public officials together to form local decision-making committees that were responsible for developing specific plans to better support service delivery in health and education, but some programs also focused on rural roads, water and agriculture sectors.

An innovative feature of ESAP is that a Management Agency (MA) partnered with a wide range of civil society organizations (CSOs) to work with communities and community-based organizations to expand their knowledge and then to empower them to better engage with public officials. These CSOs, with the support of the MA, then worked with local public officials (e.g., elected officials and service providers) and citizens to form Social Accountability Committees (SACs), which led to generalized discussions on key policy problems facing their communities. The SACs were then responsible for forming working groups that were specific to well-defined policy areas; these working groups draft and then approve a Joint Action Plan (JAP), which sets priorities in a specific policy area.

Thus, ESAP first empowers community leaders and groups, who use new knowledge in the SAC and the JAP to develop policy recommendations that are publicly supported by elected officials, service providers, and community leaders. Simultaneously, the public officials working at the local level are being encouraged by the GoE and the MA to work closely with these new organizations. There was also some piloting done to incorporate the Rural Productive Safety Net Program (PSNP) in order to bring social accountability mechanisms into PSNP and to make ESAP more attentive to the needs of Ethiopia's most vulnerable populations.

[28] *Health Sector Transformation Plan II, 2020-2025*

[29] *Building the foundation for accountability in Ethiopia, World Bank, 2020*

The World Bank, 2020 conducted an assessment to see the impact of the second phase of the ESAP intervention and contributes to the emerging literature on the effectiveness of social accountability interventions. The survey finds preliminary evidence that the presence of ESAP helped to establish the foundations of social accountability at local levels across Ethiopia. Some of noteworthy findings include: increases in citizen participation in local committees and other policymaking venues; improvements in citizen satisfaction with the more immediate delivery of basic services; increases of more critical attitudes regarding more structural problems; a more modest decline in access to information and use of specific social accountability tools (e.g. community scorecards) in comparison to steeper declines in non-ESAP woredas. Moreover, respondents in ESAP2 woredas also consistently report improvements in basic service delivery, in comparison to non-ESAP2 woredas. They were more likely to make complaints than in non-ESAP2 woredas. This evidence suggests that ESAP2 is creating the local conditions that make it more feasible for citizens to raise key issues and problems in public formats. ESAP2 respondents were more likely to believe that the act of making demands would have a positive impact. The assessment indicates an important change in the accountability relationship: citizens in ESAP2 woredas are more likely to assert that they have the power to influence basic accountability relationships.

Furthermore, using SA tools (e.g CSC, CRC & PPB), citizens can compare their experiences with services to the information they receive from the local government officials and health providers. The Social Accountability Committee[30] uses SA tools, so that service users can assess the services from various perspectives considering the different needs vulnerable groups may have.

History of Social Accountability in the Health Sector in Ethiopia

In 2017, the MoH introduced a social accountability system called community score card (CSC)[31], a local governance tool for monitoring services, empowering communities, and improving accountability of the health system. The goal of the CSC is to support stronger management of health services and to make service delivery efficient, effective, and responsive by enabling communities to measure the health facility performance and to provide feedback. The scorecard approach has six implementation phases: 1) understand community perceptions & develop standard indicators; 2) establish & empower client council; 3) facilitate community group discussions & measurements; 4) visit facilities & provide feedback; 5) conduct community facility & interface meetings; and 6) monitoring & evaluation[32]. Implementation of a community scorecard approach enhances a culture of social accountability, transparency, and engagement of citizens in planning, implementing, and evaluating maternal, neonatal, and child health services[33]. In addition, this accountability approach improved the negotiation capacities and involvement of both community members and health workers, contributing to increased availability and utilization of health services.

[30] *Social Accountability Committee: A Committee at Village and district/woreda level incorporates three distinct types of governance actors: elected officials (oversight and resource allocation), public administrators (service delivery), and civil society representatives (both CSOs and citizens).Building the foundation for accountability in Ethiopia, World Bank, 2020.*

[31] *Community Scorecard is a mechanism through which citizens monitor the quality, access, efficiency and effectiveness of community based public services. It provides the opportunity for citizens to analyze and provide feedback on any service received*

[32] Implementing Social Accountability Approach for Maternal, Neonatal, and Child Health Service Performances in Ethiopia: A Pre-Post Study Design

[33] Implementing a Social Accountability Approach for Maternal, Neonatal, and Child Health Service Performances in Ethiopia: A Pre-Post Study Design; The Global Heath: Science and Practice, 2021.

The MOH started piloting the CSC process in 36 selected districts of four regions (Amhara, Oromia, SNNP, and Tigray). Motivated by the pilot's success, the regional health bureaus scaled up CSC implementation to other districts, including non-pilot regions. Since December 2019, the CSC has been implemented in more than 600 districts across all regions[34]. As other service delivery improvement processes, the CSC implementation has been variable across and within regions[35]. To ensure community participation in primary health service delivery processes, the MOH has supported the establishment of client councils to help implement social accountability initiatives, and particularly CSC[36].The community will be involved in rating the health system; and the level of community involvement/ contribution in the health sector will be assessed. Community scorecards will be implemented to regularly measure the responsiveness of the health system and community satisfaction, and to identify priority areas within the health sector[37]. There has been no formal review or evaluation of the community scorecard approach to date.

Alignment to USAID Global and Local Priorities

USAID/Ethiopia prioritizes building community engagement and empowerment at the lowest levels of the health service delivery system and promoting accountable and responsive healthcare. USAID/Ethiopia also emphasizes capacity strengthening of local partners,[38] which is central to achieving development objectives, improving health outcomes, promoting local leadership and ownership, and sustainability of local solutions. In July 2021, USAID recommitted its support for the New Partner Initiative to engage authentically with local partners and to move towards a more locally-led development approach as it is vital to our long-term success to sustainable development. USAID/Ethiopia has a long history of strengthening community engagement platforms, including the HEP and associated local structures (e.g., governance, human resources, service delivery, supply chain, etc.) in addition to directly funding local partners.

NPI Expand in Ethiopia

Currently, USAID/Ethiopia is working with Palladium through NPI Expand to test models to fund local organizations to deliver RMNACH services and implement social accountability. Where feasible, lessons learned, etc will be leveraged to inform the start-up of this award. NPI Expand will end in September 2024.

4.4 Problem Statement

In Ethiopia, the public and private sectors do not routinely engage individuals and communities in health services and in health-related decision-making[39]. Rather communities and individuals are often treated as passive recipients of health information and services. At the community level, there are different

[34] Health Sector Transformation Plan II, 2020-2025

[35] A Roadmap for Optimizing the Ethiopian Health Extension Program 2020 - 2035

[36] Ministry Of Health: Health Sector Social Accountability Implementation Strategy(draft),2020

[37] Health Sector Transformation Plan II, 2020-2025

[38] New Partnership Initiative: EXPAND

[39] National Assessment of the Ethiopian Health Extension Program, 2019

community and social platforms such as WDA, men and youth groups, religious groups and idirs[40]. However, there is no strong coordination mechanism that effectively engages these platforms in a sustainable manner to drive improved health services for the community[41]. This and other health facility-related factors such as low client satisfaction, disrespectful treatment, geographical inaccessibility, stockout of medical supplies and equipment, lack of hygiene, and long waiting times limit use of health services has limited progress in health outcomes. This results in low community trust in the quality of public health services and in provider competence. Insufficient community awareness of available services at different system levels also contributes to low community demand and utilization of health services[42]. Sociocultural beliefs and practices, incorporating gender norms, greatly influence decisions regarding use of health facilities and do disproportionately affect girls and women.

Currently in Ethiopia, communities and individuals do not have dedicated independent platforms for meaningful engagement with the health system or to learn about health risks and practices that can improve local health conditions. Moreover, there is limited understanding and accountability between communities and their local health systems to effectively inform and organize communities to advance health issues[43]. The HSTP II SWOT analysis identified sub-optimal accountability at all health system levels and the need to further strengthen the community accountability framework at each level.

The current HEP service packages, delivery modalities, and service delivery points were found to be inadequate, leading to marginalization of males and youth[44]. The 2019 HEP Assessment[45] identified a number of problems. The expansion of HEW facility-based duties now hinders optimal community engagement, which was the original reason for introducing the WDA. One key finding detailed that the use of WDAs as the only way to engage and empower communities failed to leverage existing social capitals, such as community structures and networks encompassing men, youth, religious or traditional leaders, village leaders, and formal and informal community structures such as idirs. In addition, WDA structures were widely available but with very limited functionality in supporting HEP (only 21.5 percent of WDA structures were functional). In addition, the `WDA leaders sometimes engaged in political activities, which impacted their credibility in the community. The WDA leaders also did not demonstrate model behaviors, had low capacity for health education and outreach, and were not accepted in the community. Empowering communities with the ability to comprehend and communicate data to their members is one of the most underutilized global health resources but it may also be the most impactful[46]. Hence, this Activity will address these gaps, enhance the community's ownership of their own health, strengthen the accountability system, build non-state actor (NSA) advocacy capacity and help to strengthen and contribute to the vision of the HEP Roadmap 2.0.

[40] *Idir is a traditional "burial society" where community members contribute monthly, and receive a payment when support is needed to cover funeral expenses. In the mid-2000's the groups shifted to also support illness in response to HIV. Membership is widespread throughout Ethiopia; members can be members of idirs in their neighborhood, based at work, or operating along age or gender lines.*

[41] Ministry of Health: Revised Community Engagement Approaches in Rural Agrarian Ethiopia: An Implementation Guide for piloting of the community engagement approaches, 2020.

[42] *Health Sector Transformation Plan II, 2020-2025.*

[43] Proclamation No. 1113/2019 - Organizations of Civil Societies Proclamation

[44] *Youth: The National Youth Policy of Ethiopia classifies youth as those between the ages of 15-29 years*

[45] *National Assessment of the Ethiopian Health Extension Program, 2019.*

[46] Country ownership in global health | PLOS Global Public Health

4.5. Alignment with USAID/Ethiopia CDCS (2019-2024)

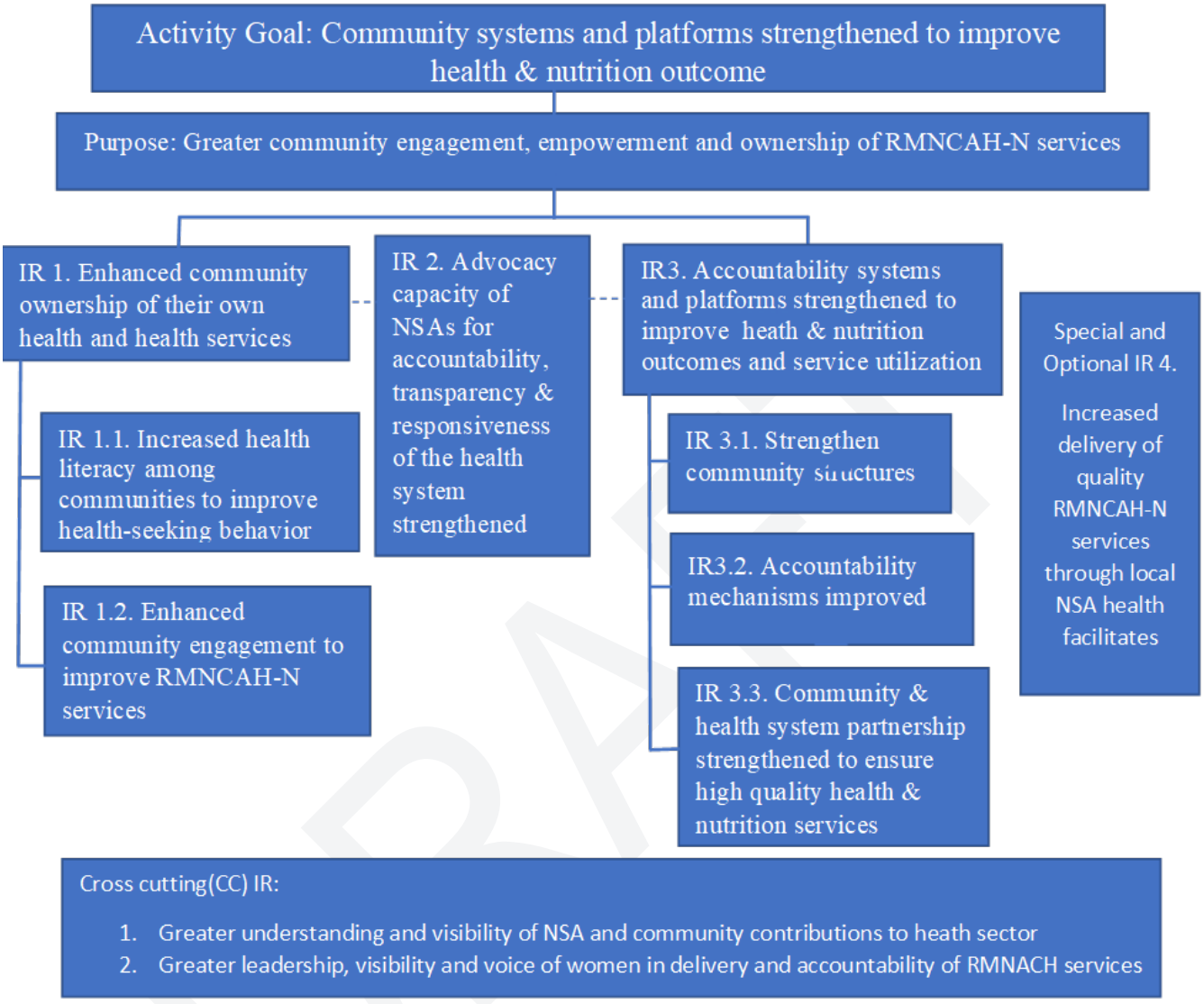
This Activity responds to USAID/Ethiopia's 2019-2024 CDCS Development Objective (DO) 4: "Sustained improvement in essential service delivery outcomes, focused on women and girls." Specifically, the Activity responds directly to IR 4.4: Utilization of quality health and nutrition services increased and also, supports IR 4.5: Health and nutrition systems strengthened for greater self-reliance, as the Empowered Communities Activity will improve health system accountability and responsiveness by improving transparency and building community in their local health system. The Activity also responds to CDCS Strategic Principle 1: Improved citizen empowerment and household and community resilience and well-being and to Strategic Principle 2: More effective and accountable systems and institutions at all levels. Engaged and empowered citizenry is foundational for sustainable, systemic improvement. Broadly, gender, youth, and vulnerable populations are CDCS priorities, and equity is also a focus for this Activity.

The Empowered Communities Activity directly contributes to ECBH Project Result 2: Increased accountability and responsiveness to community health needs by PHCU and woreda health offices for the benefit of the community at large. Specifically, the Activity contributes to IR 2.1: Enhance community mobilization for essential health and nutrition services and resources and IR 2.2: Increase opportunities and platforms for community advocacy and provider accountability. This Activity will also leverage other activities under the ECBH project engaged in quality improvement in health services, healthy behavior, and community nutrition.

5. ACTIVITY DESCRIPTION

This Activity aims to reduce maternal and child mortality and morbidity by strengthening the knowledge, skills, ability, and confidence of individuals, households, and communities to make informed decisions and to take action to manage their own health and nutrition. This Activity will engage communities through both existing and new community platform models (formal and informal) and will strengthen the capacity of non-state actors to create an enabling environment that build community health knowledge (services, fees, standards, etc) to encourage greater community ownership and informed participation in health-related forums and dialogues to stimulate greater action to improve health and nutrition status utilizing/adapting existing tools and approaches, while also proposing new innovative solutions. .

5.1. Activity Results Framework



The following table illustrates the anticipated level of effort for the Empowered Communities Activity's three IRs. Applicants should also consider the funding breakdown for this Activity.

Intermediate Results	Level of Effort
IR 1: Enhanced community ownership of their own health and health services	30%
IR 2. Advocacy capacity of NSAs for accountability, transparency, and responsiveness of the health system strengthened	35%
IR.3. Accountability systems and platforms strengthened to improve the health and nutrition outcomes and service utilization.	35%

IR 4. Increased delivery of quality RMNCAH-N services through local NSA managed health facilities	TBD by offeror

5.2. Theory of Change

Aligning with the overall vision of the Ministry of Health to see Healthy, Productive and Prosperous Citizens of Ethiopia and ia's USAID/Ethiopia Health Office motto of "Healthy People Drive a Prosperous Ethiopia," the Empowered Communities Activity theory of change is that:

IF communities and individuals are knowledge about their own health **AND** empowered to take ownership of their own health, and

IF the advocacy capacity of NSAs and citizen engagement for accountability, transparency, and responsiveness of the health system are fostered, and

IF accountability systems and platforms are strengthened to improve health and nutrition outcomes and service utilization, and

ASSUMING that simultaneous efforts successfully improve social and behavior change communication, access to and the quality of health services, and the CSO space continues to expand allowing for more collaboration and contribution;

THEN communities are empowered to utilize quality health and nutrition services, and health and nutrition outcomes of the communities will improve.

5.3. Activity IRs

This activity strives to achieve the following results and sub results:

IR 1. Enhanced community ownership of their own health and health services

Community ownership[47] can be defined as the point when community members have the capacity, empowerment, leadership, value found in the provision of health services, aspirations and are active participants and drivers of influence, exercising direct accountability, responsive health services and actions. This Activity strives to create platforms and processes to inform, engage, and encourage communities to take actions that improve their health outcomes. The goal of empowering individuals and communities is to create a well-informed (meaning health literacy) and demanding society. For this Activity, the focus will be at the kebele level where health services are provided through HPs and HCs and where community responsibility and ownership for local programs through which their health needs can be addressed. Community empowerment takes root when communities increasingly influence decisions that affect health in their communities as well as their own health-seeking behavior. This Activity will support systems that enable and better position communities to advocate for their health and to improve community capacity to manage health practices and care-seeking behaviors within communities. This IR has the following two sub-IRs:

[47] Sarriot, Eric; Shaar, Nashat, Ali. Global Health: Science and Practice. 2020 | Volume 8 | Number 3.Community Ownership in Primary Health Care—Managing the Intangible. https://www.ghspjournal.org/content/ghsp/8/3/327.full.pdf

IR 1.1. Increased health literacy among communities to improve health seeking behavior

Access to and understanding of comprehensible information is crucial to understand local health conditions and to guide actions to improve community health outcomes. Health literacy is the degree to which individuals have the capacity and ability to obtain, process, and understand basic health information needed to make appropriate health decisions[48]. Practical citizen engagement for health requires access to and use of basic health information, including the standard contents and requirements to access such services and standards of care. When both health service users and service providers share the same information on service standards, fees, performance, and health risks, joint action is possible to improve services and health outcomes. Communities also should have access to information on government health sector policies, laws, processes, service standards, health budgets and expenditures, service targets, and performance. When communities are informed and empowered to act, they are more likely to demand the health system to be responsive.

Expected Results:

- Communities' access to and utilization of health information performance and services enhanced
- Improved health literacy at community level
- Improved understand of health service, standards and patient rights

- Increased health seeking behaviors for RMNCAH-N services.

Illustrative Indicators

- % of communities that are fully aware of what services are available at nearest health facility
- % of patients accessing RMNACH services that fully understand standards of care, rights, etc.
- Percent of women with a live birth who reported seeking care from a skilled provider for a sick newborn.

IR 1.2. Enhanced community engagement to improve RMNCAH-N Services

Community engagement for health is a process of developing relationships with communities to work together to address health-related issues and promote wellbeing to achieve positive health impact and outcomes[49]. The importance of community engagement is globally recognized and reflected in numerous strategies including Every Woman Every Child[50], People-Centered Health Systems[51] and USAID's Acting on the Call[52]. The UN's Global Strategy[53] calls community health works an "essential component of health system resilience", and community engagement is one of the nine action areas required to improve health systems ownership.

Community engagement is a central component of effective community health management and helps ensure that services are appropriately tailored to population needs and values. Effective community

[48] Source: Health Literacy | Official web site of the US Health Resources & Services Administration

[49] WHO community engagement framework for quality, people-centered and resilient health services

[50] The Global strategy for women's, children's & adolescent health

[51] WHO global strategy on integrated people-centered health services, 2016-2026

[52] Preventing child & maternal deaths: A focus on sustaining lifesaving health services amidst the Covid-19 Pandemic,2021

[53] WHO global strategy on integrated people-centered health services 2016-2026

engagement facilitates checks and balances in public sector service delivery and enables the system to better respond to the community needs. It is critical to ensure all citizens are represented, including women, girls, youth, minority ethnic groups, and disadvantaged members of the community.

Reaffirmed in the HEP optimization roadmap,[54]communities have indigenous knowledge and social structures that can help identify issues and solutions related to poor health. With resources and various models to guide community engagement, the Empowered Communities Activity will aim to advance community-driven solutions to improve health and nutrition services and outcomes, including RMNCAH-N services.

Expected Results:

- Increased participation of communities, households, individuals, traditional and religious structures in the design, planning, governance, and delivery of health services.
- Community advocacy skills and demand for health services improved.
- Inclusion and participation of marginalized and underserved groups in community health governance and leadership structures increased.
- Increased participation of women (recent mothers) in decision-making forums (i.e., community-facility forums) to drive improvements in RMNCAH-N services

Illustrative Indicators:

- Number of communities members who are aware of community-facility platforms available to voice issues/provide feedback

- # of community-facility platforms/dialogues that directly address issues raised by community **AND** develop an action plan for response

IR 2. Advocacy capacity of NSAs for accountability, transparency, and responsiveness of the health system strengthened

Driving increased community ownership and accountability for health services will require the involvement, partnership and mentorship by NSAs to help build various technical, advocacy, literacy and organizational/structural functional capacities of communities, community platforms and various stakeholders. Additionally, NSAs can play a critical role in social accountability interventions which aim at fostering engagement and collaboration among community members, service users, providers, and officials to respond to community health services needs.

Therefore, this result will focus on identifying, strengthening and funding NSAs to work directly with community members, platforms and health service providers and health facility leadership to identify issues for resolutions and implement solutions for collaborative change.

Capacity strengthening needs to be intentional—requiring humility, thoughtfulness, planning, investment, and sustained commitment from all parties—and it requires resources in commitment, time, expertise, and funding.

[54] A Roadmap for Optimizing the Ethiopian Health Extension Program 2020 - 2035

This result will build the capacity of NSAs towards improving engagement, ownership and functionality of community systems/platforms to drive greater social accountability and ultimately improved health outcomes in target communities.

In Ethiopia, NSAs, including CSOs and other community structures, such as community-based organizations (CBOs) and faith-based organizations (FBOs) can effectively broker such discussions to improve community engagement but have limited opportunities to meaningfully engage in advocacy and community outreach given the primary focus on government structures.

Expected Results:

- NSAs' capacity for community mobilization and engagement enhanced [for improved demand for and utilization of RMNCAH-N services].
- CSOs' capacity for advocacy enhanced to improve the local health system accountability and responsiveness.
- Solutions that local communities have identified are implemented and collectively monitored, with adaptations as needed

Illustrative Indicators:

- CBLD-9: Percent of USG-assisted organizations with improved performance
- % of USAID-supported local partners using client or constituent feedback to improve program reach, coverage, or effectiveness.
- % of USAID-supported local partners using data generated through their monitoring systems to fine-tune activities or strategies.
- X Ethiopian birr mobilized (from local resources) for implementation of locally identified solutions.

IR 3. Accountability systems and platforms strengthened to improve the health outcomes including RMNCAH-N

Many elements of health systems in most countries are run by state actors, including Ethiopia. Holding these actors accountable and making them more responsive to the needs of the citizens they serve has significant potential to affect the delivery of health services[55]. Social accountability is widely understood to be one way that citizens can hold state actors accountable for their actions (or lack thereof).

Over the past decade, there has been a growing consensus that stronger accountability mechanisms are critical for improving health outcomes including the RMNCAH-N. Without improved local accountability, many other health investments are likely wasted. The structures to support social accountability are frequently in place but are badly neglected[56]. System-level accountability is complex

[55] The Health Systems Strengthening Accelerator: Improving Linkages between Social Accountability and Social and Behavior Change:2020.

[56] Strengthening social accountability in ways that build inclusion, institutionalization, and scale: reflections on Future Health System experience,2020

with multiple actors influencing the system performance. As a result, accountability requires the collaboration with different stakeholders at community level (health and non-health actors).

USAID/Ethiopia previously approached health from supply/demand perspectives, with a strong supply-side emphasis, aligned with the GOE at all levels. While these elements still exist, efforts to improve quality require improved supply-side accountability. By including the principle of agency of communities and individuals to determine their own health care, rather than to be seen as passive recipients of services, and by building platforms and mechanisms through which public health providers can engage with and be accountable to the communities they serve. By doing so, this activity will accelerate efforts to sustain quality health service delivery including the utilization of RMNCAH-N services.

Leveraging NSAs can also contribute to accountability by encouraging community organizations to broker health system accountability towards increased community trust, expanded access to and utilization of quality health services, increased transparency for public sector planning and execution, and increased sustainability.

This IR will strengthen existing advocacy platforms for dialogue, information exchange, participatory and inclusive decision making.

IR 3.1 Strengthened community structures

Ethiopia's societal cohesion mostly relies on different community structures or platforms. If utilized appropriately, the community structures can bridge the ongoing dialogues between local health systems and community members to instill mutual trust and shared objectives for quality health services. Both formal and informal community structures, when valued and effectively used, can amplify community-based health services, support practices to identify, refer, and care for sick individuals, and encourage inclusion and participation. Through a variety of platforms, community organizations[57] can motivate community members and households to take responsibility for their own health.

Community structures or platforms that are valued by the community drive volunteerism and trust. Community organizations are essential levers to mobilize human capital, and advocate for and ensure fair treatment and roles for members. The potential of men, youth, religious leaders, community elders and other community structures such as Idir and other similar structures have been overlooked because of reliance on W/HDA structures[58]. Thus, this activity will strengthen existing and new community structures, so communities increasingly own their health and health-related decisions. Successful community social accountability platform models will inform interventions for HEP optimization strategies. This activity will contribute to increased community mobilization, capacity building for community structures, and harness local solutions to community issues to improve the health outcomes including RMNCAH-N.

Expected Results:

- Improved community structure functionality and coordination in order to synthesize and act on

[57] *Community organizations is a general term, which could encompass any organization with a desire to equitably serve their community. The Empowered Community Activity intends to work with organizations that already exist, and the type of organization that is used may vary. These organizations could be completely voluntary or could be more formal organizations with salaried staff. Examples could include NGOs, Village Savings and Loans Associations, Mother's Groups, Health Governance Boards (for CBHI), or Adolescent Youth Clubs.*

[58] A Roadmap for Optimizing the Ethiopian Health Extension Program 2020 - 2035

community identified health priorities and solutions.

- Improved community mobilization capacity among community platforms/structures to evaluate and develop improvement plans for the physical, financial, and sociocultural accessibility of health services.
- Increased community engagement to improve dialogues on health issues including RMNCAH-N.
- Improved use of community platforms to generate local solutions and innovations for health problems.

Illustrative Indicators

- % community/HF catchment areas that have functional mechanisms for engaging communities (especially women and marginalized groups) in the design, implementation and monitoring of RMNACH service delivery
- % women and/or marginalized groups in targeted area who participate in functional accountability mechanisms
- % of clients/community members within the catchment area of health facility that report improved quality of care that is respectful and responsive to their family planning needs

IR 3.2. Accountability mechanisms improved

Efforts to integrate accountability and feedback mechanisms into community health processes and frontline service delivery have shown promising results for improving quality and participation. For example, community structures can be used to improve communication and to allow for better feedback and accountability at local levels. However, accountability, as governance, needs to be operationalized at multiple levels, and there is a need for vertical integration of accountability throughout the health system levels.

A study conducted in 2021 indicated that increased use of MNCH services resulted from CSC use[59]. Accountability approaches drive intermediate changes, such as improved transparency, efficient resource use, citizen empowerment, and improved perceptions of health services - all of which contribute to better health outcomes. Hence, this activity will strengthen (and explore additional contextually appropriate) social accountability mechanisms and feedback loops that can ensure the health system remains accountable and responsive in advancing health outcomes including RMNCAH-N.

Expected Results:

- Improved implementation of social accountability mechanisms & approaches.
- Feedback mechanisms routinely used and institutionalized to enhance accountability for health service quality.

[59] Mesele D. Argaw et al, Implementing a Social Accountability Approach for Maternal, Neonatal, and Child Health Service Performances in Ethiopia: A Pre-Post Study Design; Global Health: Science and Practice 2021 | Volume 9 | Number 1, pp 123-135,https://www.ghspjournal.org/content/9/1/123

- Increased implementation of joint community-facility actions to drive greater accountability for delivery of quality RMNCAH-N health services.

Illustrative Indicators:

- % of patients who report quality of health services are respectful and responsive to their needs.

IR 3.3. Community & health system partnership strengthened to ensure high quality health services, including RMNCAH-N services

Engaging communities in health facility management and monitoring can effectively increase health system responsiveness[60]. Linking community and service delivery interventions will systematically engage communities to drive a cycle of health system responsiveness. Multiple quality improvement initiatives have been implemented in Ethiopia; however, lack of coordination and partnership have undermined the efforts. This result will seek to strengthen functional and sustainable partnerships between the community, NSAs and and the local health systems to promote joint ownership and oversight of the health system.

Communities, NSAs and service providers will engage in constructive dialogues and joint action planning to meet community health needs. Strengthening leadership, management, and governance capacities of NSAs, community structures, kebele officials, healthcare providers, and community actors and groups will increase their ability to effectively plan, implement, fund, manage and monitor quality in local health services and systems. These entities would ideally actively exchange inputs and feedback, and also share accountability in ensuring quality services and systems. This sub-IR will support enhancing the partnerships among local health systems, communities and CSOs for increased mutual responsiveness and accountability towards improved quality and utilization of health services including RMNCAH-N.

Expected Results:

- Improved trust in the health system among community, providers and local government health authorities.
- Promote transparency and openness of the health system using various interfaces between the community and the health system
- Joint planning, implementation and monitoring of the health services by community, CSOs and health managers.

Illustrative Indicators:

- Percent of USAID-supported local partners/community structure targeted working collaboratively with local governance structure on determining locally identified solutions
- % of joint planning and dialogues that discuss how to mobilize new resources or identify redistribution of available resources to fund local solutions
- Number of joint planning meetings conducted

[60] Feasibility, acceptability, and initial outcome of implementing community scorecard to monitor community level public health facilities: experience from rural Bangladesh; 2020.

Special and Optional IR 4. Increased delivery of quality RMNCAH-N services through local NSA managed health facilities

A priority under the HSTP II is to improve health outcomes by increasing the access and quality of comprehensive health services. This sub-IR will be aligned in improving access to quality RMNCAH-N services through NSA managed health facilities. This activity will support the NGO health facilities to provide comprehensive and essential RMNCAH-N services to the community. This is an optional result. When the full solicitation goes out publicly, offerors can choose to submit applicants that include proposed strategies and solutions to reach this Special and Option Result 4. While an organization will be penalized for not opting to submit an application to address this result, applications that do include solutions for this result will get additional points on top of the total points possible. Offerors can propose to either build up the capacity of existing NSA owned and or managed facilities to deliver existing or expanded services (including sustainable solutions that can continue after USAID funding ends) or propose solutions to develop new NSA managed RMNACH services i.e. through static, mobile or hybrid approaches. Clients should have a choice on when, where and to whom they seek services.

Expected Results:

- Improved leadership and management skills of local NSA health facility managers
- Improved technical capacity of local NSA to provide essential RMNCAH-N services
- Improved readiness NSA operated services outlet to provide quality RMNCAH-N
- Enhanced integration of NSA operating RMNCAH-N services in the national health system

Illustrative Indicators:

- Increased proportion of local NSA health facilities that consistently use the standards of care for all RMNCAH-N thematic areas
- HL.7.1.2 Percent of USG assisted service delivery sites providing FP counseling and/or services
- HL 6.3.63: Number of newborns who received postnatal care within two days of childbirth in USG supported program

6. SUBGRANTS

This Activity will focus on strengthening local community health systems and support local leadership to improve community engagement to ensure better quality of care and sustainability of advocacy efforts. In alignment with USAID's Localization Agenda[61] and its New Partnerships Initiative (NPI), local capacity development and diversification of local partners are an Agency priority. Various models and approaches exist in order to facilitate capacity building and identifying local and diverse partnerships.

In line with the Agency's Localization Agenda and its New Partnerships initiative, USAID/Ethiopia seeks to expand and diversify its pool of partners for collaboration both as resource and implementing partners, including new, underutilized, and non-traditional local organizations. Therefore, the Recipient should integrate subgrant awards for local organizations to ensure local ownership, sustainability in implementing this Activity. Technical area sub-grants should be considered based on past experience on local solutions and innovations in implementing specific health elements (e.g., social accountability, RMNCAH-N) at community level. Hence, for the purposes of this program description, 'local

[61] https://www.usaid.gov/locally-led-partnerships

organization' is defined as follows for Applicants to inform local consortium member or subgrantee selection:

- A local organization exists as a non-governmental, non-partisan, entity established under the laws of Ethiopia by at least two or more Ethiopians or by lawfully admitted permanent residents in Ethiopia or both, on a voluntary basis and registered with Agency for Civil Societies Organizations to carry out any lawful purpose.

- The Applicant must submit supporting documentation within its application as evidence that the proposed organization meets the criteria listed below at the time of application:

    - Is incorporated or legally organized under the laws of and has its principal places of business in Ethiopia.

    - Currently exists (or has willingness to establish presence) in at least one of the four regions targeted for this Activity - Amhara, Oromia, Sidama or SNNP.

    - Is 75% beneficially owned by citizens and/or lawfully-admitted permanent residents of Ethiopia.

    - Where the organization entity has a board of directors, at least 51% of the board members must also be citizens and/or lawfully-admitted permanent residents of Ethiopia.

    - Is not controlled by a foreign entity or by an individual or individuals who are not citizens and/or lawfully-admitted permanent residents of Ethiopia.

        ➢ The term "controlled by" means a majority ownership or beneficiary interest as defined above, or the power, either directly or indirectly, whether exercised or exercisable, to control the election, appointment or tenure of the organization's governing body by any means, e.g., ownership, contract or operation of law. "Foreign entity" means an organization that fails to meet any part of the "local organization" definition outlined above.

- Past technical experience on local solutions and innovations in health advocacy and/or implementing specific health elements within RMNCAH-N services at community level.

- Has not received USD 500,000 or more in USAID funding (either from the country mission or Washington headquarters) as a prime and/or subgrantee over the last two years (2020-2022). However, for IR 4. exceptions on this dollar threshold (USD500,000/year) will be waived for local organizations that are considered under IR 4. The threshold remains in place for local organizations that will receive sub-grants to support implementation of IRs 1-3.

Applicants are also expected to give high consideration to youth-led and/or women-led organizations which satisfy the requirements outlined above.

Applicants can propose up to 50% of the total number of local organizations that will be funded under this award. The remaining 50% of local awards will jointly be decided with USAID after award.

Cross-Cutting (CC) Results:

CC IR 1. Greater understanding and visibility of NSA and community contributions to health sector

The contribution of NSAs including CSOs, FBOs, and community structures may not be well documented and meaningfully communicated to leadership within and outside the health sector. Therefore, the full value and meaningful contributions of these NSAs are often not seen or understood. Therefore, the applicant should propose solutions to support greater understanding and visibility of NSAs and community structure contributions.

Expected results:

- Data system and indicators (or baselines, mid-term, end-line) developed to document community contributions to RMNACH service improvement/delivery
- Increased forums to directly communicate NSA and community contributions to local, woreda, regional and national health sector leadership

Illustrative Indicators:

- # of health sector leaders that understand activities and results of NSAs and communities supported to improve quality and or delivery of RMNACH services

CC IR 2. Greater leadership, visibility and voice of women in delivery and accountability of RMNACH services

This activity will focus on strengthening understanding, ownership, accountability and quality of RMNACH services. Therefore, having women at the center of all solutions is critical including having women in leadership positions/roles to advocate for other women, bring their experiences (visibility) and voice to drive solutions is critical. This activity should identify opportunities and solutions to strengthen women and girls involvement in decision making that affects how RMNACH services are delivered or adapted.

Expected results:

- Increased voice of women in community forums
- Increased women leaders in advocacy and social accountability activities

Illustrative Indicators:

- # of women in leadership roles in community dialogues/community-facility forums

7. SUSTAINABILITY

Overall, it is expected that by the end of Year 3, a certain proportion of local partners/NSAs funded under this award can be potentially transitioned from funding under this award (no future sub-award through this mechanism) or to direct awards with USAID/Ethiopia, other donors or through local resource development, where appropriate and feasible.