



Access to Social Protection

by PLHIV and Key Groups

**A research report prepared for the
Community of Practice on HIV and
Livelihoods in Ethiopia**

**STOP
AIDS
NOW!**

Colophon

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The study 'Access to Social Protection by PLHIV and Key Groups' is part of the Linking & Learning project of the Community of Practice on HIV and livelihoods (CoP) in Ethiopia, supported by STOP AIDS NOW!

COP members: Action for Self-Reliance (AFSR), ComunitàVolontari per Il Mondo (CVM Ethiopia), Dorcas Aids International Ethiopia, Hundee Grass Root Development Initiative (Hundee), Integrated Service for AIDS Prevention and Support Organization (ISAPSO), Jerusalem Children and Community Development Organization (JeCCDO), Meserete Kristos Church Relief and Development Association (MKC-RDA), Network of Networks of HIV Positives in Ethiopia (NEP+) and Organization for Social Services for AIDS (OSSA).

The CoP is offering social protection programmes to people living with HIV, people at high risk of HIV (like sex workers, housemaids) and people affected by AIDS (like orphans, vulnerable children, widowed households).

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Summary

Effective social protection is vital to reducing the disadvantages and inequalities that make people vulnerable to HIV infection, enabling PLHIV to live healthily and profit from treatment, and mitigating the impact of HIV and AIDS on households. The Community of Practice (CoP) on HIV and Livelihoods, a collaborative initiative among 9 Ethiopian non-government organisations (NGOs) commissioned this study to understand the extent to which clients of its programs are able to access and benefit from Ethiopia's social protection programs.

The study compares the experience of four groups:

- People living with HIV (PLHIV)
- Members of key groups (MKG) i.e. people at high risk of HIV, such as housemaids and sex workers, and people affected by AIDS, such as OVC and widow-headed households
- People with disabilities (PWD)
- People not living with HIV or major disabilities (PNHD).

The first two groups are typically the clients of CoP partners, the second two groups are comparators whose experience is important to capture. Study participants were recruited from the clients and non-clients of CoP partners working in four sites: Addis Ababa-Bole (a large city), Goba (a large rural town), Debre Eliyas (a smaller rural town) and Fincha (a sugar plantation and adjacent town).

We used a survey questionnaire in particular to gain quantifiable information on knowledge of and access to social protection programs provided by the state, CoP partners, other NGOs and community institutions.

Focus Group Discussions (FGD) were used to gather qualitative information regarding knowledge of and access to these programs, the obstacles encountered and ideas on improving effectiveness and equity. We also asked what they knew of the Citizens' Charter (CC), part of the civil service reform introduced in 2012 and designed to improve awareness of available services, increase transparency in their provision and advance accountability.

In key informant interviews, we sought the views on these and related issues of the staff of government agencies and CoP partners and local government officers involved in administering these programs.

The sample included 304 survey respondents (83% women), 123 focus group participants (76% women) and 52 interviewees from state agencies, local government and CoP partners (40% women). The unbalanced gender distribution in survey and FGD participants reflects the bias for women in CoP and NGO programs. Thirty-eight percent of survey respondents were clients of the CoP or other NGO programs; many of these were also members of a group or association that these organizations facilitated.

The study's findings are summarized under its five key questions.

What are the social protection programs that are available and for which PLHIV and key groups are eligible?

The state-administered social protection programs are largely similar across the sites: Provision of Basic Social Services, Support to Vulnerable Children, Support to Persons with Disabilities and Employment Promotion. NGOs such as the CoP partners broaden the services available under these programs although unevenly across sites. They also complement support provided by community institutions such as *iddirs*¹.

PLHIV and other groups are in principle eligible for all programs for which they meet the entry criteria.

In some sites, CoP partners are expanding the coverage of Government programs such as paying the medical costs of PLHIV and MKG under Basic Social Services.

¹ A neighbourhood or village association for mutual assistance which provides support in the form of loans or grants in times of hardship or emergency, including to the family of a deceased person.

To what extent are PLHIV and key groups actually accessing these social protection programs?

Respondents know of a relatively large number of the potentially available programs. Some know of programs, such as Food Security, that are not yet implemented in their area, suggesting that people are hearing about programs through other than official channels.

Along the sequence from knowledge of programs to obtaining support from them, the largest gap occurs between the number of programs respondents believe they are entitled to and the number they attempt to access support from.

PLHIV generally know of and obtain support from more programs than other groups. Considering Government, NGO and community-led programs, on average, PLHIV obtain support from 2.0 programs, PWD from 1.3 programs and MKG and PNHD from 0.9 programs. Broken down by site, respondents on average obtain support from 1.6 programs in Goba, 1.5 programs in Debre Elias, 1.2 programs in Addis Ababa-Bole and 0.6 programs in Fincha. Across all groups and sites, respondents obtain support from 1.3 programs on average.

Access to social protection appears to be very unequally distributed. Among all respondents, 37% do not receive support from any program, whoever the provider. Among MKG, the proportion rises to 54%.

The factor having the greatest influence on the number of programs a respondent obtains support from is being a client of a CoP partner's programs (often this involves membership in a facilitated group or association). This differential, the "membership advantage", is greatest for MKG and least for PLHIV. MKG who are clients obtain support on average from nearly 8 times as many programs as a non-client; for PLHIV the ratio is 1.7 times and for PWD and PNHD, it is approximately 3 times.

Non-clients of the CoP partners have access primarily to Government-run social protection programs. They obtain support from 0.73 programs on average, a third as many as CoP clients (2.1 programs). This support is even more unequally distributed than among all respondents: 57% of non-CoP clients receive no social protection support. Among MKG, the proportion is 85%.

We estimate that approximately a quarter of non-CoP clients are accessing support from other NGOs. If these respondents are excluded, those remaining, who have access only to Government programs, could be accessing as few as 0.23 programs on average, depending on the assumptions made, and the proportion without access to any social protection support would be greater.

In all groups, Employment Promotion, Provision of Basic Services, Urban Housing and Support to Vulnerable Children are among the most accessed programs. Surprisingly few respondents (3%) have obtained support from Community-based Social Protection.

What are the obstacles PLHIV and key groups face in accessing social protection programs?

Some factors affect access for all:

- Lack of information about programs and how to approach them is the most commonly cited obstacle.
- Programs like the Food Security Program, which respondents believe they are entitled to and for which they express a keen need, are not available in any of the sites.
- The medical fee waiver program is so limited in its implementation in some sites as to be effectively unavailable.
- What focus group participants and key informants see as unrealistic eligibility criteria limit access to several critical programs:
 - Livelihood Strengthening and Employment Promotion are often unavailable to men and women without children.

- Not being among the “poorest of the poor” is an exclusion criterion for several social protection programs. This is being interpreted so as to exclude people who have managed to accumulate productive assets that place them incrementally above that level, thereby penalizing initiative and undermining social protection’s promotive goal.

Three factors are found to underlie the membership advantage in access:

- More programs are available to the clients of a CoP partner or other NGO.
- Where both Government and NGOs are providing ostensibly similar services, those provided by the NGO may, for a number of reasons, be more accessible and attractive. Focus group members point to the more effective training and follow-up.
- Clients of an NGO’s programs are more successful in accessing Government programs even in areas of social protection in which the NGO is not itself active. Contributing to this are reliable information on available services the NGO provides, together with the strength and confidence which members in a group or association of people facing similar challenges often enjoy.

The differences between the four groups in their success in obtaining support appear to result from the selective attention of programs and those administering them. According to key informants, PLHIV, school age OVC and, in some cases, sex workers have benefitted from more consistent attention while younger OVC, the elderly and especially PWD are said to have received less attention, leaving large needs unaddressed. The key informants seldom mention groups such as housemaids who are at high risk of HIV.

Focus group participants describe experiences which confirm this selective attention:

- PWD participants indicate that they have often been met with negative stereotypes when approaching agencies, limiting the support they receive and its quality. Their ideas on how support might be more effectively provided have often gone unheeded. They may be experiencing this selective attention as discrimination.
- PLHIV participants say that while stigma and discrimination against them have declined in the past decade, confirming the findings of other studies, they still prevent some PLHIV from attempting to access programs or to make good use of the support they obtain. However, they are not sufficient to reverse the relative advantage in access PLHIV enjoy.
- The comparatively low levels of support PNHD obtain may reflect that those with particular vulnerabilities, such as living with HIV or disabilities, are being attended to. However, it may also reflect the fact that this group has the lowest level of CoP or NGO clients.

An important structural factor that limits access is that participants in the four groups rarely see the support that social protection agencies or NGOs provide as a right that they can claim. Key informants in CoP partners and government agencies generally see social protection as a right if a person meets the programs’ criteria and some see providing it as their duty, but acknowledge that in a context of limited and uncertain provision, people lack the confidence to press for their rights.

The Citizens’ Charter is being implemented in the four sites: Government informants say awareness is growing though much remains to be done. However, the CC appears to be relatively unknown. None of the focus group participants and CoP staff in only two of the four sites had heard of the CC. While CoP informants recognize the CC’s potential to increase awareness of social protection and to improve accountability, this cannot be achieved if people do not know what entitlements have been confirmed.

Clients surer of their rights and more confident that they will not be penalized if they claim them can contribute to improving access to social protection and the quality of its provision, particularly in situations of severe resource constraint.

How useful do PLHIV and key groups find the social protection programs they are able to access?

More than 65% of respondents who received support said that without it their lives would have been somewhat or a lot worse. Keeping their children in school was the most frequently cited benefit in all four groups; 2/3 of

MKG, which includes OVC, for whom it is particularly important, cited it. PLHIV frequently mentioned maintaining health and nutrition and providing more food, which are critical for people on ART and often a challenge.

A number of women spoke of the skills and self-confidence gained from employment promotion support, and the benefits they derive from membership in a group or association, including solidarity and life skills. Some of their testimony suggests that well-conceived and implemented social protection programs can have transformative effects, altering the risk structures they face, as the National Social Protection Policy envisages.

To what extent do the COP's programs complement those of state social protection and how can that be improved for the benefit of PLHIV and key groups?

For the most part, the relationships between NGOs and government departments appear to involve coordination: avoiding duplication of effort, assisting in recruiting clients and exchanging information. Broader collaboration, involving joint assessment of needs and opportunities, agreement on how the efforts of different organizations can complement each other and joint evaluation and learning is still limited although some CoP and government informants are clearly interested in moving in that direction.

Dorcas in Addis Ababa-Bole provides one such example. They have set up a steering committee for their projects composed of all stakeholders, including government sector offices, local government administrations and community leaders. The committee reviews activities in the past six months and the challenges encountered, then discusses how these problems can be overcome and each other's efforts better complemented.

In Debre Elias, a Community Care Coalition (CCC) has recently been established, governed by a committee composed of community, iddir and religious leaders, together with government officers and kebele administration leaders. It serves as a forum for discussing and coordinating initiatives proposed by NGOs and others, ensuring that limited resources are used equitably and reach those most in need. It is also intended to raise funds for locally initiated efforts however this has been constrained by the limited financial capacity of the community.

Conclusions

Access to social protection programs is very unequal: 37% of respondents and more than half of MKG receive no support from social protection programs, of whatever source. Among respondents who are not clients of CoP partners or other NGOs, who can access only Government programs, at least 57% and more than 85% of MKG receive no social protection support. For all respondents, access to programs such as Medical Fee Waivers is variable and arbitrary. The Food Security program, for which respondents express a keen need, is not being implemented in any of the sites.

While it is important to keep these large unmet needs in view, the achievements the study documents are nonetheless significant. PLHIV, once marginalized and still encountering stigma and discrimination, obtain support from more social support programs than other groups. Moreover, PLHIV that are not clients of the CoP partner's programs – so without the membership advantage – obtain support more frequently relative to clients than do non-clients of any other group. Programs are widely seen to pay greater attention to PLHIV and OVC than to other groups and more so than previously.

This is a partial and relative success but indicates what other groups might achieve through the concerted efforts of a range of actors. The evidence also suggests that the experience of these groups in relation to social protection programs has often been similar and that they have a shared interest in the development of more responsive, coherent and accountable programs. There is an unrealized potential to develop and administer programs that keep in mind the capabilities of groups such as PWD and the elderly and that take account of their ideas on how support can be more effectively provided.

The confidence, practical skills, and links to a range of services that some of the most marginalized people appear to have gained through membership in CoP-facilitated groups and associations appear to have transformed the risk environment they formerly confronted.

Recommendations for research

It is important to examine whether the pattern of selective attention which has worked to the disadvantage of groups such as PWD and the elderly is found in other parts of the country. The reasons for the low levels of access to Community-based Social Support need to be further investigated. The gaps in this study notably with respect to the access to social protection by men and people in rural villages should be filled in.

Research should document and help evaluate institutional innovations such as the CCC and others being explored by CoP partners which aim at improving coordination and advancing collaboration among the providers of social protection services.

Recommendations for policy

Unrealistic eligibility criteria and counterproductive program designs should be reconsidered. In some cases, programs are now excluding people with clear need for support; in others, clients' initiative is being penalized, thereby undermining the promotive objectives of the National Social Protection policy.

Government should explore means to extend the coverage of the food security program and health care waiver provision for which this study has revealed a large unmet demand.

State offices providing social protection services should be vigilant that their selective attention to certain groups does not leave others underserved. The study suggests that this may be occurring with respect to PWD, the elderly, young OVC, the childless poor and people who are not NGO clients. Means to bring these groups up to the level that those benefiting from attention have achieved should be explored.

The Government's Citizens' Charter should be fully implemented, including development of charters at the level of local offices providing social protection services. These are meant to spell out the standards of provision that clients have a right to expect. If widely publicized, these charters will help create an environment in which, more confident of their rights, clients can forthrightly contribute to the progressive refinement of social protection programs.

Institutional innovations such as the Community Care Coalition and others such as those being explored by CoP partners should be promoted and encouraged. They offer means through which the social protection efforts of all providers can be coordinated and adapted to local conditions and opportunities. With effective leadership and the involvement of all stakeholders, including clients, more coherent and equitable provision of social protection can be delivered.

Recommendations for CoP partners and other NGOs

Discuss with clients and local partners the reason for the apparently very limited access to Community-Based Social Support and what can be done to improve on it.

Explore how groups and associations can provide benefits even to non-members, for example in facilitating access to state social protection programs.

Develop and refine coordination and collaborative initiatives with state and community actors providing social protection services.

Increase awareness among staff and clients of the Community Charter and progress in its local implementation.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CC	Citizens' Charter
CCC	Community Care Coalition
CoP	Community of Practice
HIV	Human immunodeficiency virus
ILO	International Labour Organization
MKG	Members of key groups
MoLSA	Ministry of Labour and Social Affairs
MSED	Micro and Small Enterprises Development
PLHIV	People living with HIV
PNHD	People not living with HIV or disabilities
PWD	People living with disabilities
SHG	Self-Help Group
SP	Social Protection

1. Introduction

1.1. Social Protection, HIV and AIDS

The Community of Practice (CoP) on HIV and Livelihoods is a collaborative initiative among 11 Ethiopian non-government organisations (NGOs), established in 2012 and supported by STOP AIDS NOW! It builds on the recognition that many NGOs and micro-finance institutions working in these areas confront similar challenges in designing and delivering effective programs but that the diverse practices they have evolved, largely on their own, have seldom been closely evaluated and that there is therefore much that these organizations can learn together (Loevinsohn, Tadele and Atekyereza 2012). The CoP has pursued this learning objective with a number of methods: a baseline study that gathered information on members' practices and perceptions, experience sharing visits, thematic workshops and research on jointly decided themes. Practice guidelines have synthesized the findings from these methods.

This study of the extent to which the clients of the CoP's programs are able to access and benefit from Ethiopia's social protection programs was one of the priorities partners agreed in 2013.

Social protection has been defined as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalized with the overall objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalized groups." Social protection is more than cash and social transfers—cash, food, vouchers, etc.—it encompasses economic, health financing, insurance and employment assistance to reduce inequality, exclusion and barriers to accessing basic services" (UNAIDS, 2013).

Effective social protection is vital to reducing the disadvantages and inequalities that make people vulnerable to HIV infection, enabling PLHIV to live healthily and profit from treatment, and mitigating the impact of HIV and AIDS on households. Social protection is one of the ten elements in UNAIDS' strategy to achieve the vision of zero new infections, zero discrimination and zero AIDS-related deaths.

The report is structured as follows. The remainder of this introduction presents the study's objectives, outlines the Ethiopian government's policy on social protection, the main programs involved, and points of similarity with CoP programs. It then discusses previous research on access to social protection by people living with or confronting HIV and its consequences and describes the study's design: the core groups it focuses on, the study sites, and key questions.

Chapter 4 outlines the methods used, describes the sampling plan and procedures, deviations from the sampling plan in carrying out the study and analytical approaches.

Chapter 5 first describes the study's participants then reports its findings organized around the five key questions.

Chapter 6 considers the strength and limitations of the study then discusses the findings, again organized by key question. Conclusions and recommendations follow in Chapter 7.

1.2. Objectives

The objectives of the study are:

1. Clarify the opportunities for PLHIV and key groups to benefit from state social protection programs and the obstacles they face in doing so.
2. Compare the experience of PLHIV and key groups with that of people with disabilities and others who are not living with HIV or disabilities.
3. Identify ways in which the COP can improve the livelihoods and wellbeing of their beneficiaries by better aligning their programs with those of the state's social protection and by communicating this study findings to government and civil society .

1.3. The scope of social protection in Ethiopia

What qualifies as social protection in practice is not always clear. Many programs, undertaken by different entities, can have social protection objectives. Crucial however, is how the Ethiopian government understands social protection. In the 2012 draft of the National Social Protection Policy (Ministry of Labour and Social Affairs 2012), the government lists the following as the social protection programs available in the country:

1. **Social Insurance Program:** a contributory pension scheme, limited to employees of government and parastatal organizations. Some private and charitable organizations have their own provisions.
2. **Food Security Program:** which includes:
 - Productive Safety Net Program (PSNP), provides cash or food to chronically food insecure households during lean months in exchange for their labour to build productive assets, as well as direct support to households where no member is able to work.
 - Household Asset Building Programme (HABP) promotes the skills and income of food insecure households, many of whom would no longer be supported by PSNP.
 - Voluntary Resettlement Programme (VRP) enables chronically food insecure households to migrate in order to access land to farm and
 - Complementary Community Investment Programme (CCI) supports capital-intensive community infrastructure to benefit people in chronically food insecure woredas of pastoral, semi pastoral and moisture-stressed highland areas.
3. **Provision of Basic Social Services,** implementing the constitutional provision that all Ethiopians have the right to social services including health care, education and good nutrition, fee waivers, approved by the *woreda* government, are given to many of the most vulnerable to allow them free access to health services related to communicable diseases such as TB and HIV and immunization, maternal and neonatal health care. The Health Extension Programme (HEP) and the associated National Nutrition Program provide free access to EPI, impregnated bed nets, treatment for malaria and for severe malnutrition and pneumonia among young children. Free school feeding is provided to students in six regions where enrolment is low and food insecurity is chronic.
4. **National Nutrition Program** Implemented through the Enhanced Outreach Strategy /Targeted Supplementary Feeding programme (EOS/TSF) is a free service that aims to reduce morbidity and mortality amongst children and lactating mothers screened for acute malnutrition. Since 2008, community therapeutic feeding of severely malnourished children has been implemented by health extension workers. The focus is on strengthening existing community structures – health posts, kebeles and community-based organizations – in order to reach mothers and children.

5. **Support to Vulnerable Children** The Bureaus of Labour and Social Affairs, often together with Bureaus of Women, Children and Youth and with Women's Associations manage programs that target households with children who are defined as vulnerable with micro credit or grants, often together with training aimed at improving the livelihoods of their households. In some regions these bureaus are helping *kebeles* set-up social protection committees that raise resources to implement a *kebele* social protection action plan.
6. **Health Insurance** Community based health insurance (CBHI) is being scaled up and by the end of the 2014/15 financial year was expected to cover about 40 per cent of the population (35 million people).
7. **Disaster Risk Management** The aim is for affected people to receive more predictable and timely food relief. Health and nutrition, water and environmental sanitation, and agriculture and livestock services make up the non-food component of DRM. It also supports early warning, contingency planning and strengthening of institutional capacity. There has been a recent shift to a multisectoral and multi-hazard focused disaster risk reduction strategy.
8. **Support To Persons With Disabilities** This involves an expansion of prosthetic and orthotic services aimed at enhancing access to physical rehabilitation services.
9. **Support to Older Persons** The Ministry of Labour and Social Affairs (MoLSA) coordinates the National Plan of Action for Older Persons, which aims to mainstream the cross-cutting issues of older persons in sectoral plans. However, since the action plan was not budgeted, satisfactory services have not been delivered to older persons.
10. **Urban Housing And Grain Subsidies** Policy aims at improving access for the urban poor to housing by replacing slums with condominiums. City administrations are improving slum areas by building access roads, providing public toilets and improving the public tap water supply. Government is subsidizing grain costs for low income households, reducing taxes on grains, and regulating grain export.
11. **Employment Promotion** Employment creation is at the centre of the country's development strategy. Unemployed persons are being encouraged to start their own businesses. Micro and small enterprises (MSE) are being supported by Technical and Vocational Education Training.
12. **Community-based Social Support** *Iddir* and *ikub* are local institutions, the former providing financial and other support during emergencies, the latter creating a revolving fund that members draw on to build their assets. In rural areas, transferring grain to households experiencing difficulty during the lean periods is also widespread. The formal social protection programs are intended to buttress these informal institutions.

The second draft of the National Social Protection Strategy that appeared two years later in 2014, groups the above set of social protection programs into five main focus areas and presents their effects in relation to the four main objectives of the Social Protection Policy i.e. protection, prevention, promotion and transformation:

	Protection from deprivations	Prevention of deprivations	Promotion of livelihoods	Transformation and empowerment
Focus Area 1: Social Safety Nets	Social transfers improve food security and access to essential services	In case of shocks, social transfers prevent loss of life, catastrophic asset depletion, the irreversible damage caused by infant malnutrition and the separation of children from their families	By enabling productive investments, social transfers promote livelihoods	Social transfers can empower women and vulnerable groups by increasing their control over cash
Focus Area 2: Employment and Livelihoods			Tailored support promotes employment and livelihoods of the poor	Increased implementation of labour standards protects the rights of vulnerable workers
Focus Area 3: Social Insurance		Social insurance prevents/mitigates the negative (and sometimes irreversible) effects of shocks on lives and livelihoods	By enabling households to better manage risks, social insurance enables engagement in activities with higher returns	
Focus Area 4: Access to Health, Education and other Social Services	Fee waivers, health insurance subsidies and social transfers increase access to essential services for the most vulnerable	In the case of a health shock, fee waivers, health insurance subsidies and social transfers prevent loss of life and depletion of household assets	By enabling investment in children's health and education, their long-term productivity is enhanced	
Focus Area 5: Addressing Abuse, Violence, Neglect and Exploitation				By preventing and responding to abuse, violence, neglect and discrimination, the rights of the most vulnerable are promoted

It is important to note that the Social Protection Policy and the Community of Practice (CoP) frame their objectives using the same language. “The Policy envisages providing coverage to broad categories of society that are in need of social protection focusing on the protective, preventive, promotive and transformative actions necessary progressively to fulfil the constitutional requirement of social protection” (Ministry of Labour and Social Affairs 2012) p.16).

These four policy objectives are precisely those that we have used in the Linking and Learning project to review our own programs and to assess the degree of agreement between what they are intended to achieve and what they are actually pursuing.

- Protection - providing relief from deprivation
- Prevention - averting deprivation
- Promotion - enhancing real incomes and capabilities
- Transformation - addressing social inequity and tackling exclusion.

It is also important to note that the people of greatest concern to the Social Protection Policy include the groups the CoP works with (underlined):

“Social protection actions will focus on the elderly, labour constrained individuals and households, people with disabilities, pregnant and lactating women, **persons living with or directly affected by HIV and AIDS** and other chronic debilitating diseases, **vulnerable children**, the unemployed, people affected by natural and manmade calamities and victims of social problems (such as drug use, beggars, victims of trafficking and **commercial sex workers**) and **people having difficulties in accessing basic social services**” (Ministry of Labour and Social Affairs 2012) p.16.

The CoP are themselves providing what should be considered as social protection programs. The fact that the SP Policy and the CoP’s programs share these objectives and priorities suggests that this study should be of great interest to policy makers and those responsible for administering key state programs. Complementarity among social protection providers is a key principle of the SP Policy (Ministry of Labour and Social Affairs 2012) p.22.

1.3.1. HIV and social protection in other countries

The International Labour Organization recently completed a study on access to social protection by PLHIV and key populations in Rwanda, Guatemala, Ukraine and Indonesia (ILO 2014). Among its main findings:

- The number of PLHIV receiving social protection was quite small in three of the four countries, though those who do receive it report generally positive effects.
- The top three barriers to PLHIV’s accessing social protection programs were persistent stigma and discrimination, lack of knowledge amongst PLHIV about the programs and the complicated procedures for accessing them.
- With the possible exception of medical services, social protection access for PLHIV and key populations is wanting in the four countries.

The ILO study emphasized the importance of complementarity among social protection programs in order to address people’s diverse needs and of ensuring that programs are adequately resourced. “It is not only a matter of a sound combination of benefits, but of getting more benefits to reach more of the population in need” (ILO 2014) p.11.

A limitation of the ILO study is that it did not examine the ability of people ostensibly HIV-negative to access social protection programs. As a result, it was not possible to conclude that the obstacles to access for PLHIV that the study revealed were any more severe than those faced by others. The present study attempts to avoid this problem by including three other groups, as described below. Nonetheless, the ILO study provides an important point of comparison for our own study which in turn can contribute to the international evidence base.

1.4. Study design

1.4.1. Core groups

Our study focuses on the experience with social protection programs of four groups. Two of these are groups confronting HIV that CoP partners work with:

- People living with HIV (PLHIV) and
- Members of key groups (MKG) which includes people who are at high risk of HIV, such as housemaids and sex workers, and groups affected by HIV and AIDS, such as OVC and widow-headed households.

We also examine the experience of two groups of ostensibly HIV-negative people:

- People with disabilities (PWD) such as physical or mental challenges and
- People not living with HIV (i.e. who haven't self-identified as being HIV+) or major disabilities (PNHD).

It is important to capture the experience of PWD, firstly because they may also experience stigma and discrimination when attempting to access social protection services and secondly because a significant number of PLHIV themselves live with disabilities. Neuro-cognitive disorders and problems with mobility and other functions are common among PLHIV; many live with more than one disability (Crossley and Brew 2013; Devendra et al. 2013). It is also important to document the experience of PNHD, likely the majority of people seeking social protection services, who may have significant unmet needs.

Being able to assess how common the obstacles to social protection access are will affect the acceptance of any recommendations offered. If the obstacles are widely experienced and observed, it will be easier to build a broad consensus, within and outside government, in support of needed change.

1.4.2. Study sites

Four sites were selected in the operational areas of four CoP partners with the aim of having as diverse a range of social and economic environments as possible (Table 1). They include a large city, a larger and a smaller town and a sugar plantation and town with high migration rates. Programs aimed at different groups are being implanted there by the CoP partners.

Table 1. Summary of research sites

Research Site	Focus of intervention	Focal Organization (COP partner)	Site Location	Site Setting
Site 1	Highly vulnerable children project	HUNDEE	Goba Town, Oromiya Region	Large town (32,000 – 2005) in a “food surplus” agricultural area
Site 2	Housemaid support groups, Bar-workers support groups	CVM	Debre-Elias, Amhara Region	Small rural town in a “food surplus” area
Site 3	HIV and livelihoods – PLHIV, OVC and poor women	MKC-RDA	Fincha, Oromiya Region	Large factory and plantation. Workers live on-site, others in the nearby town
Site 4	HIV and livelihoods – PLHIV, OVC and poor women	Dorcas Aid International Ethiopia	Addis Ababa: Bole sub-city, woreda 13	High density urban area

1.4.3. The Citizens' Charter

We also set out to examine whether the Citizens' Charter (CC), released by the Ministry of Civil Service in 2012 as part of a wide-ranging civil service reform program, is influencing the provision of social protection services and people's understanding of their entitlements in relation to social protection. Each government office or agency at the various administration levels is expected to produce its own CC which will specify the services it delivers, the conditions clients need to meet in order to obtain these services, the expected quality of services delivered, and the complaint mechanisms should clients be dissatisfied with what they receive (Fekadu 2014).

The CC was designed to improve effectiveness and efficiency in the delivery of services and to increase the public's awareness of the services available to them. In launching the CC, the Civil Service Minister said that it will ensure Government's accountability to the public and improve openness and transparency (Ethiopian Herald 2012). The extent to which this has been achieved is not clear. A review published in 2013 found that despite the trainings on the CC concept for officials at several levels, implementation had lagged (Nigussa 2013). Our study can provide a current picture of progress in implementing the CC, the perspectives of different actors on the effect it is having on social protection provision and their views on its potential.

1.5. Key questions

- What are the social protection programs, provided by state and non-state actors, that are available and for which PLHIV and key groups are eligible?
- To what extent are PLHIV and key groups actually accessing these social protection programs?
 - How does access vary by gender, rural and urban environment and among PLHIV and key groups?
 - Are members of these groups who participate in COP programs also better able to access the state's social protection programs?
 - How does their ability to access these programs compare to that of eligible PWD and PNHD?
 - How does their ability to access these programs compare to the standards contained in the Citizens' Charter?
- What are the obstacles PLHIV and key groups face in accessing social protection programs?
 - How do they compare to the obstacles faced by eligible HIV-negative people?
- How useful do PLHIV and key groups find the state social protection programs they are able to access?
 - Do people at high risk of HIV find they are better able to avoid infection?
 - Do people living with the consequences of HIV find they are better able to avoid impoverishment?
 - Are PLHIV better able to maintain health and strengthen livelihood?
- To what extent do the COP's programs complement those of state social protection and how can that be improved for the benefit of PLHIV and key groups?
 - Are CoP members facilitating access to state programs e.g. by improving awareness and information?
 - Are CoP members aligning their programs to fill gaps in the provision of state programs

2. Methodology

2.1. Participant selection and field methods

We sought the views of the four core groups PLHIV, MKG, PWD and PNHD and of the staff of government agencies, local government officers and CoP staff involved in implementing social protection programs. We asked these groups related questions on key issues in order to develop a coherent understanding of their perspectives and enhanced the validity of our conclusions by using complementary quantitative and qualitative methods.

Participants were selected by the CoP partner organization in collaboration with local government bodies such as kebele administrations and woreda offices following clear selection guidelines which were communicated in advance of the fieldwork and discussed further when we arrived. The people thus identified were recruited by the local community facilitators or volunteers with whom the CoP partners work.

For PLHIV and MKG, we aimed at roughly equal numbers of clients and non-clients of the organization's programs, of similar age and socio-economic status. The same procedure was followed for PWD and PNHD where the partner organization had programs with these groups. Where they didn't, participants were selected of similar age and socio-economic status as the PLHIV. Some of the PWD and PNHD participants who were not clients of a CoP partner may have been clients of programs organized by other NGOs or churches. However, we did not ascertain this.

Clients of an organization's programs, whether those of a CoP partner or not, are often assisted in forming a group such as a Self-Help Support Group (SHSG) or an association. While all members of such a group or association are clients of an organization, not necessarily all clients are members but we did not distinguish between the two.

Note that in what follows, the terms "member" and "client" are used interchangeably.

We aimed to conduct 20 individual interviews and one FGD (8-10 participants) with each of the four core groups in each of the four sites. Deviations from the plan in conducting the study are discussed below.

2.1.1. Survey

We used a **survey questionnaire** in particular to gain quantifiable information on knowledge of and access to social protection programs. The programs we asked about were the 12 included in the National Social Protection Policy ([above](#)) plus "other programmes" implemented by non-state actors, in particular the CoP partners. Discussions with key informants clarified which programs were locally available and what services they provided.

By asking respondents which social protection programs they had heard of, believed they were entitled to, had attempted to access and had succeeded in obtaining support from, we could locate at what step respondents and different groups encountered the largest obstacles to access, for example in terms of knowledge of available programs, problems "getting to the door" or problems "once through the door" of the agencies or organizations administering the programs. We also asked about the benefits respondents had gained from the support they had obtained and the difference this had made for them and their families.

Table 2. Number of survey participants (number of women)

Category	Goba	Debre Elias	Fincha	Addis-Bole	Total
People living with HIV	22(18)	20(15)	20(17)	20(20)	82(70)
Clients*	14(13)	9(6)	9(8)	12(12)	44(39)
Non-clients	8(5)	11(9)	11(9)	8(8)	38(31)
Members of key groups	19(18)	18(18)	14(9)	19(17)	70(62)
Clients*	5(4)	11(11)	3(0)	12(10)	31(25)
Non-clients	14(14)	7(7)	11(9)	7(7)	39(37)
People with disabilities	19(12)	19(14)	14(6)	1(1)	53(33)
Clients*	13(9)	0(0)	1(1)	1(1)	15(11)
Non-clients	6(3)	19(14)	13(5)	0(0)	38(22)
People not living with HIV or disabilities	23(21)	27(24)	23(17)	26(24)	99(86)
Clients*	17(16)	3(3)	2(1)	4(4)	26(24)
Non-clients	6(5)	24(21)	21(16)	22(20)	73(62)
Total	83(69)	84(71)	71(49)	66(62)	304(251)
Clients*	49(42)	23(20)	15(10)	29(27)	116(99)
Non-clients	34(27)	61(51)	56(39)	37(35)	188(152)

* Clients of the CoP partner

2.1.2. Focus Group Discussions

We led **Focus Group Discussions** to gather qualitative information regarding access to the social protection programs that are locally implemented, the obstacles encountered and ideas on improving effectiveness and equity. We asked how participants understood their rights as regards social protection and what they knew of the Citizens' Charter.

We also conducted five unstructured interviews with a few selected participants from among people encountered during individual interviews or FGDs whose experiences with regard to social protection were illustrative or particularly striking.

Table 3. Number of focus group participants (number of women)

Category	Goba	Debre-Elias	Fincha	Addis-Bole	Total
People Living with HIV	8(5)	9(5)	9(5)	8(8)	34(23)
Members of Key Groups	8(8)	8(8)	6(5)	8(8)	30(29)
People with Disabilities	5(4)	9(5)	5(2)	8(8)	27(19)
People not Living with HIV or Disabilities	9(5)	6(3)	9(6)	8(8)	32(22)
Total	30(22)	32(21)	29(18)	32(32)	123(93)

2.1.3. Key informant interviews

In each of the four sites, we conducted semi-structured **Key Informant Interviews** with staff of the below listed organizations who are implementing or involved in social protection programs. We used these to gather qualitative information on the social programs available in the area, to pursue key issues that emerged in the FGDs and individual interviews and to seek their views on the prospects for improving collaboration between Government, community and NGO-led social protection programs.

Key Informant Selection List:

- Organization staff (COP partner selected for the study)
- Representatives of woreda level Micro and Small Enterprises Development agencies
- Representatives of Kebele/woreda housing administration and development offices
- Representatives of woreda HAPCOs
- Representatives of woreda Women, Children, and Youth Affairs (WCYA) offices
- Representatives of woreda health offices and kebele health extension workers
- Representatives of woreda education offices
- Representatives of local Associations of PLHIV and PWDs
- Heads of Woreda and Kebele administration offices
- Leaders of community organizations and association such as iddirs

Table 4. Key informant interviews with staff of CoP partners and local government and community organizations (number of women)

	Goba	Debre-Elias	Fincha	Addis-Bole	Total
CoP partner	7(1)	2(1)	2(1)	4(3)	15(6)
Local Government and Community Organizations	9(5)	12(3)	11(4)	5(3)	37(15)
Total	16(6)	14(4)	13(5)	9(6)	52(21)

2.2. Deviations from sampling plan

We were able to conduct as many focus group discussions, key informant and in-depth interviews as planned. The sample of PLHIV and PNHD in the survey attained the 20 per site that we had aimed at. This target was almost met for MKG and PWD in Goba and Debre Eliyas and for MKG in Addis Ababa-Bole and at 70% for both groups in Fincha. The only serious shortfall was for PWD in Addis Ababa-Bole where only one respondent could be reached in the time available. We used robust methods which can accommodate this imbalance in the statistical analysis and point out where this shortfall may affect our findings and their interpretation.

We had planned to include roughly equal numbers of men and women in our study but despite our efforts, women make up 83% and 76% of survey and FGD participants, respectively. In Addis Ababa-Bole, the proportions reached 94% and 100%. This is primarily because we sought the assistance of CoP partners and government line agencies in recruiting participants and both target women in their programs, in some cases exclusively so. We discuss how this may affect our findings and conclusions.

2.3. Data Analysis

Quantitative data from the individual interviews was coded and entered in IBM Statistics SPSS (Ver 20). We used analysis of variance and generalized linear mixed models to assess differences in the number of social protection programs people access and the rates with which they attempt to and succeed in accessing these programs. Qualitative data from the FGDs, KI interviews and in-depth interviews were transcribed and analysed systematically in relation to themes based on the study's key questions.

3. Results

3.1. Characteristics of participants

About half (47%) of our survey participants are in the 28 – 37 age range, and 79% of them have had limited or no formal education: 38% have never attended school while 41% have not completed primary level education (Table 5).

Table 5. Participants' characteristics

	N	Female (%)	Age (% of respondents)							Highest level of education (% of respondents)				
			< 18	18-27	28-37	38-47	48-57	58-67	≥ 68	Never attend-ed school	Primary	Secon-dary	Tech-nical / voca-tional	Uni-versity
PLHIV	82	85.4	0.0	18.3	43.9	20.7	13.4	3.7	0.0	45.1	30.5	22.0	1.2	1.2
MKG	70	88.6	12.9	44.3	34.3	5.7	2.9	0.0	0.0	30.0	51.4	15.7	2.9	0.0
PWD	53	62.3	13.2	20.8	26.4	15.1	11.3	3.8	9.4	30.2	39.6	22.6	5.7	1.9
PNHD	99	88.7	2.0	17.2	34.3	26.3	9.1	10.1	1.0	40.4	43.4	15.2	1.0	0.0
N	304	251	18	89	144	72	39	18	6	114	125	56	7	2

Most respondents (71%) are currently economically active; of these, almost 90% are either self-employed or informally employed (Table 6). Note that of the 19 people employed in private enterprises, 11 are day labourers hired by the Sugar Factory in Fincha. The main means of livelihood cited by respondents are illustrated in Fig. 1.

Table 6. Employment situation of participants

	Economically active (%)	Self-employed		Formally employed		Informally employed (including daily labour, domestic work, and sex work)
		Self-employed (paid)	Working in one's home (unpaid)	Government employed	Private enterprise employed	
PLHIV	69.5%	56.1%	3.5%	1.8%	3.5%	35.1%
Clients	70.5%	48.4%	3.2%	3.2%	0.0%	45.2%
Non-clients	68.4%	65.4%	3.8%	0.0%	7.7%	23.1%
MKG	84.3%	25.4%	0.0%	0.0%	13.6%	61.0%
PWD	43.4%	66.7%	0.0%	4.2%	8.3%	20.8%
PNHD	77.8%	62.3%	0.0%	0.0%	9.1%	28.6%
N	216	111	2	2	19	82

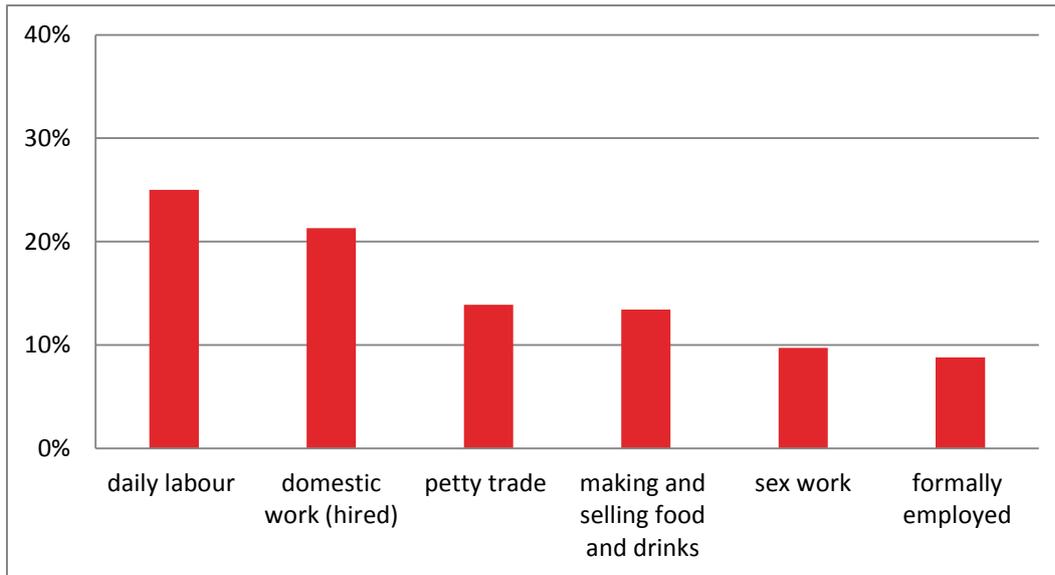


Figure 1. Most frequently reported means of livelihood among economically active respondents (N=216).

Figure 2 shows the marital status of survey respondents. The composition of PLHIV and PNHD is similar: most are married with substantial proportions widowed or divorced. MKG and PWD are dominated by single persons. As Fig. 3 illustrates, the majority of respondents in all groups are household heads.

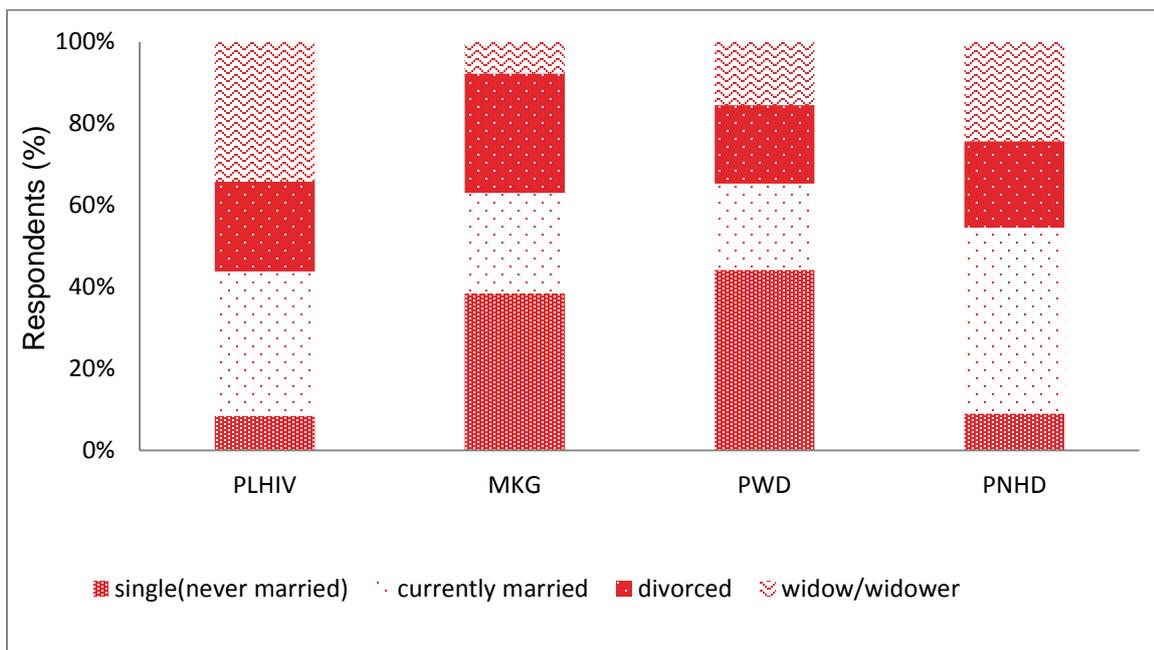


Figure 2. Marital status of survey respondents (N=304)

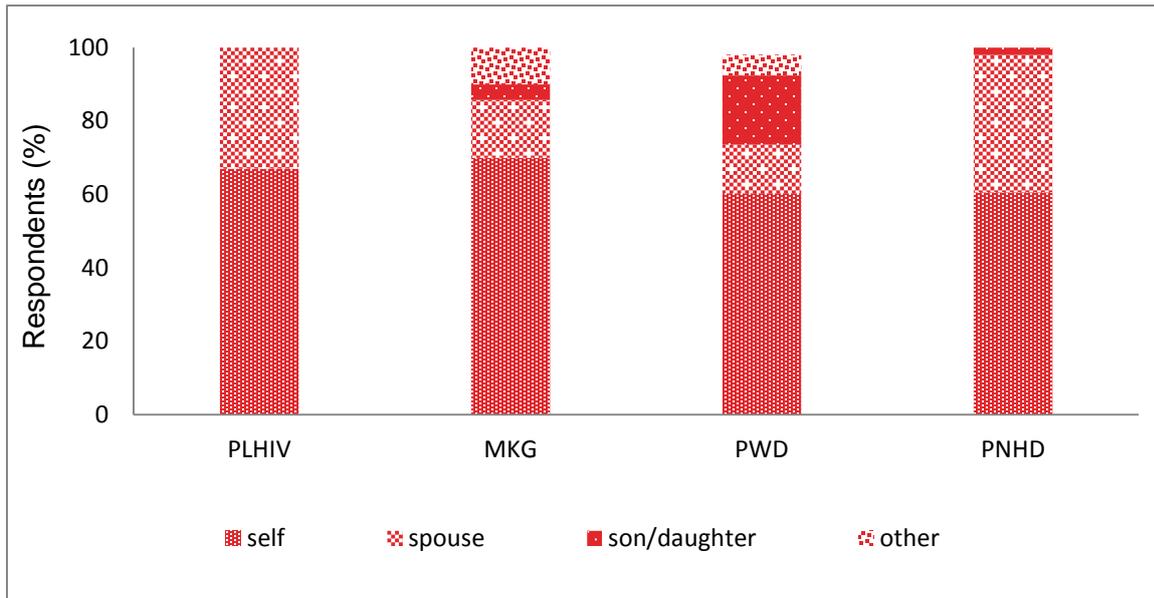


Figure 3. Relation of survey respondent to household head (N=304)

3.2. What are the social protection programs, provided by state and non-state actors, that are available and for which PLHIV and key groups are eligible?

In each site, we attempted to establish the number and type of social protection programs that are available (being implemented). We mainly relied on the KI interviews with local government officials, leaders of community based organizations, and staff of the COP partner to establish this. However, we also included a question that addressed this topic in the FGDs we held with the four groups. This helped us to corroborate the information from the KIs, gauge the level of people’s awareness people of these programs, and capture their experiences in connection with accessing and benefitting from these programs. It also provided us another opportunity to learn of any other social protection programs that may not have been captured in the KIs.

Table 7 provides a summary of the available social protection programs i.e. that are in principle being implemented in the four study sites from among those listed in the 2012 draft of the Ethiopian Social Protection Policy. The table also indicates the number of programs which are implemented by Government, NGOs and community institutions. Some programs are implemented by more than one of these providers.

Table 7. Summary of the locally available social protection programs in the four study sites ✓ - available, ✗ - not available

Program	Goba	D.Eliyas	Fincha	Addis-Bole
1 Social Insurance Program	✓	✓	✓	✓
2 Food Security Program	✗	✗	✗	✗
3 Provision of Basic Social Services	✓	✓	✓	✓
4 National Nutrition Program	✓	✓	✓	✓
5 Support to Vulnerable Children	✓	✓	✓	✓
6 Health Insurance	✗	✗	✗	✗
7 Disaster Risk Management	✗	✗	✗	✗
8 Support to Persons with Disabilities	✓	✓	✓	✓
9 Support to Older Persons	✓	✗	✗	✓
10 Urban Housing	✓	✓	✗	✓
11 Employment Promotion	✓	✓	✓	✓
12 Community-based Social Support	✓	✓	✓	✓
13 Other programs				
Support to PLHIV	✓	✗	✓	✓
Support to MKG	✗	✓	✗	✗
Total	10	9	8	10
Number of programs in which provider is active				
Government	5	5	3	6
Non-government	5	3	4	5
Community	1	1	1	1

In principle, members of the four groups are eligible for these programs, as is any citizen, if they meet the respective criteria, for example being of the right age to qualify for Support to Older Persons or having worked for a public sector organization to qualify for the Social Insurance Program. In the following two sections, we will examine factors that affect the effective availability of programs and issues with the application of these eligibility criteria.

Table 8 draws on testimony from KI interviews and FGDs to describe in more detail the services that are being provided under each of the principal programs by Government, community institutions and NGOs – the CoP partners primarily in these cases. The diversity of social protection services available in the four sites is apparent. For example, although the Support to Vulnerable Children and Support to PWD programs are both being implemented in Fincha, fewer services are available under them than in Goba, Debre Eliyas and especially Addis Ababa-Bole.

The CoP partners are primarily responsible for these differences. They provide a broader range of services than is available under the government-led programs although not uniformly across the sites. For example Government-run Support to Vulnerable Children is limited to strengthening livelihoods of parents/guardians, whereas CoP programs add to this provision of school supplies, food and clothing and assistance with school fees. Medical coverage and life skill and vocational training is also provided by CoP partners in some sites. In other cases, CoP partners are offering the same services as Government, for example coverage of medical costs for PLHIV and MKG in Addis Ababa-Bole and Goba, increasing the number of people that can be covered.

The National Social Protection Policy foresees complementarity among providers in the planning and implementation of programs (Ministry of Labour and Social Affairs 2012). In later sections we examine how the principle fares in practice.

Table 8. Detailed description of the locally available social protection programs in the four study sites. ✓ - available, ✗ - not available

		Goba	D. Elias	Fincha	AA-Bole
Provision of Basic Social Services	Government				
	TB and malaria treatment and ART provision (free of charge)	✓	✓	✓	✓
	Pregnancy follow ups and delivery services (free of charge)	✓	✓	✓	✓
	Medical fee waivers for people identified by their kebelles as “the poorest of the poor” and issued certificates for free medical care	✓	✓	✓	✓
	School feeding program for children	✗	✗	✗	✓
	Non-Government				
	Coverage of medical care costs by the COP partner organization (for clients of the organization’s programs such as PLHIV and OVC)	✓	✗	✗	✓
Support to Vulnerable Children	Non-Government				
	Provision of materials needed for school (pens, pencils, exercise books, and school uniforms)	✓	✓	✓	✓
	Coverage of or exemption of school registration fees	✓	✓	✓	✓
	Food and clothing	✓	✓	✓	✓
	Medical care (coverage of medical care costs by the COP partner organization)	✓	✗	✗	✓
	Life skills and vocational skills training for OVC	✗	✗	✗	✓
	Government and Non-Government				
	Livelihood strengthening support for mothers/guardians of OVC (SHSG formation, provision of loans and material assistance)	✓	✓	✓	✓
Support to PWD	Government and Non-Government				
	Provision of mobility devices (prosthetics, orthotics, and occasionally wheel chairs)	✓	✗	✗	✓
	Livelihoods strengthening/employment creation assistance	✗	✓	✓	✓
	Government				
Monthly subsistence allowances (350 Birr) and a yearly clothing allowance (600 Birr) for disabled students	✗	✓	✗	✗	
Support to Older Persons	Government and Non-Government				
	Initiatives aimed at garnering community support for older persons	✗	✓	✗	✓
	Livelihoods support/employment creation attempts (most in their early stages)	✗	✗	✓	✓
	Non-Government				
Shelter-based elderly care	✓	✗	✗	✓	
Housing	Government				
	Low-rent kebele housing	✓	✓	✗	✓
	Non-Government				
House repairs/renovation	✓	✗	✗	✓	

Employment Creation and Livelihoods Strengthening	Government				
	Micro and Small-scale Enterprises Development program	✓	✓	✓	✓
	Non-Government				
	SHSG formation (Group based savings and loans)	✓	✓	✓	✓
	Business skills training	✓	✓	✓	✓
	Technical and Vocational Skills training	✗	✓	✗	✓
	Provision of Loans/ Start up grants	✗	✓	✗	✓
Provision of materials needed for starting small businesses	✗	✗	✓	✓	
Community-based support	Government-led				
	Community Care Coalition	✗	✓	✗	✗
	Church-based/led:				
	Occasional support to PWDs and the elderly (food and clothing)	✓	✓	✓	✓
	Occasional provision of school materials for OVC	✓	✓	✓	✓
	Iddir-based/led:				
	Occasional support to PWDs and the elderly (food and clothing)	✓	✓	✓	✓
Occasional provision of school materials for OVC	✓	✓	✓	✓	
Occasional support to PLHIV (food, clothing, financial support)	✗	✗	✗	✓	
Other programs	Non-Government				
	Monthly (subsistence) allowances for PLHIV	✗	✗	✓	✓
	Comprehensive medical care for PLHIV (free of charge)	✗	✗	✓	✓
	Association formation and capacity building support for domestic workers and sex workers (including SRH & HIV/AIDS awareness education, business skills training, linking with local government bodies)	✗	✓	✗	✗

3.3. To what extent are PLHIV and key groups actually accessing social protection programs?

3.3.1. How many programs do respondents know of and attempt to access?

We begin with analysis of the survey data, focusing first on the number of social protection programs respondents know of and access. Figure 4 shows that the number of programs people have heard of is greater than the number they believe they are entitled to which is generally greater than the number they attempt to access and the number they actually succeed in obtaining support from. As we shall see below, people’s knowledge of programs is not limited to those implemented in their community; some have heard of programs that have yet to be rolled out. On average, PLHIV obtain support from 2.0 programs, PWD from 1.3 programs and MKG and PNHD from 0.9 programs.

These are programs implemented by all providers: Government, NGO and community institutions. Below we consider access to Government-provided programs.

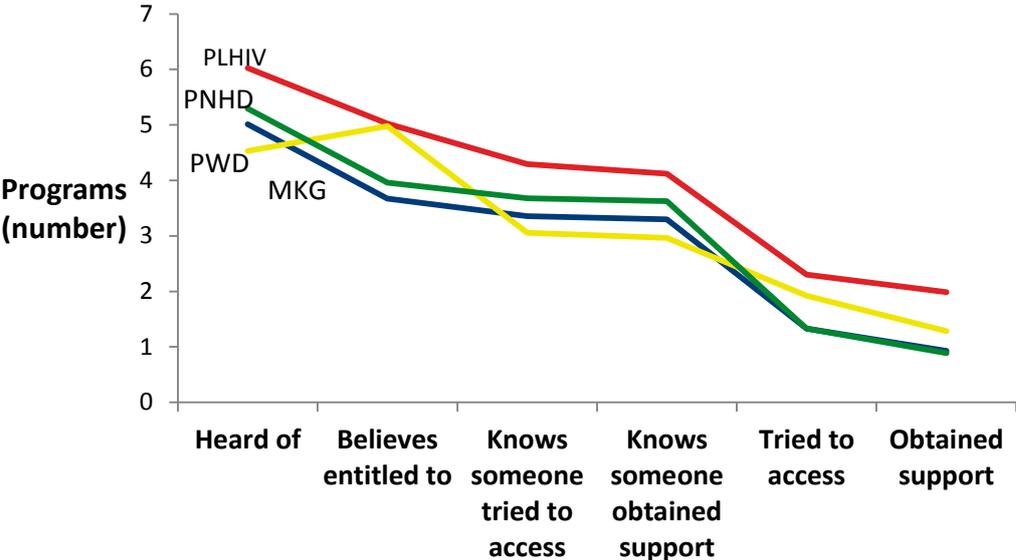


Figure 4. Mean number of social protection programs participants know of and attempt and succeed in accessing, by group.

For each group, the largest gap can be seen to occur between the programs respondents believe they are entitled to and those they attempt to access. Across all groups, respondents have attempted on average to access 2.6 programs fewer than they believe they are entitled to. The gap between the number they have heard of and the number they believe they are entitled to is 0.9; between the number they attempt to access support from and the number they succeed with, the gap is 0.4. We look at these gaps in greater detail in the following section².

Mistaken ideas about eligibility might contribute to the large number of programs respondents have not attempted to access. However people know others who have attempted and succeeded in accessing support from

² One might also want to know about the gap between the number of programs available locally and the number of programs people have heard of. We have not presented this gap because it is difficult to interpret. It is reduced by people having heard of programs which are not implemented locally, which is common. The gap is increased by people not having heard of programs which don’t matter to them e.g. a non-disabled person not knowing of Support to PWD, which is not really significant. These cases obscure the significant situations e.g. a PWD not knowing of Support to PWD. The available-heard of gap is more illuminating with respect to individual programs, which we consider below.

only slightly fewer programs than they believe they are entitled to, suggesting that they generally have some basis for their beliefs. Note the increase between the number of programs PWD have heard of and the number they believe they are entitled to. This may be due to people hearing about some programs for the first time from the interviewer. Some respondents in the other groups also showed such an increase. This suggests that the number of programs people believed they are entitled to before being interviewed would have been slightly less and the decline to the number they have attempted to access not quite as steep.

Other factors that may contribute to the decline include a lack of information on how to access the organizations or agencies administering the programs and beliefs about their chances of success or the value of the support they might obtain should they succeed. We examine these obstacles in detail in the following section.

Figure 5 illustrates the same information as Figure 4 broken down by site. Broadly, the same pattern of decline from the number of programs people have heard of to the number they successfully access is seen as in the breakdown by group with the largest fall generally occurring between the number people believe they are entitled to and the number they attempt to access. On average, respondents obtain support from 1.6 programs in Goba, 1.5 programs in Debre Elias, 1.2 programs in Addis Ababa-Bole and 0.6 programs in Fincha. Key informants and FGD participants in Fincha remarked on the limited range of social protection programs available, a point to which we return below. The spread among the sites is much greater in the number of programs people have heard of than in the number they attempt to and succeed in accessing. Possibly respondents are better informed about social protection programs in Addis Ababa, a large city, and Goba, a large town, than they are in Debre Elias, a small town, and Fincha, a rather isolated “company town”, but this is speculative and difficult to assess given the small number of sites. Too much should not be read into the differences between Addis Ababa-Bole and the other sites since it is based on only three groups: PWD are missing.

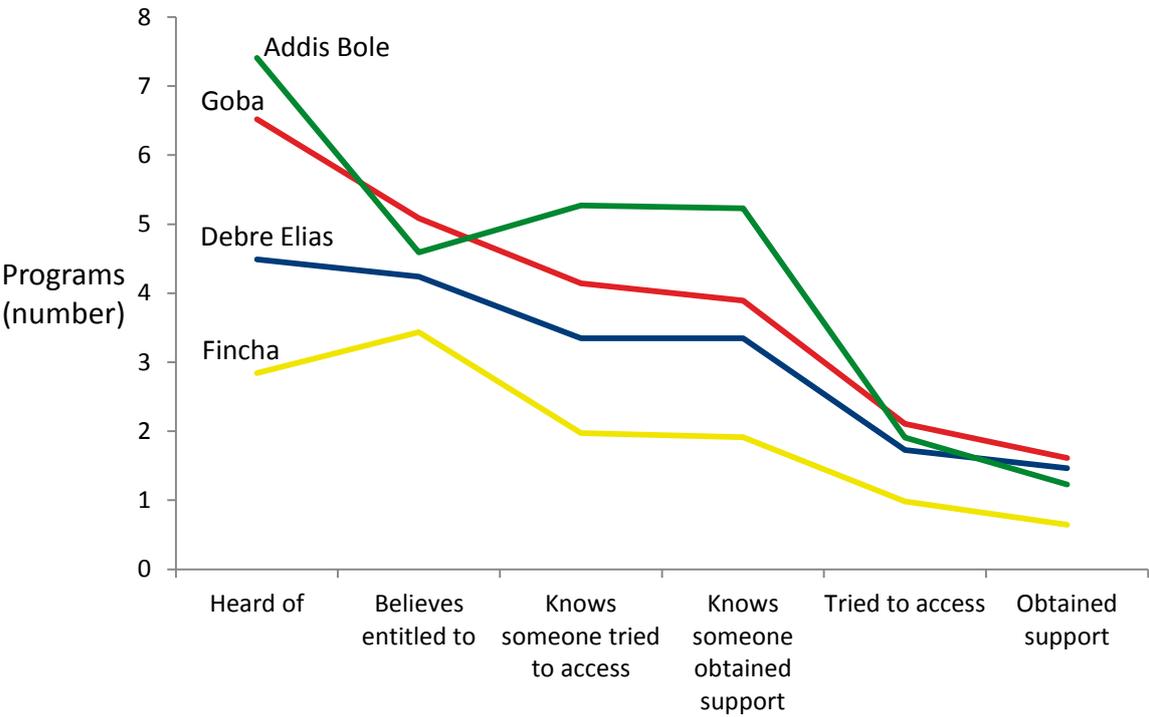


Figure 5. Mean number of social protection programs participants know of and attempt and succeed in accessing, by site

An analysis of the source of the differences among respondents in the number of programs they obtain support from is summarized in Table 9³. It indicates that variables such as the person's age, level of schooling and whether or not they are employed do not have a significant effect⁴. Which of the groups one belongs to is a significant factor, as Figure 4 suggested, but the greatest influence on how many programs one is likely to obtain support from is whether or not one is a member of an organization's programs.

Table 9. Individual-level factors affecting the number of programs respondents obtain support from. N=203 valid cases.

Factor	Probability	Interpretation
Group	P<0.001	Highly significant
Member of an organization's program	P<0.001	Highly significant
Age class	P>0.1	Not significant
Educational attainment	P>0.3	Not significant
Employment status	P>0.1	Not significant
Interaction: group x program member	P<0.02	Significant
Overall model	P<0.001	Highly significant
Among sites	P<0.001	Highly significant

The analysis also indicates that membership interacts significantly with group affiliation: members are more advantaged than non-members in some groups than in others. This is illustrated in Figure 6 below.

The graph shows the ratio between the number of programs a member has heard of, believes they are entitled to and so on and the corresponding number for a non-member. In all cases, the ratio is greater than 1, meaning that members are always at an advantage. The further above 1 a curve lies, the greater the advantage in being a member.

The curve for PLHIV lies below those for the other groups; the curve for MKG lies above the others, indicating that membership in an organization's programs confers the least advantage to PLHIV and the greatest advantage to MKG. Note that all the curves rise towards the right which means that the advantage of membership is greatest in relation to the number of programs respondents obtain support from. The increase for MKG is particularly steep. An MKG member on average obtains support from nearly 8 times as many programs as a non-member (1.8 vs. 0.23). In contrast, a PLHIV member receives support from 1.7 times as many programs as a non-member (2.5 vs. 1.4). For PWD and PNHD the ratio is just over 3. In other words, as far as access to support is concerned, being a member of an organization's programs is most important for MKG and least important for PLHIV.

³ A hierarchical, generalized linear mixed model was fitted using SPSS 20. The detailed listing of coefficients is provided in the appendix.

⁴ Site, not an individual level factor, is a significant contributor to the number of programs accessed, as the final line of Table 9 indicates. Gender was not included in this analysis because a univariate analysis (i.e. considering gender separately from other explanatory variables) indicated that men and women did not differ in the number of programs they obtained support from, overall and for each of the four groups. The small number of men among the survey respondents makes finding a difference difficult, even if it exists.

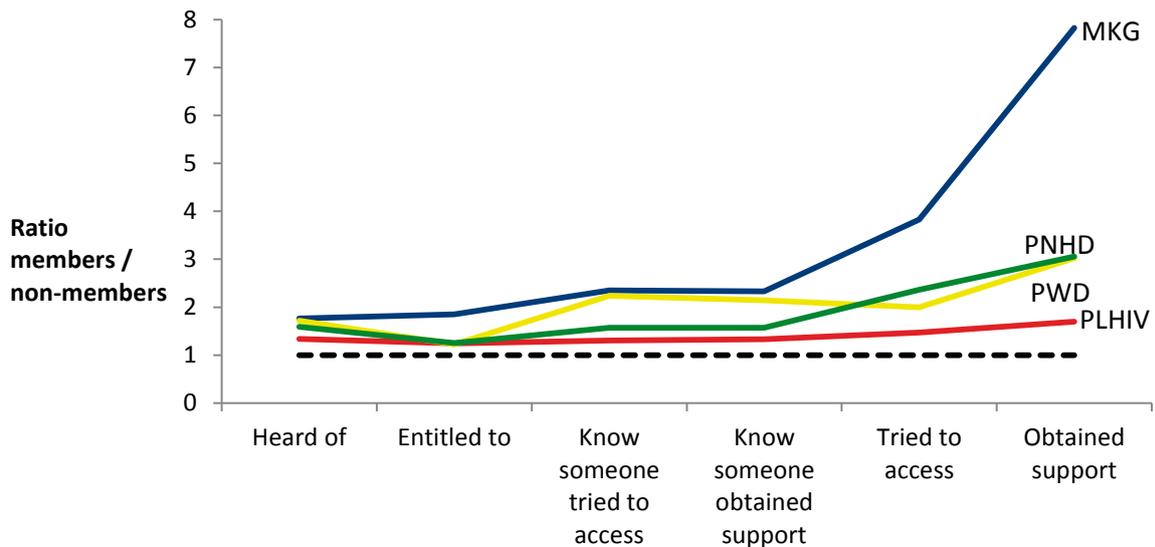


Figure 6. Knowledge of and access to social protection programs: the effect of membership in an organization’s programs. The graph indicates the ratio of the number of programs members know of and try and succeed in accessing to the corresponding number for non-members. All ratios are greater than 1 (dashed line), meaning members are always at an advantage. The greatest advantage is seen for MKG members in the number of programs they obtain support from.

3.3.2. Access to Government-run programs

The analysis to this point has considered access to programs whoever provides them. However, one of the study’s objectives is to clarify the extent to which PLHIV and the other groups are able to benefit from state-provided social protection programs. Separating out access to state-provided and NGO-provided social protection is not simple because respondents who are NGO-clients do not always know who is providing the service. Community-Based Social Support is accessed by few respondents, as we shall see below,

One way to estimate the accessibility of state-provided social protection is to consider the experience of survey respondents who are non-clients of the CoP partners. As we noted earlier, some of these are clients of other NGOs. Although we are not sure of their exact number, 27% is a reasonable guess. If we exclude these respondents, we come up with an upper and a lower estimate of the number of social protection programs that respondents who are not clients of either the CoP partners or other NGOs are able to access support from, based on two different assumptions (Table 10)⁵. We believe the lower estimates would likely prove closer to the truth.

⁵ The number of non-CoP clients who are clients of other NGOs is estimated from the number of non-CoP clients who obtain support from Support to Vulnerable Children, a program almost exclusively provided by NGOs (see below). The upper estimate assumes that clients of other NGOs are no better able to access SP programs than are non-clients of the CoP partners; the lower estimate assumes they are equally able to access SP programs as CoP clients.

Table 10. Number of programs from which respondents obtain support from, by provider

Category	Programs provided by	PLHIV	MKG	PWD	PNHD	MEAN
CoP clients	CoP and Government	2.5	1.8	2.5	1.7	2.1
Non-clients of CoP or other NGOs	Government - upper estimate	1.4	0.23	0.82	0.57	0.73
Non-clients of CoP or other NGOs	Government - lower estimate	0.73	0.0	0.46	0.17	0.23

On average, non-clients of any NGO obtain support from 0.23-0.73 government-run programs, compared to 2.1 programs – both state and NGO-provided – that clients of CoP partners are able to access.

The analysis to this point has focused on the mean number of programs respondents know of or seek to and succeed in accessing support from. It is vital, however, not to lose sight of how access is distributed. Among all survey respondents, the largest number, 37%, did not receive support from any program at all. Almost a quarter (24%) received support from just one. Figure 7 shows the distribution by member (i.e. CoP client) and non-member. More than 57% of non-members obtain no social protection support, compared to just over 5% of members.

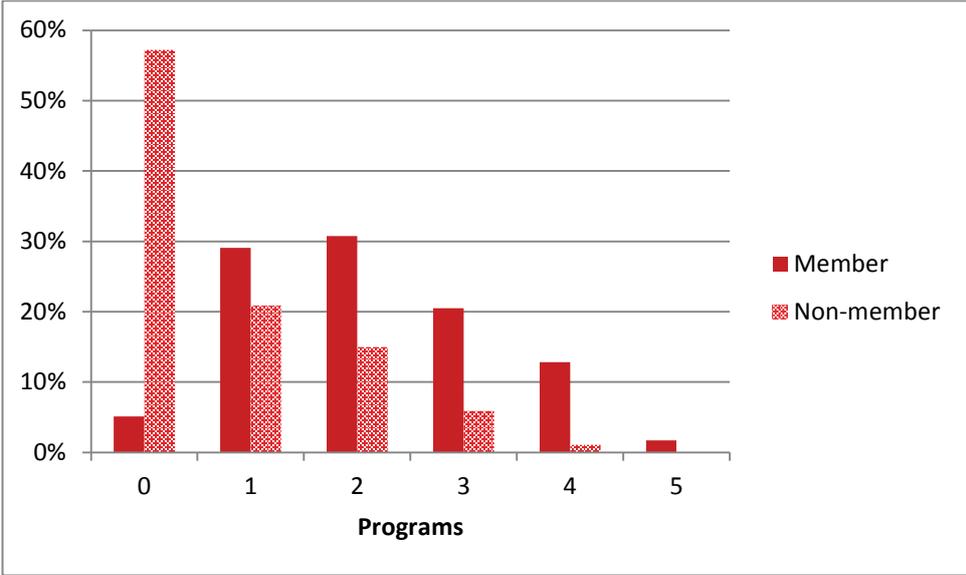


Figure 7. Number of programs accessed by respondents (N=117 members and 187 non-members).

The distribution of access to social protection support in the four groups is shown in Figures 8 a-d. The highest proportion of respondents who did not access any programs is seen among MKG non-members (85%), the smallest proportion among PLHIV members (0%).

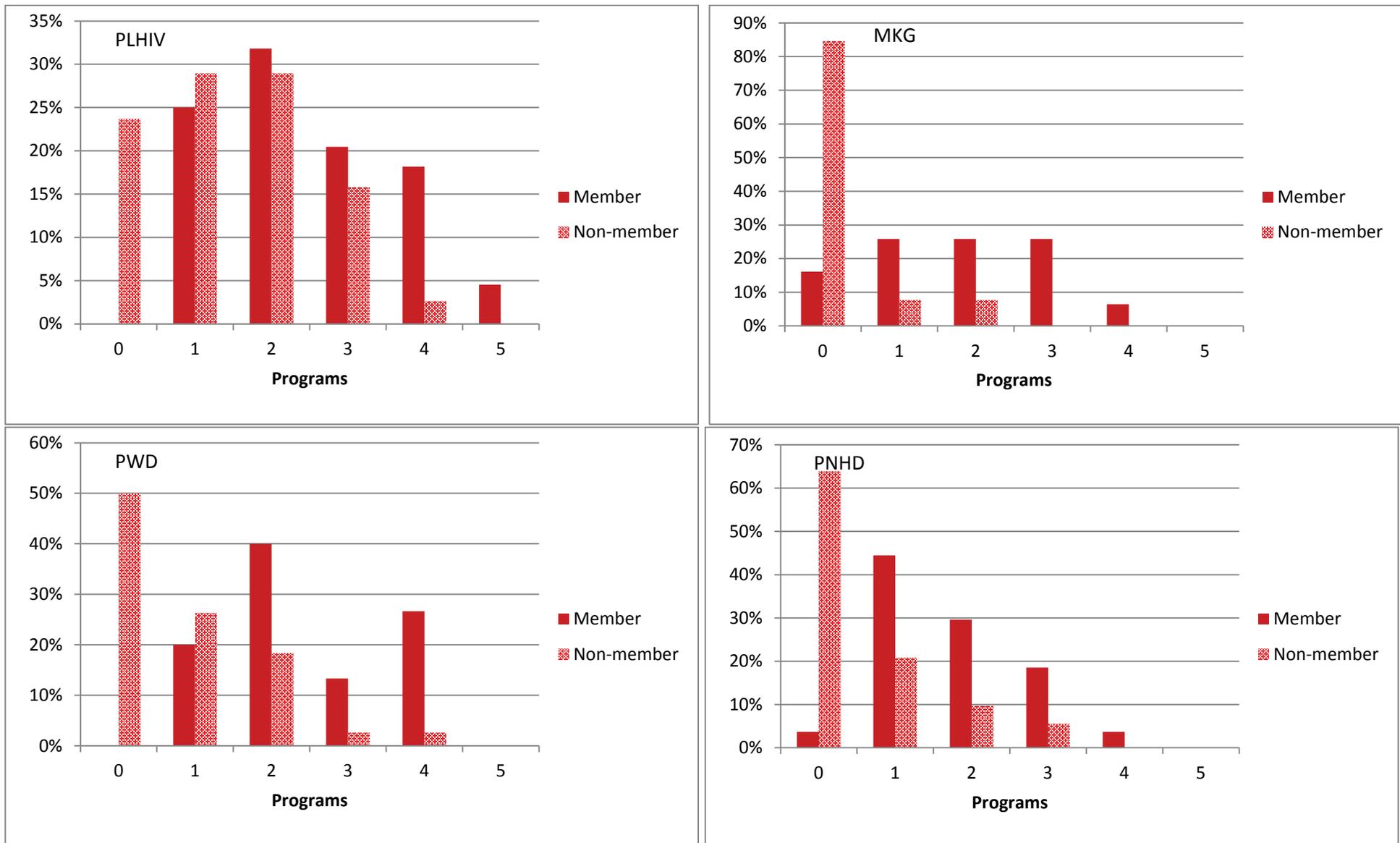


Figure 8 a-d. Number of social protection programs accessed by respondents by core group: PLHIV (N=44 members, 38 non-members), MKG (N=31, 39), PWD (N=15, 38) and PNHD (N=27, 79).

These distributions correspond to the upper estimate of access to social protection support when Government is the only available provider (Table 10). The proportion with no access to support would be even greater if the calculations were based on the lower estimate.

3.4. What are the programs respondents know of and attempt to access?

We move now from the number of social protection programs known to and accessed by respondents to consider the identity of these programs. Table 11 provides details of the programs that respondents have heard of by group and site.

Table 11. Participants (%) who have heard of specific social protection programs by group and site (N=304).

Program	Goba					Debre Eliyas					Fincha					Addis-Bole					Overall total
	PLHIV	MKG	PWD	PNHD	Total	PLHIV	MKG	PWD	PNHD	Total	PLHIV	MKG	PWD	PNHD	Total	PLHIV	MKG	PWD	PNHD	Total	
Social Insurance	86	53	74	70	71	45	33	42	33	38	25	57	57	39	42	70	95	-	96	88	59
Food Security	68	37	63	44	53	0	0	0	0	0	10	14	7	0	7	45	16	-	27	29	22
Basic Social Services	82	53	58	83	70	85	50	37	52	56	20	50	21	26	28	75	90	-	81	82	59
National Nutrition Program	68	16	21	39	37	20	28	11	11	17	0	0	0	0	0	5	21	-	12	12	17
Support to Vulnerable Children	96	32	74	83	72	85	67	63	78	74	35	57	29	30	37	90	95	-	81	88	68
Health Insurance	32	0	11	13	15	0	0	0	0	0	20	43	43	39	35	35	58	-	42	46	22
Disaster Risk Mgmt.	46	11	26	22	27	0	0	0	0	0	0	0	0	0	0	35	5	-	23	23	12
Support to PWD	73	26	74	57	58	45	50	58	48	50	0	7	21	9	9	45	53	-	54	52	43
Support to Older Persons	55	32	53	61	51	10	22	16	26	19	0	0	0	0	0	45	79	-	65	64	33
Urban Housing	96	37	47	91	70	85	94	63	85	82	5	0	0	0	1	95	95	-	100	97	63
Employment Promotion	77	47	42	61	58	75	67	37	44	55	70	71	64	87	75	95	100	-	96	97	69
Community-based support	82	47	74	65	68	75	67	58	41	58	35	14	43	39	34	55	47	-	54	53	54
Other programs	5	5	0	4	4	0	0	0	0	0	60	0	0	0	17	25	16	-	0	12	8

Figure 9 shows those programs that more than 20% of all respondents have heard of.

Compare this graph with Figure 10 which illustrates the programs that more than 10% of respondents have obtained support from (a lower cut-off is used because fewer programs are accessed than are known to respondents). Not surprisingly, the best-accessed programs are also among the best-known programs: Employment Promotion, Provision of Basic Services, Urban Housing and Grain Subsidies and Support to Vulnerable Children. There are other programs, however, which substantial numbers have heard of, such as Social Insurance (59%), Community-based Social Support (54%), Support to Older Persons (33%), Health Insurance (22%) and Food Security (22%) but which few or no respondents, overall or in any of the four groups, obtain support from (Figure 11 a-d).

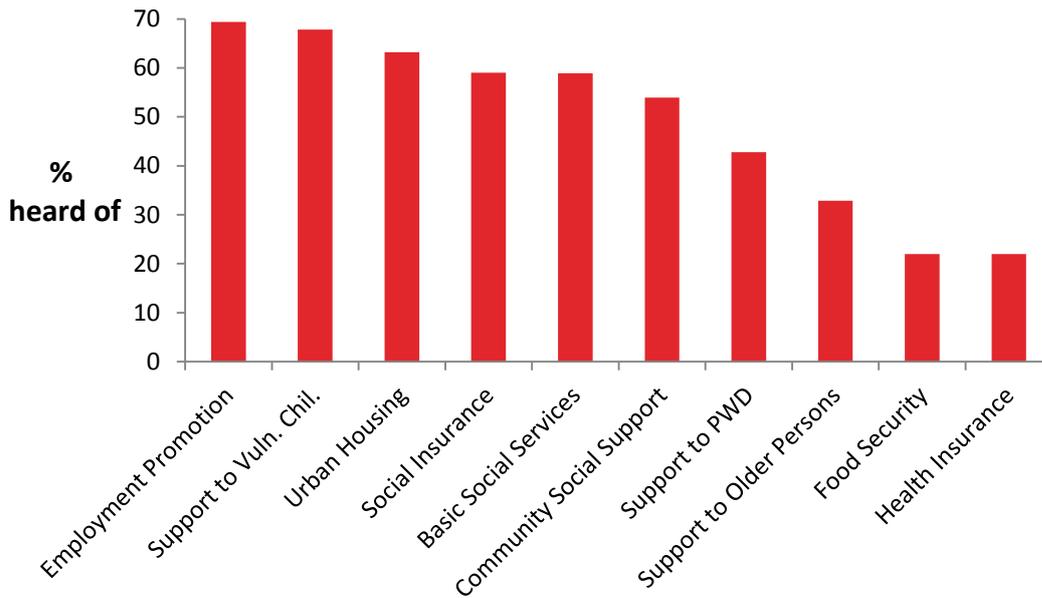


Figure 9. Social Support Programs which more than 20% of respondents have heard of. N=304.

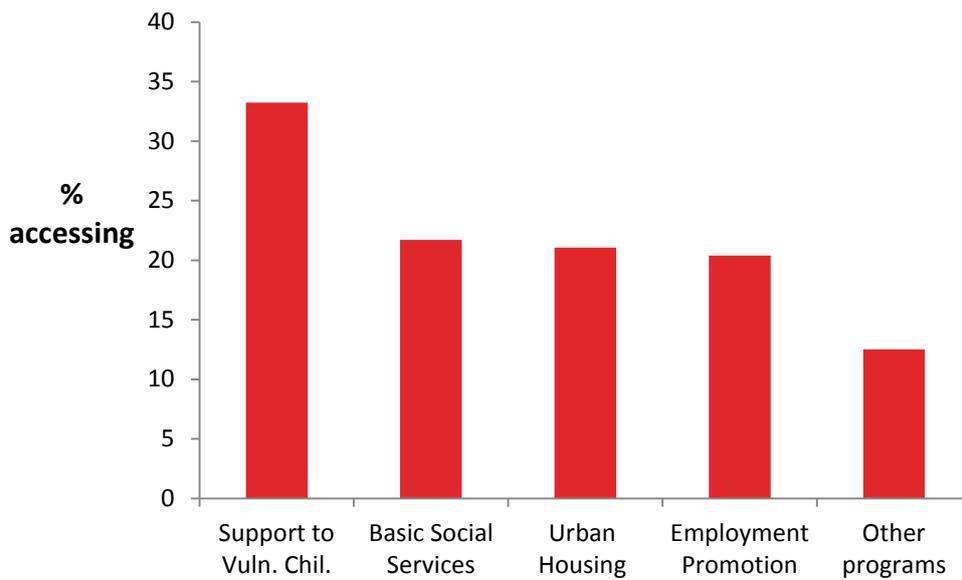


Figure 10. Social Support Programs from which more than 10% of respondents have obtained support from⁶. N=304.

⁶ As can be seen in Table 8, some services are provided in more than one SP program. Survey respondents didn't and often couldn't know under which program they were receiving e.g. employment creation support. Therefore, we recorded all instances of employment creation support under Employment Promotion. CoP clients who received support for their health costs were recorded under Other Programs. This means that support under Basic Social Services was Government-provided; assistance under Support to Vulnerable Children was CoP partner-provided.

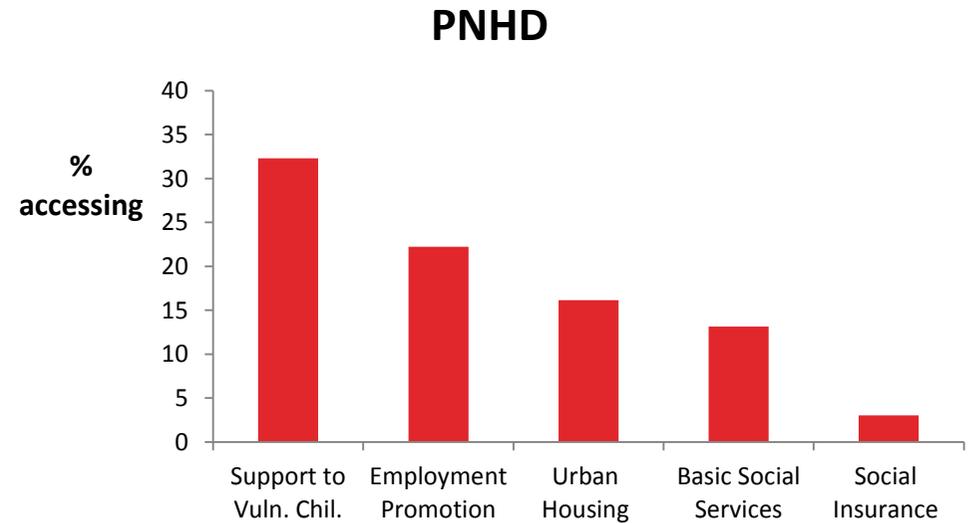
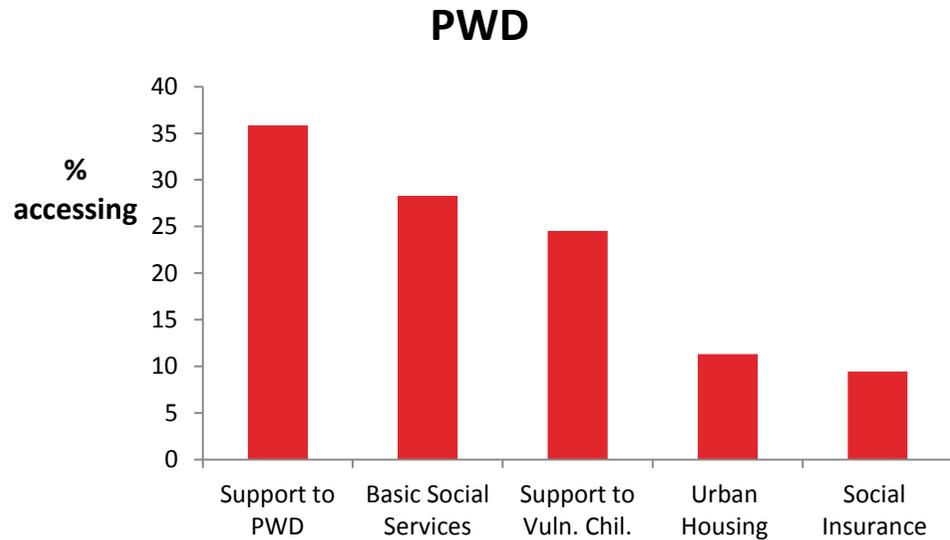
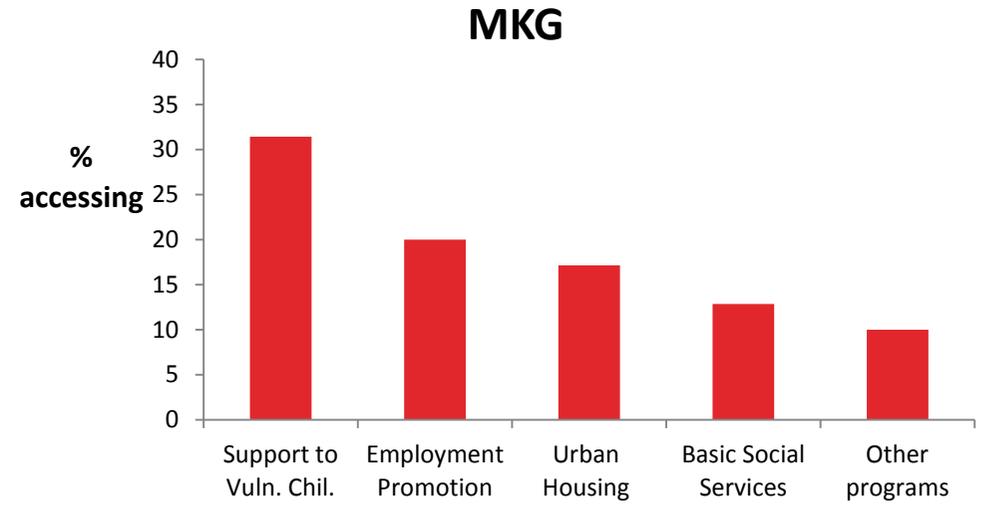
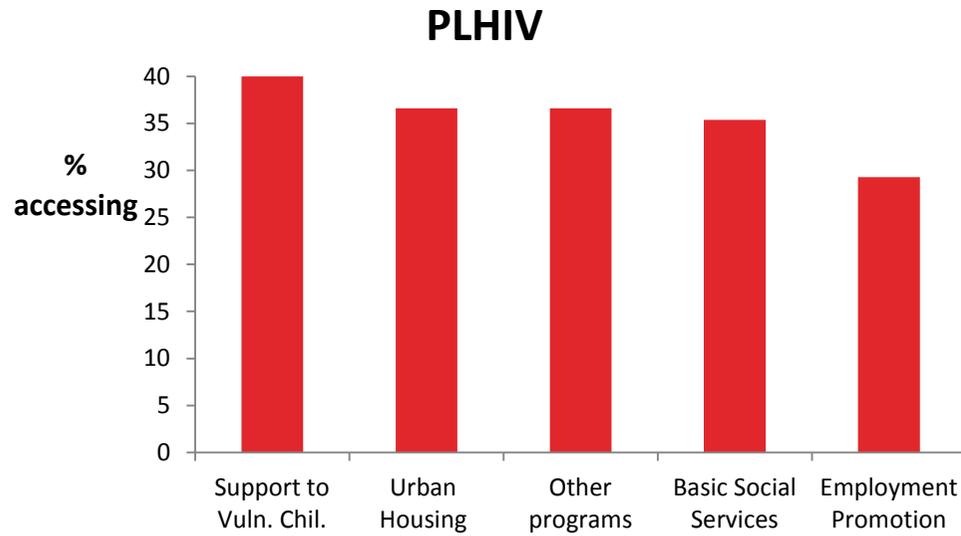


Figure 11 a-d. Proportion of survey respondents obtaining support from social support programs: the five most widely accessed programs for each of the core groups. PLHIV (N=82), MKG (N=70), PWD (N=53) and PNHD (N=99).

Given respondents' age profile, it is not surprising that very few have accessed the Support to Older Persons Program. However, almost 60% of respondents overall have heard of Social Insurance and almost 90% in Addis Ababa-Bole yet it is currently only available to workers in the public sector and parastatals sector, less than 1% of the economically active respondents (Table 6); only 2.5% of respondents now benefit from it. Health Insurance and Food Security are not implemented in the study communities although the National Social Protection Policy envisages a widening of their coverage, yet these two programs are still known to almost a quarter of respondents overall and almost half in some sites. These results suggest that people are hearing about these programs through other than official channels such as publicity campaigns. These programs appear to be of intense interest: as described below, focus group participants and key informants see a vital need for expanded access to them.

The low levels of access to Community-based Social Support are surprising: only 9 of the 304 respondents (3%) have obtained support from this source although 44% know someone who succeeded in doing so. Most of the attempts respondents have made to access it (53.8%) were made 5 or more years ago. This contrasts with attempts to access other programs, most of which were more recent: more than 70% were made in the last four years (Table 12). We discuss this further below.

Table 12. Timing of attempts to obtain support from the five most frequently accessed social support programs (N=432).

Within the last 2 years	3-4 years ago	5 or more years ago
41.2%	31.3%	27.5%

3.5. What are the obstacles PLHIV and key groups face in accessing social protection programs?

The study's different data sources, the quantitative data from the survey and the qualitative data from focus group discussions, key informant and in-depth interviews, provide complementary perspectives on the factors that limit people's attempts to access social support programs and their success in these attempts.

Figure 12 illustrates attempt and success rates for the four groups and for members and non-members of an organization's programs. We calculate the attempt rate as the number of programs respondents attempt to access divided by the number they believe they are entitled to and the success rate as the number they succeed in obtaining support from divided by the number they attempt to access.

In each case, attempt rates are lower than success rates, which is also evident in Figures 4 and 5. The two rates vary significantly among the four groups (both $P < 0.001$). PLHIV have the highest attempt (57.6%) and success rates (87.9%), MKG the lowest attempt rate (36.3%) and PNHD the lowest success rate (68.3%). Members have significantly higher attempt and success rates than non-members (both $P < 0.001$). The disparity is the most striking in attempt rates: members attempt to access 60.6% of the programs they believe they are entitled to, non-members only 32.7%

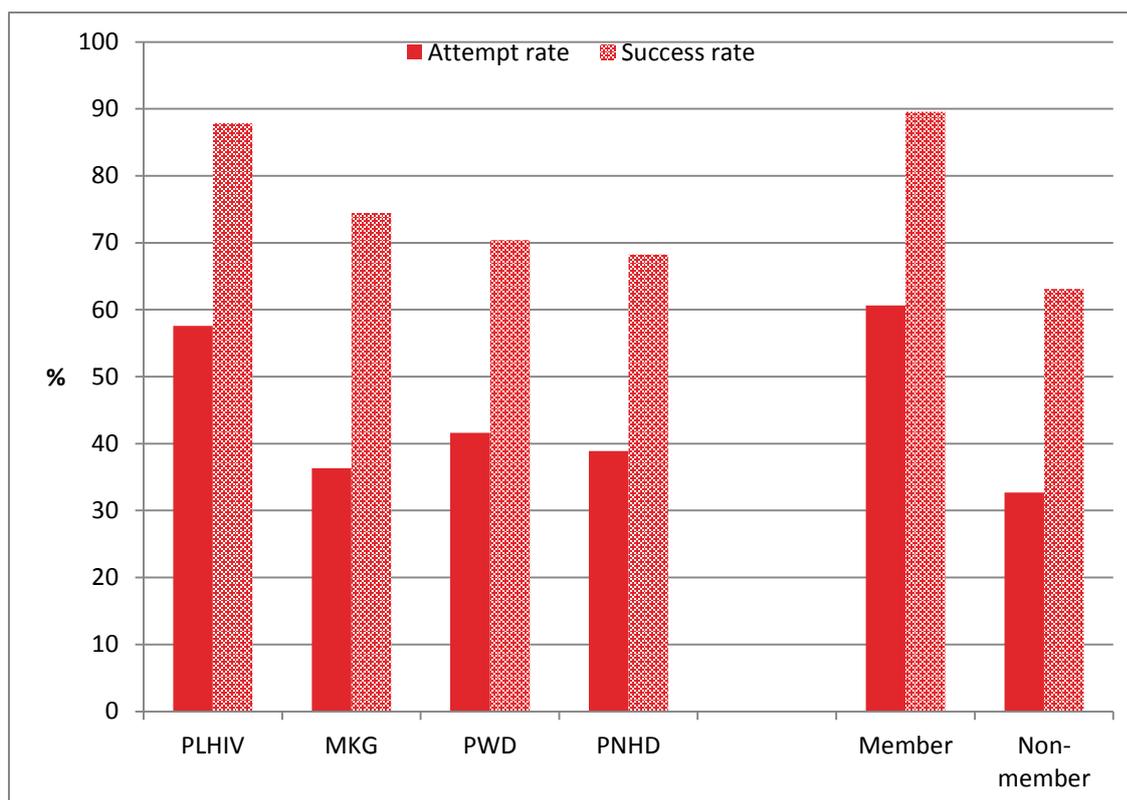


Figure 12. Attempt and success rates in accessing social support programs by group and by membership status. The rates are defined in the text.

Survey respondents provided information on the factors contributing to these rates. Relevant to attempt rates, Table 13 lists the reasons respondents who made no attempt to access any social protection program gave for not doing so. Factors relating to lack of information about the programs, their eligibility for them or how to approach them were the most common reasons cited.

Table 13. Among survey respondents who did not attempt to access any programs (N=73), the reasons given for not doing so.

Reason for not seeking support	Frequency (%)
Didn't know where to go, whom to ask	18 (24.7)
Didn't think they were eligible	14 (19.2)
Didn't need support	10 (13.7)
Didn't know there was such support	5 (6.8)
Was discouraged by what they heard from others	4 (5.5)
Other reasons	23 (31.5)

Testimony from FGD participants and KI interviews provides more insight into the obstacles participants face in attempting to access programs that they may know about and believe they are eligible for.

3.5.1. Effective availability of social protection programs

Some social protection programs for which many voice an acute need are not available and, where available, are extremely limited both in coverage and in the support that is offered. The first response that we often encountered in FGDs to the question, "What support programs are available to people such as you in this area?" was "There is no support here". We encountered this response in every site, except Addis Ababa, and from all

four groups. What people experienced as the absence of social support was the local unavailability of several support programs and the inaccessibility of the few that could be said to be available.

3.5.2. Some programs are unavailable in all four sites

Sites like Goba and Debre Elias are situated in areas that are classified as having a production surplus and are not ranked among the food insecure. The company town of Fincha sits in the middle of a major state-owned sugar cane plantation and small scale household farming is non-existent since all land in and around the town is owned by the company. But in all three sites, FGD participants and key informants we interviewed were keen to stress that the most important program that people wanted, the Food Security program, was completely unavailable.

In Goba, a PNHD man observed:

“This area is known to have two harvests in a year so people don’t think there is food shortage here. Even then, there are a lot of people who don’t have anything to eat here in the town. Food support is given to people in some nearby rural areas: poor families get some corn or wheat every month. But the government doesn’t seem to understand that the poor live in the town in greater numbers. The poor, the disabled, they are here in Goba in much greater numbers than in the villages”.

An officer of the woreda WCYA (Women, Children and Youth Affairs) Office in Debre Elias said:

“This woreda is considered food secure and it is a surplus producer even. Because of that, there is no food security program both in the rural areas and in the town. The woreda is indeed a surplus producer but there are a lot of poor people who are not eating even one full meal a day, especially here in town. So I think there should be some way of providing a food security program for those who need it even if the woreda as a whole is not food insecure”.

3.5.3. Some programs are effectively unavailable

As indicated in Table 8, one of the major components of the provision of basic social services is the government-run program which grants fee waivers to people who are too poor to pay for their medical care. This support is accessed through kebele-issued letters on which basis people obtain certificates, issued by the woreda, for free medical care at any government-owned health care institution. While people in all four sites and from among all groups were aware of the existence of this support, they often pointed out that getting such certificates is extremely difficult and obtaining free medical care if one has the certificate is no easier.

In Goba for example, PNHD participants stated that people are rarely able to get this type of support. One participant said that it exists now in name only.

“I really don’t think this type of support exists any more, it used to be given in the past but kebelles are always saying there is no budget for it. Just recently, this poor woman fell ill and we had to go out on the street and ask people to make a donation so we could take her to a hospital. I also don’t think people can make much use of a letter from the kebele for free medical care anyway, even if they manage to get one. They may go to the hospital and actually get to see a doctor and he will tell them the medicine they need is not available at the hospital and they have to buy it outside [from a private pharmacy]. They never seem to have the medicines people need.”

Other Goba FGD participants pointed out that that they have been unable to even obtain the certificates. A PLHIV commented:

“My wife fell ill recently and I went to the kebele. They told me they don’t give such certificates any more. So I had to borrow money from all the people I knew to get her treated. I am disabled; I live with HIV, and have five children. It is not like I am sitting idly and demanding that I be supported. I still work as a daily labourer and do my best to take care of my family. I struggle but I am able to put food on the table for my family. There is no way I could afford the treatment my wife needed. I had no choice but to put myself into debt. What else could I do, sit and watch her suffer or even die? So I can’t say there is such a thing as free medical care. I am surprised that people here think this still exists”.

A community volunteer who worked closely with Hundee also indicated that the unavailability of needed medicines is a major problem for the people the NGO supports.

“If one of the beneficiaries I work with gets ill, I will go to the organization and get them a letter with which they can receive medical care at the hospital without paying. But the doctors are always telling us they don’t have the medicine in the hospital and that we have to buy it outside. Hundee’s support only covers costs from government hospitals”.

The above quotations come from Goba but similar experiences were encountered in other sites, though with some notable differences in Addis Ababa, as described below. PLHIV in Debre Elias claimed that it was impossible to get letters from the kebele for medical fee waivers as the kebele would take anything they may own, no matter how small and insignificant, as proof that they are not absolutely poor. When asked if they themselves had ever tried to get the support, they replied that they hadn’t as they considered it a waste of time. None of the participants in the PNHD FGD had attempted to obtain support from this program and no one knew anyone who had.

In the MKG FGD, participants stated that it was practically impossible to get this type of support.

“There is no such thing: if you want to get medical treatment, you have to pay for it. There is no other way”, one participant stated. “If it is HIV, you can get medicine [ART] for free; for anything else you have to pay. ... You may be ten times poorer than the poorest person in town but you won’t get such a paper from the kebele. But if such people are seriously ill, people in the community will raise money and take them to the health centre here or the hospital in Debremarkos”.

This difficulty may be explained by the fact that woredas, which issue the medical fee waiver certificates, have limited budgets allocated for this support. In Debre Elias, key informants told us that the budget for free medical care was 10,000 Birr for the entire year. KIs were well aware that this was extremely limited in comparison to the number of people seeking support but argued that the woreda could do no more than seek out and support those whose need is the gravest. A staff member of the woreda WCYA Office said:

“The budget is far too small; there is no doubt about that. Realistically, 10,000 Birr might not even cover the costs of 10 people, considering how expensive medicines are these days. ... But when possible, the woreda administration can look into its budget utilization to see if there are one or two places where costs can be cut and a little more added for this purpose, supporting perhaps a few more people”.

In Fincha, the annual budget allocated for this support was somewhat higher at 30,000 Birr, and KIs indicated that some 124 people had received free medical care in the current year. Nevertheless, few FGD participants who lived in the company town were aware of the existence of this support and none of those we talked with had ever attempted to access it.

In contrast, in Addis Ababa-Bole, FGD participants stated that getting certificates for free medical care was relatively easy and KIs stated that they have never had to turn down requests due to budget limitations. Here, kebelles and woredas are proactively seeking households/families that may be in need of this support through grassroot level structures such as the women’s league, development teams, and health extension workers. A PNHD participant commented:

“There are grassroots structures like the women’s league. There are also one or two health extension workers in each ‘qetena’ [an administrative unit below the kebele] who give health education and monitor the health situation of every household. We go to each household with the health extension worker and there are forms we fill and data we collect about the household. Things like how they live, how much income they have, whether their children are attending school and getting vaccinated, how well they keep their hygiene, whether they live in rented houses or their own and so on. So we have detailed data about each household and it can easily be determined whether a particular household needs to get the certificate or not. If either the league leaders or the health extension workers becomes aware of a particular household where someone is ill and is unable to get treatment because they are too poor, they refer them to the kebele/woreda immediately and all the woreda has to do is look at the information and decide right away. If there are no data about them, then they will try to verify their

status and ask them to bring one or two witnesses. But it usually doesn't go that far. So I think it is easy to get the certificate"

If getting a certificate is not generally a problem, Addis participants pointed out that this is not always the case for free medical care itself. People are often asked to undergo medical examinations or laboratory tests and to buy medication from private healthcare facilities and pharmacies at their own expense when these are not available at government-run health centres and hospitals.

The testimony indicates that access to free medical care for the poor varies in relation to the budgets available to local governments and the priority they attach to this critical facet of social protection. An efficient health insurance program would reduce the arbitrariness and uncertainty in this provision, as might a functional Citizens' Charter, which we take up below.

3.6. Unrealistic eligibility criteria

Another barrier that complicates or prevents access to available programs is the definition of targets and eligibility criteria. The most widely available program, Support to Vulnerable Children, is exclusively targeted at poor women who have OVC under their care. This may seem only logical given the program's aim. However, OVC care and support programs, state and non-state, also provide livelihoods strengthening and employment promotion for OVC mothers and guardians. These interventions are of interest to a much wider population and are often sought after by poor and economically vulnerable households and individuals, including women without children. In the absence of other programs providing these services, many people in need are being denied support as long as they don't have children. An informant from the Goba Woreda Labour and Social Affairs Office, pointed out:

"Most of the organizations, including the churches and the NGOs that work here, focus on children. So a poor woman can only access the support they give if she has children; if not, she is considered to be ineligible no matter how poor she is and how desperate her need".

A male PLHIV participant in Goba also decried this fact:

"If you ask me what my experience is like, I will tell you it is hard to get any kind of support around here if you don't have any children, and even more so if you happen to be a man. NGOs don't care about the likes of me; they don't know I exist, I am none of their concern".

A narrow focus on women with children in livelihood strengthening programs was also described in the study that stimulated the CoP's creation (Loevinsohn, Tadele and Atekyereza 2012).

Another eligibility criterion that seems to have become a stumbling block for many who have tried to access available support programs is the definition of poverty. As a matter of principle, all support programs aim at benefiting "the poorest of the poor": it is often the most important criterion set by organizations providing support, both government and non-government. While there is no doubt that this is a legitimate eligibility criterion, it is usually not well defined for operational use. This leads to subjectivity in its application, increasing inclusion and exclusion errors. Moreover, the manner in which the criterion is currently being used may in some cases inadvertently undermine the goals of the Social Support Policy, as the following examples suggest:

"Once, the Health Office posted a notice calling for PLHIV whose children weren't being supported by any organization to come and register. So I did. They took down our names and how many children each of us had and so on. I had five children who weren't getting support so I passed the initial screening. After that, one of the ladies from the Health Office said that she wanted to visit our homes to ascertain that we are indeed in need of support. I keep five hens, I don't have much else. I live in a kebele house: it isn't much but we at least have a roof over our heads. So she came to my house and looked around. When she saw the hens, she told me right there that I was not eligible for support – all because I had five hens! There was another woman in my neighbourhood, she had a cow. She lost her husband to AIDS and had nothing but this one cow. She was told the same. It is beyond understanding! Did they want this woman to sell her only remaining possession? She could sell the cow and eat for a while, but what will she do once the money runs out?" [Male PLHIV with disability]

"[A woman working with the Missionaries of Charities] had given me a card with which I could get free medical care. But she took it away after she came to my house and saw that I had a TV. I sell tea and areqe [locally brewed alcoholic drink]. I have to do something to earn a living and that's what I do. And if I serve drinks, I have to have a TV for people to watch while they drink my areqe. It's good for my children too; they have something they can watch and relax with rather than being bored and depressed all the time. It made them feel they were no worse than anyone else's children too. But no, this woman couldn't have that! I was too rich to be supported if I owned a TV so she took away my card" [Female PLHIV].

It is vital not to ignore those who are marginally better off than the very poorest: withholding support puts them at great risk of joining the very poorest from the slightest shock. These exclusion criteria also appear to undermine the promotive goals of the Social Protection Policy, in particular by discouraging initiative.

3.7. The membership advantage in accessing social protection

We now examine what contributes to the greater success clients of a CoP partner or other NGO (who, as we indicated above, are also often members of a group, such as a SHSG or association) enjoy in accessing social protection programs compared to non-clients. We refer to that relative success as the membership advantage.

3.7.1. The programs available to clients

As discussed above, Support to Vulnerable Children was consistently indicated as the most widely accessed social support program by survey respondents. FGD participants and KIs indicated that even in sites such as Debre Elias and Fincha where they told us there was little social protection to be had, it was OVC care and support programs, however limited the support they actually provided, that were said to be the most available. In all four sites, these programs are predominantly run by non-government organizations. They are typically part of larger HIV/AIDS prevention and impact mitigation programs targeted at individuals and households that are living with or considered to be vulnerable to HIV infection or affected by AIDS. More often than not, the last category consists of very poor, low income households – usually those headed by single mothers.

A slightly different situation exists with respect to Employment Promotion. The CoP partners, like other NGOs, assist clients in the formation of SHSG (Self-help Support Groups), teach them occupational skills, offer loans and sometimes provide materials to start up a small enterprise. Like Support to Vulnerable Children, these programs are often, although not always, delivered to clients along with HIV/AIDS and OVC care and support programs. Clients are thus able to access and make use of the NGO-delivered program as well as the government-led MSED program. In fact, many NGOs with such programs work with local MSED offices to facilitate their clients' access to assistance and support that is available from the Government program. The only employment creation/promotion support that is available to non-clients is the government's MSED program.

3.7.2. Attractiveness and accessibility of NGO programs

Evidence from the focus group participants suggests that there are factors which make the MSED program undesirable, at times even inaccessible, to the very people who need its support the most. These include the terms and conditions around accessing loans and loan repayments which participants often stated were too difficult to meet, the unavailability of assistance in obtaining work spaces as well as the lack of regular, adequate and sustained follow-up on the side of the MSED office.

In explaining why DORCAS's employment creation/promotion support program was preferred over that offered by the MSED, participants of the PNHD FGD observed;

"I think most of us have had one kind of training or another through the kebele and MSED offices. The problem is, they train you to do this or that and at the end of the training it proves difficult to do what you were trained in because you can't get a loan or find a place where you can work from. There are also problems with groups, the trainings are short and not as intensive as the ones DORCAS gives. The kebele doesn't try to make the groups they form functional, as DORCAS does. They don't train people on things like how they can get along with one another and ensure that their group functions well. So the groups tend to break up not long after they have been formed. It isn't easy to work in groups, but DORCAS have warned us about this the very first day they called us here and made us form groups. They have taught us

how we should deal with disagreements and conflicts and it is these things we learned from them that have kept us together as a group”.

“If we take a group loan from MFIs through the MSED office and one member of the group is unable to repay, it is the rest of us who will be held responsible. ... But here in DORCAS, it is the association/group that will be liable and the loan of the person who defaults will be paid from the association’s saving not from our individual savings. More importantly, there is a lot more follow-up and supervision from DORCAS. They make sure that we are meeting every week, making our savings and repaying our loans regularly so the chance of someone in the group defaulting is really low”.

Participants of the PLHIV FGD in Debre Eliyas had similar reservations about the support they got from the MSED program:

“I took a loan from X Credit and Savings and used it to open a shop. But it didn’t work out well. Between the rent, taxes, and license fees the money I borrowed was disappearing all too quickly. And I had to pay back a certain amount every month. If you take out 5000 in loan, you have to pay back about 380 Birr at the end of each month. So it proved to be more trouble than it was worth and I didn’t want to go through it again once I paid it back”.

“I have tried to take out a loan from X Credit and Savings, too. There were five of us and we went and talked to them. They said we could take out a loan but asked us for collateral but only one among us had her own house. They said they would take that as collateral for the group but the woman wasn’t willing to risk her house for the group”.

3.7.3. Success in accessing Government programs

Analysis of the survey data suggests that members of an organization’s programs more frequently seek support from Government-run social support programs and succeed in obtaining it even where the organization is not itself delivering programs of this kind. This can be seen by examining the experience of respondents in Goba and Addis Ababa-Bole with respect to four programs in which there is no reported NGO involvement (see Table 8): Basic Social Services, Support to Vulnerable Children, Urban Housing and Grain Subsidies and PWD Support.

Figure 13 indicates that members of all four groups access support from these programs significantly more often than do non-members ($P < .001$). The difference is particularly striking with respect to MKG: The 21 MKG who were non-members succeeded only once in accessing these 4 programs; the 17 members succeeded 19 times.

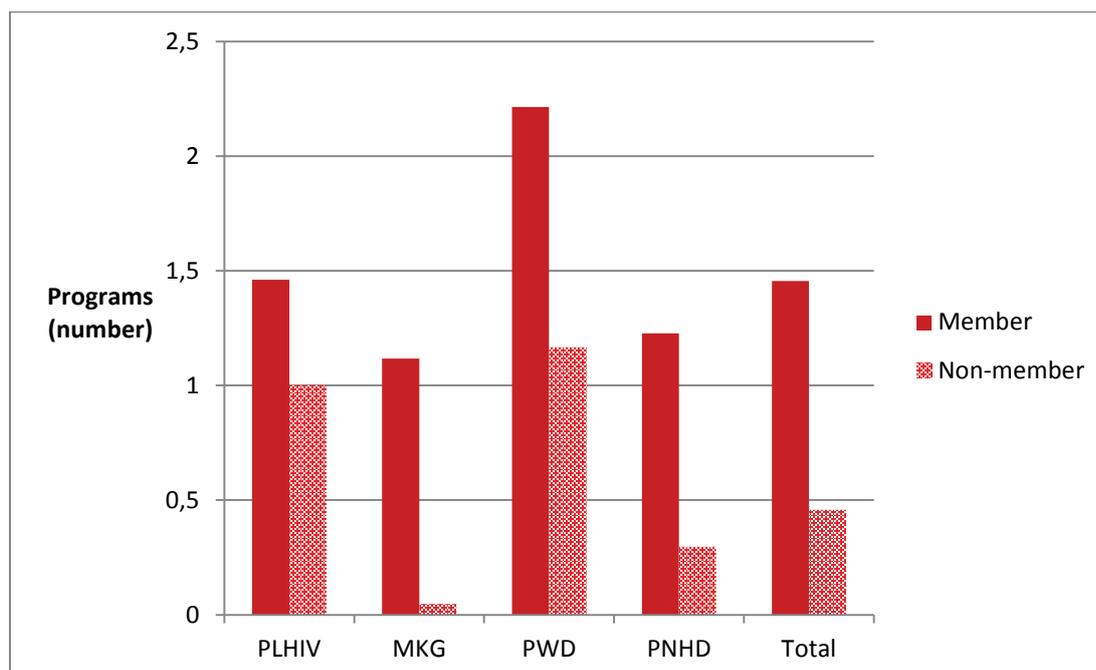


Figure 13. Mean number of programs respondents successfully accessed of the four that are provided in Goba and Addis Ababa-Bole by Government, apparently without NGO involvement. N (members/non-members): PLHIV (26/16), MKG (17/21), PWD (14/6), PNHD (27/49).

Figure 14 illustrates the membership advantage over all stages, from the number of these programs respondents in Goba and Addis Ababa-Bole have heard of to the number they obtain support from, in the same manner as in Figure 6. Recall that the farther the ratio lies above 1, the greater the advantage to members. The curves are more erratic than in Figure 6, as might be expected given the smaller numbers involved (for example, only 20 PWD, members and non-members together) but follow roughly the same pattern: PLHIV respondents have generally the least membership advantage, MKG respondents the greatest (note that the value of the ratio for MKG in access to support, 23.5, is too large to show on the graph). Overall, the advantage is greater in respondents' access to support from these programs than it is in their knowledge of them. The number of people surveyed is too small to conclude whether the membership advantage is larger or smaller for these four programs in these two sites than it is across all programs and sites but it is clear that members have an advantage in accessing Government-led programs even when their organization is not itself active in that area of social protection.

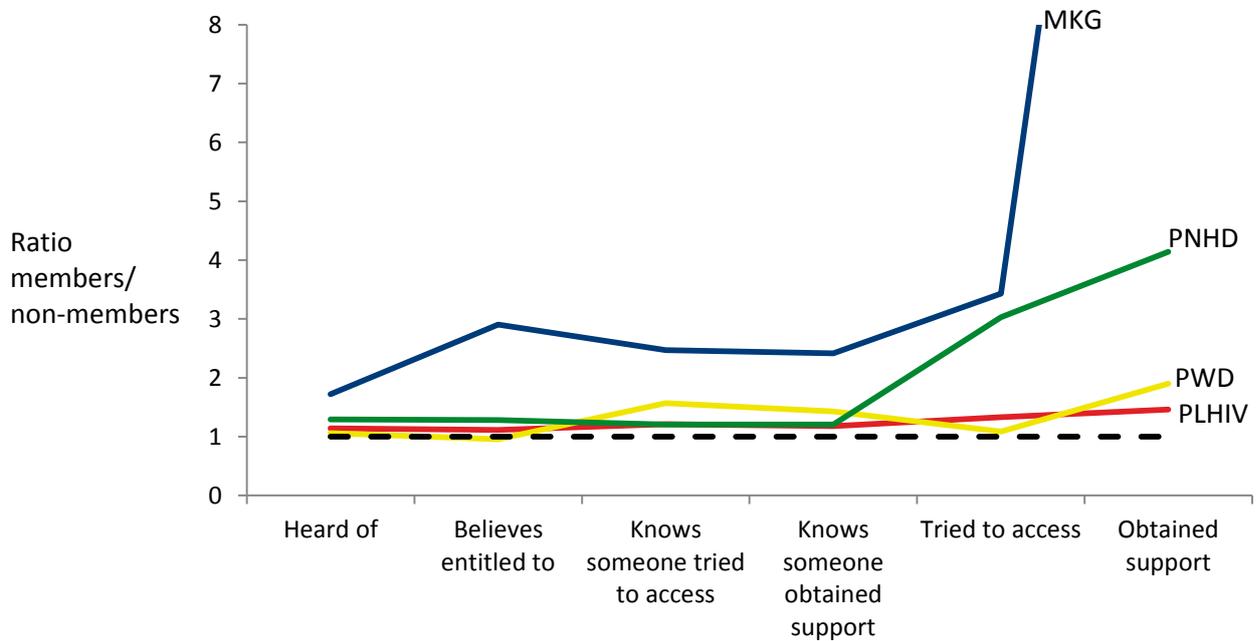


Figure 14. Knowledge of and access to social protection programs that are administered by Government without apparent NGO involvement in Goba and Addis Ababa-Bole, showing the effect of membership in an organization's programs. The graph indicates the ratio of the number of programs members know of and try and succeed in accessing to the corresponding number for non-members. All but one of the ratios are greater than 1 (dashed line), meaning members are always at an advantage. The exception is PWD in the number of programs they believe they are entitled to. The greatest advantage is seen for MKG members in the number of programs they obtain support from (23.5 – off scale). Numbers per group are as in Figure 13.

The survey respondents provide indications of what this aspect of the membership advantage might consist of. Table 12 above suggested that lack of information about social protection programs was the most common reason respondents gave for not attempting to access them. Reliable information, advice and encouragement is something that members could expect to receive from staff of a competent, experienced NGO, such as the CoP partners. Table 14 indicates that support from the staff of another agency or organization was the most common

response people gave when asked whether anyone had been of particular help to them in their successful attempts to obtain support from a program.

Table 14. Respondents’ answers to the question, “Was there anyone or anything that was an important help in obtaining support?” (N=191 respondents who succeeded in obtaining support from at least one social support program).

Source of support	Frequency (%)
Staff of another agency or organization	90 (47.1)
Staff of the agency or organization itself	85 (44.5)
Information they had received	28 (14.7)
A friend or relative	27 (14.1)
Nothing in particular	6 (3.1)
Other reasons	3 (1.6)

The testimony of KIs and focus group participants provides more insight on this aspect of the membership advantage. As we shall see further below, being part of an organized group or association was one of the most important benefits participants cited from the support they had received, making possible a range of additional benefits such as training on livelihoods and financial management. How being part of a group or association might provide an advantage when attempting to obtain support from Government-run programs is suggested by the following testimony from a CoP staff in Debre Eliyas working with MKG – the group for whom the membership advantage was found to be the greatest:

“No one gave any attention to domestic workers: they were no one’s concern. They had no voice and couldn’t access any form of support. I am not saying that we have succeeded in bringing them to everyone’s attention ... they are still one of the most ignored groups of society. But the support that we have given them has at least enabled them to form an association, voice their concerns, access awareness creation and skills training programs: to better advance their interests and enjoy a few rights that they shouldn’t have been denied in the first place. ... When we assisted them to establish their associations, we also arranged meetings and introductory sessions with the WYCA office and the community policing units. They have easy access to these bodies and contact persons...The same with the children’s associations we have helped to set up.”

Preventing and responding to abuse and violence is one of the objectives of the Social Protection Policy (FDRE 2014) and this quotation suggests how being part of this NGO-facilitated association has enabled these women to access the state agencies charged with these responsibilities, in addition to awareness creation and skills training, aspects of social protection that are the primary concern of the programs on which this study has focused.

The following quote from a member of the Debre Eliyas domestic workers’ association amplifies the staff member’s observations.

“The most important thing we have gained from forming the association is the power to protect the rights of domestic workers. In the past, domestic workers had no power at all. Many who have worked for years have been kicked out by their employers without the salary they were owed or even the clothes they owned. But not anymore. Now a domestic worker can terminate her employment whenever she wants and can leave with what she has earned through her work. We now have contracts between domestic workers and their employers which clearly indicate what kind of work she is expected to do, how many hours she will work, how much she will be paid and so on. The domestic worker and her employer go to the Women’s Affairs office and sign a contract before she starts work. All of this was made possible by the life skills training we got from CVM and because we have an association. I can’t describe to you what a difference it has made. ... We have started saving... We have a program with health workers every three months where we learn about STDs and HIV and how we can protect ourselves. We ... take HIV tests regularly so we know our status. All of this wouldn’t have been possible without the support we got. We wouldn’t even have known each other let alone done all these things.”

A broad range of benefits from being part of the association emerge from this woman's testimony: better health care and health awareness, access to legal services, but also self-confidence and the strength gained from getting to know and joining with others in a similar situation.

3.8. Selective attention and discrimination

Analysis of the survey data indicated that the four groups differed in the extent to which they succeeded in accessing support from social protection programs. We look now at the evidence from participants in the focus groups and from key informants that may help to explain these differences. First we consider what we refer to as selective attention: the orientation of programs and the focus of those implementing them with regards to particular groups. Second, we consider evidence of discrimination against certain groups by those administering social protection programs.

MKG, such as the domestic worker just quoted, are not the only ones to find that their conditions are not appreciated and their needs neglected by the organizations responsible for administering social protection programs.

Testimony from a CoP staff member in Debre Eliyas with experience working with PWD describes some of the obstacles in designing programs oriented to this group:

"Support programmes for PWDs are more demanding than those for other groups: they need much more comprehensive support than people who are able-bodied. It is not as simple as giving them a few trainings and telling them to go make a living. Perhaps that is why so few organizations have tried it: it is a lot of work. Besides, programs like job creation and promotion may not be as successful with PWDs as with other groups such as youth and women. All organizations like to do things that have high impact; that is how they sustain themselves. They need to show that they have achieved this and made that impact. So they may not want to get into such high cost, low impact programs."

Participants in the PWD focus group in Fincha have clear ideas about the support they need and the opportunities that are being missed by the state-owned enterprise to provide it. Two of them commented:

"What we want is to work and earn a living like anyone else. The problem is, we need to be supported to do that. With able-bodied people it's easier: they can do all kinds of work, they get along with the community, they are not despised or pitied. So it is not as easy for us to become independent and self-reliant but we can still do it. What I suggest is for someone or some organization to study the problem closely, to determine what kind of support PWDs need and provide assistance based on that. ... I think there is an attitude problem in this area. No one pays us any attention, no one asks us what it that you need is or how can we assist you to make a living, to improve your life. People also think that since there is this factory here, everyone has a job, everyone is employed and there is no need for support. That is not the case..."

"There are jobs like time keeper that are not physically demanding; the factory could keep these easier jobs for disabled people and PLHIV. But they give them to people who are able-bodied and could do other work. Their attitude is all wrong; they think that we will be a liability if they employ us. People who couldn't find jobs in their area come here from all over the country and they get jobs. Why is it that we who have lived here all our lives can't get jobs?"

PWD in Goba were able to obtain support from the Employment Promotion program but found it was not at all appropriate to their condition.

"We were given a 20,000 Birr grant to start a business but told we could use it for sheep fattening, nothing else. Look at me [she cannot stand or walk]: how can I pull a sheep or feed one? We begged them to let us use the money for something that doesn't require physical strength but they refused. They said fattening sheep had been identified as a very good business for the Goba area and we were to do that. So we started a business. One of our members fell while chasing a sheep and broke her brace. Still we tried

our best and our business eventually had some promise. But then our leader, an ex-soldier, disappeared with all the money we had..."

Participants in several PWD and MKG focus groups believe that they have a harder time accessing social support programs than PLHIV and suggest why that might be. A PWD in Goba observed:

"I think PLHIV get better support than anyone else including us [PWDs] and people who are not disabled. They are given all the care and support that there is. Maybe it is because they have the ability to be a threat. In comparison with them, we are treated like dirt. ... It is not aid that we want: it's only my legs that don't work, not my head. What I need is a little support, a little assistance. But people don't think we are capable of anything. ... People need to change their attitude, especially those in positions of leadership in government offices. They are the major obstacles. What is the Social Affairs there for? But if I talk to them like this, they will say they aren't there for me. They don't even tell us about opportunities that we could make use of."

When the MKG focus group in Debre Eliyas was asked why they think it is easier for PLHIV to access the social protection programs, one woman observed:

"I think it is because they are afraid that if they don't support people with HIV and don't give them what they ask for they will be accused of discrimination. Maybe it is also because they think PLHIV are more in need of the support than us, that we are better off. There is nothing wrong with them supporting PLHIV but we deserve support as well. We work hard to improve our lives but we are giving away what we earn with our sweat in rent. ... We have to choose between eating and paying our rent."

Another MKG participant commented:

"It is PLHIV who ... are given whatever support there is: money, sheep. After them, maybe people with disability also get some support."

Key informants in Fincha generally supported the view that PLHIV are one of the two groups that get most attention from social protection programs, the other being school-age OVC. Women generally were seen to be given priority over men. The key informants cited PWD, the elderly, OVC not yet attending school, people in villages and people who are not members of an association facilitated by an NGO or other organization as the groups receiving least attention.

However, the head of the local PLHIV association sharply disagreed with the KI's assertion that PLHIV are favoured:

"I am sorry to say this but there is very little being done to support PLHIV... A lot of people from the government and non-governmental organizations talk about doing this and that for PLHIV but it is all talk and never materialises. People from all corners of the country come here because of the employment opportunities. As a result, this area has become an HIV hotspot. We at the association are trying our best to teach the community, to raise awareness and to serve as examples. I think our efforts are paying off and that fewer people are getting infected every year. But there are still a lot of PLHIV who need support and the support that we do receive is minimal..."

Staff of the CoP partners and local government in other sites shared the view expressed by the Fincha key informants concerning the relatively greater attention that has been paid by social protection programs to PLHIV and OVC; PWD and the elderly were generally seen as the groups that have received the least attention and for whom the unmet needs are the greatest. But informants in several sites emphasized that these differences must be kept in perspective. A CoP staff member in Debre Eliyas:

"It is difficult to say that any one of these groups has better access to support programs than the others because the support that is available is very little. PLHIV, OVC, and poor women – but especially OVC – may have been relatively better supported than the other groups but even for these, the support that is available is nowhere near what is needed both in terms of the numbers supported as well as the quality of the support provided. Unemployed and out of school youth are also getting some attention, especially

when it comes to employment creation and promotion. However, there is no doubt in my mind that PWDs are the ones that have been supported the least. ...”

A fairly consistent view emerges from focus group participants and key informants across the sites: PLHIV have generally benefited from the selective attention of social protection programs while PWD have received possibly the least attention. Few of the key informants mentioned women at high risk of HIV, suggesting they are not likely to receive particular attention, corroborating the testimony from domestic workers cited above. Groups that our study did not explicitly consider, notably older persons, were also seen as being relatively neglected.

This evidence suggests that selective attention by social protection programs has been an important reason for the relative success of PLHIV and the relative lack of success of PWD and women at high risk of HIV in obtaining support, corroborating the findings from analysis of the survey data.

3.8.1. HIV/AIDS related stigma and discrimination

Two recent studies in Ethiopia have explored the experience of stigma and discrimination by PLHIV: the People Living with HIV Stigma Index (NEP+ 2011), a national-scale study, and a study commissioned by the CoP and carried out in the operational areas of four partner organizations, different than the four covered in the present study (Loevinsohn, Teshome and G/Giorgis 2015). Both concluded that stigma and discrimination, particularly their most extreme forms, had declined in the past decade. Participants in the latter study reported that stigma and discrimination still caused distress and in some areas were a significant obstacle to PLHIV pursuing livelihoods.

Similar evidence emerges from the present study. The most widely expressed view in both FGDs and KI interviews was that HIV-related stigma and discrimination have decreased significantly in the last decade. However, several experiences were cited which illustrate that stigma, including self-stigma, and discrimination still prevent some PLHIV from attempting to access available programs or making good use of the support they are able to access. Despite the progress of the last decade, PLHIV feel that public disclosure of one’s HIV positive status, often a requirement to join a PLHIV association, entails real risk and is not a decision to be made lightly.

A PLHIV participant in Addis Ababa-Bole observed:

“PLHIV don’t want to come out into the open unless they have no other way to lead a quiet and less visible life. You might think that stigma and discrimination are things of the past but they aren’t; there is still a lot of whispering behind your back. ... Other groups like disabled people, orphaned children, and the ordinary poor don’t have to face the dilemma we do. If you are disabled or orphaned or poor, this is readily visible to people and they don’t talk behind your back or avoid you as they do with us. So there is nothing that holds you back from showing yourself as poor or disabled or orphaned and accessing whatever support is available to you. ... But it’s not like that for us: we think twice before deciding if the support we might get is worth the risk that comes with being known.”

It is striking that both this respondent and the PWD respondent from Goba cited above see their own situation as the more severe but possibly have little understanding of the other’s experience or what they have in common. For PLHIV, the cost of public disclosure can be severe, as one PLHIV participant from Debre Eliyas describes:

“All I have gotten so far for disclosing myself [and joining the PLHIV association] is to be called names; to hear people say I have AIDS, to be discriminated against. Medicine is the only support I get and even that is only for the HIV. I fell ill the other day so I went to the health center. The doctor said I had to buy this and that medicine. Who does he think I am? How can a woman who doesn’t have enough to eat buy all that medicine? I think I was mistaken to disclose my status and join the association. I wouldn’t have to cry like this if I had remained silent and unknown. People would still come to my [tea] house; I would still be selling tea, tella and areqe (locally brewed alcoholic drinks) and earning enough to live on. I tell myself they will come back, that I will sell a little tea and a little areqe tomorrow and that it will all be better. But it won’t.”

Others have refrained from attempting to access available services for fear of advertising themselves to people. A PLHIV participant from Addis Ababa-Bole said:

“I also heard there was a similar support program [a PLHIV-focused employment creation initiative] in my woreda. But when I went to the woreda to enquire about it, I got nothing more than people looking at me oddly and pointing fingers behind my back. I am beginning to think that all you get out of going here and there and asking for support is simply advertising that you are living with the virus, nothing else”.

In addition to preventing or complicating access attempts, stigma and discrimination can also make it hard for PLHIV to benefit fully from programs they have already accessed. A CoP staff member in Addis Ababa-Bole recounted:

“We trained PLHIV and OVC guardians in hair dressing and styling. This is what they told us they wanted training in. But after completing the training, some of the PLHIV were not able to find work in the field they were trained in; some were afraid of what people would say if they found out they were HIV positive, some said it will not be good for their health to stand all day and so on. But we didn’t experience any problems with the OVC guardians. So there are issues like stigma and discrimination that make it difficult for PLHIV to make use of the support services and programs that are available. Sometimes, it is the stigma and discrimination that they imagine they will experience that holds them back. It can also be their self-esteem and confidence: some PLHIV think they are physically weak and fragile and say they won’t be able to do this or that kind of work even when they are quite healthy. But there is still quite a lot of stigma and discrimination that is real. There are people who are not willing to rent houses for PLHIV or throw them out when they discover they are HIV positive.

Another CoP staff member observed:

“We have also experienced problems with some of our SHGs. One group had a mix of PLHIV and non-PLHIV women. They trained together, started saving and progressed well until they began the income generating activity they had agreed on: an injera making business. The PLHIV women found it hard to work with the others. They were continually telling them not to touch the dough or saying things like ‘who do you think will want to eat what you’ve put your hands into?’ So the PLHIV women abandoned the group because of that. We had a similar experience recently with another group that had started a food preparation business. Some of the women were not willing to work with the PLHIV women. They said that there were knives and such and that it wouldn’t be safe for them. So I think there is a lot of stigma and discrimination that is real.”

While stigma and discrimination evidently still affect PLHIV’s ability to pursue and obtain social protection support, it does not reverse their greater success in these terms than other groups. Below, we discuss the evidence on whether PWD experience stigma and discrimination.

3.9. Social protection as a right

During the FGDs and KI interviews we posed the question “Do you think that people generally see the support provided by these programs as a gift or something that they have a right to expect when they are in need?” We asked this of FGD participants who were or were not clients of the COP partner’s program and of the organization’s staff as well as local government and community leaders. Important differences were evident in the responses of these groups.

Staff of the CoP partner organizations generally expressed similar views across locations. They considered it the client’s right when they provided them support and what they were doing as their duty rather than charity. Many local government officials stated that people had a right to the services and support their offices provided so long as they meet the eligibility requirements and procedures that have been put in place. When it comes to support programs run by NGOs, such as the CoP partners, however, these officials pointed out that NGOs cannot be held to the same level of duty and responsibility as government and therefore the support they provide cannot be taken as a right that can be claimed.

Responses from FGD participants, clients and non-clients alike, were quite different. Although there were a few dissenting voices, the majority view, in all FGDs, was that support, whether government-provided or not, cannot and should not be seen as something people could expect as a matter of right and claimed as such. Participants agreed that for the people who needed the support most, it is, in principle, correct to say that receiving it is their

right, so long as they meet the criteria that have been set. However, participants pointed out that it would be unreasonable, unwise or unproductive to make the leap from principle to practice. The following quotes illustrate this well:

“For those who are truly in need of support and who meet the criteria, it could be said that it is their right to receive it. It is for them that the support is there isn’t it? But I won’t say it is their right, I won’t go that far. They should try to access what is available, ask for it, and explain how they meet the criteria set and so on. That is as far as they can go. They can’t claim it as a right” [Male, PNHD, Goba].

“The only support that is really mine by right is my pension. I am entitled to it and the government has a duty to pay it to me. Other than that, for the support given by NGOs, I don’t think that can be seen as a right at all since the NGO doesn’t have a responsibility or a duty like the government does” [Community Leader, Goba, PNHD].

“It is very difficult to see it that way [as a right]; it is very unnatural. I can’t go to this or that organization and say ‘it is my right, you ought to give me this or that kind of support’. Even if I was bold enough to say that, it feels very odd and awkward. ... [Narrates the many difficulties she went through after she lost her husband to AIDS]... But through it all, I never once demanded that I should get support because it is my right. ... [PLHIV, Addis Ababa].

“Things are hard enough already and we will only make them worse if we went around asking for support ‘because it is our right’. Government officials feel that we [PLHIV] have already gone too far: they think that we are asking too many things of them. There is this thing they are fond of saying whenever we go and ask them for anything; they say: ‘You people have become too much to bear – you want to get everything’. I have heard this more times than I can count” [PLHIV, Addis Ababa].

The reasoning differs somewhat but there is a strong sense among participants from the four groups that support is not something that can be expected as a matter of right or demanded and that doing so would likely be detrimental to one’s interests.

The practical reasoning of people in need of support approaching officials administering programs with inadequate and uncertain resources is described by a CoP staff member in Debre Elias:

“I think that people still feel some insecurity about the support and fear that it might stop all together if they demanded it as a right. If for example two people out of seven are getting support and I am among those who are not getting it, if I go and demand that I too be supported, the organization might simply pack up and leave all together. I think that is how people reason this out.”

An official from the woreda Finance and Economy Office in Goba had a rather different interpretation of their clients’ behaviour:

“I think you have to put this in the proper context. Our people [Ethiopians] are very humble. You will see people being grateful and thankful when they receive their pensions – their own money – so it is not surprising to see them being humble and grateful for food support and the like. If they get any support, they are grateful for it; if they don’t they might lament their ill-fortune but will not demand it as their right”.

Evidently not all are humble. A PWD in Goba, not a CoP client, recounts her experience when attempting to access what policy indicated she could expect to receive:

“There was a notice that came from higher up in the government about giving PWD priority for employment if they were equally qualified. I think it was in 2005 [EC] that it came out and I had a copy⁷. So I went to the Zone Social Affairs office to ask about it and whether it meant that I could get a job. But

⁷ This is most likely a directive concerning Proclamation No. 568/2008 relating to the Rights to Employment for Persons with Disabilities. None of the other participants were aware of this particular law or other policies concerning the rights of PWD.

the man I talked to didn't even try to talk seriously with me; he only mocked me. 'So do you have a master's or a bachelor's'? These are the kinds of people we deal with. We don't have anyone who cares about us, about our rights. Not here in Goba, not in Robe."

3.9.1. The Citizens' Charter

Related to these issues of rights and responsibilities, we investigated whether the Citizens' Charter, released by the Ministry of Civil Service in 2012, has been taken up and translated into clear operational standards by social protection agencies, as it is intended to be. We asked government officials at woreda levels about the status of the CC in their respective sector offices, how it is being used and whether it has helped to bring about any changes in the provision of services. We also asked FGD participants and staff of the CoP partner organization if they were aware of the CC and whether it had helped to improve the provision of social protection services.

Our findings suggest that the CC is being implemented in all four sites and all government sector offices as part of the civil service reform program. However, people outside the sector offices, including staff of some of the CoP partner organizations, are often unaware of the CC. Not a single participant from the 16 FGDs we conducted in the four sites had heard of the CC and neither had staff of two of the four CoP partner organizations.

The following description from a key informant from the Woreda Administration Office in Debre Eliyas describes the way the CC is being implemented in the four sites.

"Each [woreda level] sector office has discussed what it is to do and what services it is to provide to its clients in detail with its employees as well as its clients. Once each sector has done this, all sectors come together at the woreda level and present their outputs. We then discussed each sector in turn to establish what its clients expect from it, what its duties are, what activities it needs to carry out, and how it should go about carrying out these activities and services. We also discussed possibilities for integrating the activities and services of sector offices where these have a common purpose or target. In this process, consensus has been reached over the responsibilities of each sector and the way each sector has to carry out its activities. Each sector is also expected to discuss these things with its clients on a continuing basis so that they know what they have a right to expect from it. This is being done but I can't say that all people in the woreda are fully aware of the agreement. We are still working on that and it will take time".

KIs in the four sites indicated that they were in the early stages of implementing the CC and stressed there is still a long way to go; it is probably safe to assume that this explains the lack of awareness we observed among members of the general population and staff of some of the CoP partners. But KIs were also keen to point out that they have made, and are still making, efforts to create widespread awareness of the CC among the general population. KIs nevertheless stressed that the CC has already started to make a positive difference, especially in relation to improving peoples' awareness about available services and programs. An officer in the Goba woreda MSED Office told us:

"We are only in the second year of implementing it [the CC] and we still have quite a long way to go. However, I can say that more people this year are aware of what our office does and what services it provides than last year when we started implementing it. ... We are still working on reaching more people."

Staff of the CoP partners who knew of the CC recognized its potential but remained largely skeptical about the likelihood that this potential will be realized. Two staff members commented:

"It has the potential to increase accountability, to make people aware of the services they are entitled to and to demand them as a right. But in practice, there is little awareness among people about the Citizen Charter. What we are seeing is the government signing the agreement with itself rather than the people. It is the speaker of the woreda council who signed the agreement as the people's representative with the different sector offices. In this situation, the people are unaware of what was signed and what pledges were made by the different sector offices. You can't expect people to hold the sector offices accountable when they are not even aware of the signing or what was promised in the agreement. ... So at present, I don't think it is anything more than a document".

“I think the right awareness has not been created among people about what this is and what it is supposed to do. Not much work has been done in terms of raising people’s understanding of their rights and what they can expect to receive from these offices as a matter of right. It is difficult to say it has brought any observable change although I must say this is my personal view and not based on any concrete data”.

The Citizens’ Charter is still a work in progress. Many Ethiopians have a large stake in its full implementation.

3.10. How useful do PLHIV and key groups find the social protection programs they are able to access?

We approached the issue of how useful people found the support they had received from social protection programs in several ways. First, we asked survey respondents to make an overall assessment across the programs they had benefited from: “Can you imagine what your life and that of your family would be like without the support you received from these programs?” Figure 15 indicates that more than 65% in each of the four groups responded “somewhat worse” or “a lot worse”. Among PLHIV, 63% thought their lives would be a lot worse; among MKG the proportion was 34%. Among MKG and PWD, 17% said their lives would have been little different without the support they received; among PLHIV it was less than 10%. The larger proportion of PLHIV who say the support received has made a difference in their lives might be expected since on average they received support from more programs (Figure 4) however the figures for the other groups do not correlate well with the number of programs they received support from.

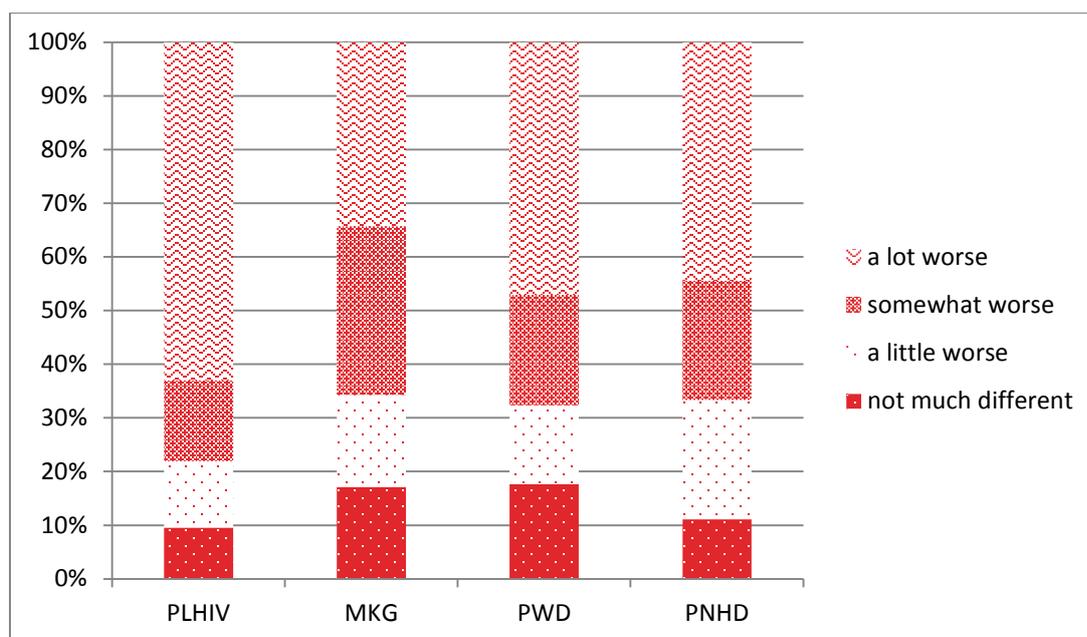


Figure 15. Survey respondents’ answer to the question: ‘Can you imagine what your life and that of your family would be like without the support you received from these programs?’ (Percent share)

When respondents were asked what the support has enabled them to do, educating their children – keeping them in school – stood out as the most frequently cited benefit, in all groups and locations (Figure 16 a and b). This is consistent with the earlier finding that OVC care and support programs were the most widely accessed social protection program.

A sub-question of Key Question 4 was whether PLHIV are better able to maintain health and strengthen livelihood. Their responses indicate that social protection support has made a difference in this regard for at least some: among the benefits they cite are maintaining health and nutrition (34%), providing more food (44%), paying their own medical costs (42%), increasing savings or assets (36%) and improving their house (30%).

Another sub-question asked whether people at high risk of HIV find they are better able to avoid infection. Among MKG, 36% responded that support has enabled them to avoid infection or illness. However, MKG also include OVC and those supporting them, so the question cannot be clearly answered.

A final sub-question was whether people living with the consequences of HIV find they are better able to avoid impoverishment. This particularly addresses OVC and those supporting them, but again the question cannot be clearly answered because MKG also include those at high risk of HIV. Nevertheless, it can be noted that 2/3 of MKG respondents cited keeping children in school as the major benefit of social protection. Removing children from school is one of most difficult decisions economically hard-pressed families are forced to make. A substantial number also mentioned increasing savings and assets.

Women in several of the focus groups spoke of the skills and self-confidence they have gained from employment creation and promotion support, and the benefits they derive from membership in a group or association. A PNHD in Addis Ababa-Bole observed:

“For me, the greatest thing I have gained from DORCAS is realizing the importance of saving and making it a habit. I have realized that saving even 10 Birr that would have otherwise been spent so easily for no important purpose will make a great deal of difference in my life in the long run. Our group meets every week on Thursday and each of us adds 10 or 20 Birr and sometimes 40 or 50 birr to our individual savings account, in addition to the 10 Birr we have to put into our joint savings account. Before I joined DORCAS, I didn’t know about saving ... Some people had iqubs, but that was a once in a month saving. This is every week, and when it is every week it makes us think twice about what we spend: perhaps I should put this in my savings rather than spending it for this or that. So it has been tremendously useful for me”.

A PNHD in Fincha recounted:

“I was organized into a self-help group by MKC’s project and received trainings. I had been a housewife and rarely left my house. It was only after I got the training that I realized there were many things I could do to earn money and improve my life. I started petty trading at the market and I saved the little I earned from that. Within a year and a half I had saved enough to open a small shop. It’s not much but I earn some money from it and it means a lot to me. I had never earned money before. I am able to give my children a lot more than I was able to provide just two years ago and it is all because of what I learned from the trainings”.

We cited earlier the testimony of the domestic worker and the CoP staff member in Debre Eliyas. Membership in an association and the skills, awareness, self-confidence and solidarity that the woman and her colleagues appear to have gained do more than help protect them from immediate and severe economic and health risks: there is a strong suggestion that their situation has been changed and that they have gained important capabilities that can enable them to avoid these risks in future, although there clearly remains much to be done to secure these benefits. Theirs and some of the other testimony presented suggest that well-conceived and implemented social protection programs can indeed have transformative effects, as the Social Protection Policy envisages.

It is important, however, to keep this potential in perspective: more than 37% of all respondents and more than 54% of MKG receive no support whatsoever from social protection programs (Figures 7 and 8).

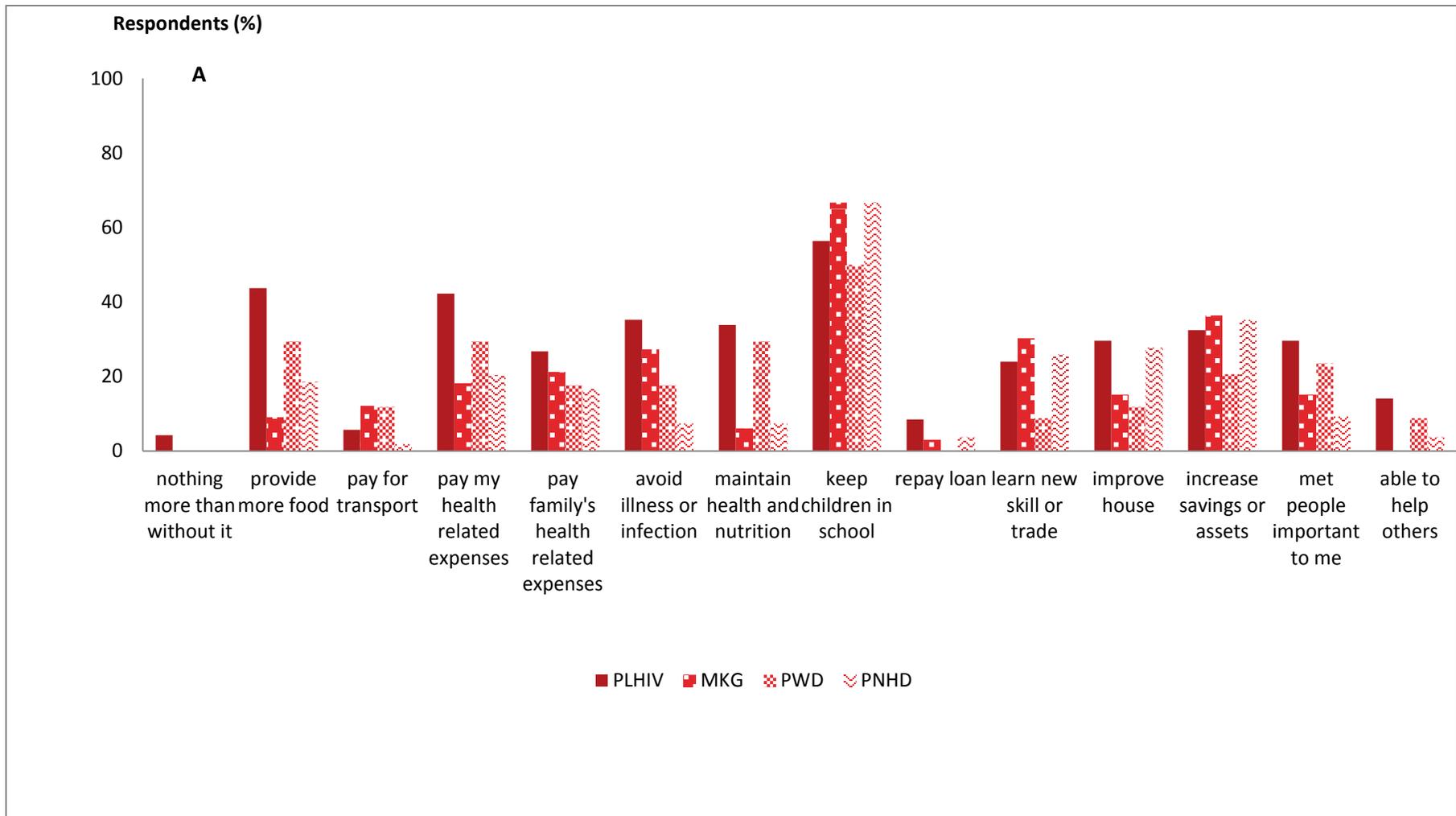
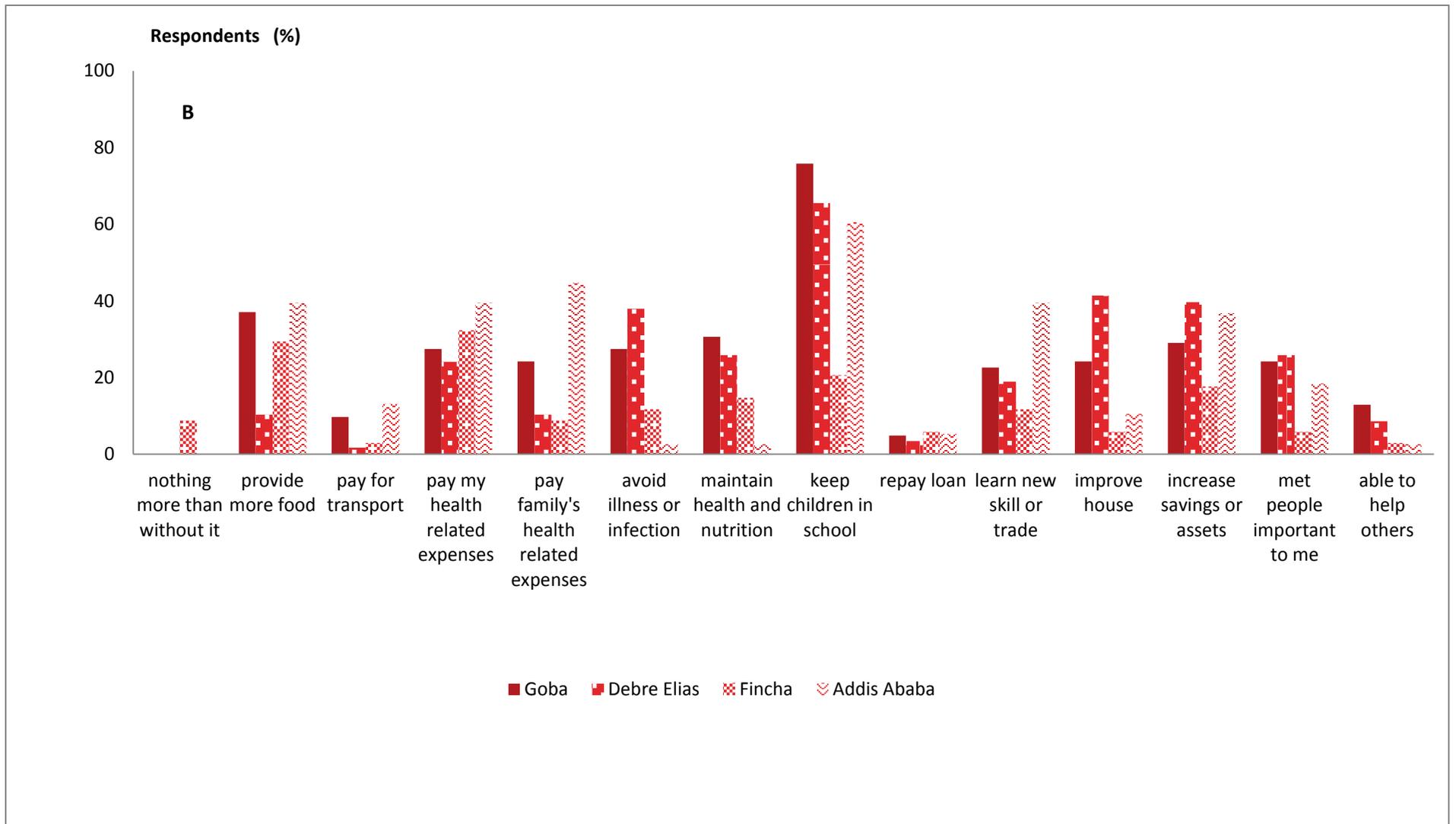


Figure 16. Benefits participants obtained from the support they received from social protection programs by group (A) and location (B). N=192.



3.11. To what extent do the COP's programs complement those of state social protection and how can that be improved for the benefit of PLHIV and key groups?

For the most part, the accounts offered by staff of local government and CoP partners regarding the relationships between them and among NGOs and government departments focus on the challenges in achieving what can be seen as fairly basic coordination: avoiding duplication of effort, assisting in recruiting clients and exchanging information. The evidence these informants provide suggests that broader collaboration, involving joint assessment of needs and opportunities, agreement on how the efforts of different organizations can complement each other and joint evaluation and learning is still very limited although some informants are clearly interested in moving in that direction. Note that in some quotations, "coordination" and "collaboration" have been used interchangeably.

In Goba, an official in the woreda Finance and Economy Office observed:

"I haven't seen much in the way of coordination. The few NGOs that work here do the things they do separately, each in their own way and following their specific programs. Perhaps Hundee is slightly better: they try to work with and involve government sector offices and community organizations like iddirs in their activities. There are even some who don't submit their activity reports to sector offices let alone try to work together with government offices and other NGOs. Because of this, it is not unusual to find some people who are receiving support from multiple NGOs. There are NGOs we have had a hard time evaluating because we simply did not know enough about what they were doing. From the side of the government, the support programmes are very few and these are usually based on data that are five years old. ... Not much is done in the way of assessing the current situation and determining people's needs. So I have to say there is little attempt to coordinate from both the government and non-government sides.

Staff of the Goba CoP partner, Hundee, described how they attempt to coordinate with Government and other NGOs to ensure equitable access to support by their clients, including but going beyond avoiding duplication of efforts:

"We try to work with and involve government sector offices. Our project focuses on OVC care so we work closely with the WCYA office. Among other things, they ensure that the children that we support aren't supported in other projects and that reduces duplication of efforts. I think other NGOs do the same. ...

"We have an identification number for each of our clients and we try to make sure that they are not getting supported by other organizations simultaneously. However, we don't prevent our clients from getting support from other organizations if it is different from what they receive from us and if we think that they need it. ... In reality, none of the NGOs that work here, including Hundee, provide support that adequately meets people's needs so it is actually ideal for the people we support to get additional support. For instance, the WCYA office convenes all NGOs that have OVC support programmes including us. We discuss what we are doing and try to exchange information and so on. But this rarely goes beyond information sharing and discussion. In terms of combining all our efforts and coordinating what we are doing to make it more effective, we haven't gone very far. There is a lot that needs to be improved".

Staff of Dorcas, working in Addis Ababa-Bole, describe similar efforts to avoid duplicating the efforts of other organizations while ensuring that their clients are not prevented from receiving complementary support from other's programs. The assistance of woreda offices has also been sought in recruiting clients for Dorcas programs although those proposed have not always met the agreed selection criteria. A staff member describes an innovative approach Dorcas is following to expand the scope for collaboration:

"We have set up a steering committee for our projects composed of all stakeholders including government sector offices, local government administrations and community leaders. The steering committee meets here in our office every six months. We report the activities that we have undertaken and the challenges that we have encountered. We discuss how we could solve these problems, supplement each other's' efforts and so move forward".

A CVM staff member describes the recent history of coordination in Debre Elias:

"There used to be very little coordination between the different organizations in the past. Each government sector did what it did by itself and each NGO signed its agreements with the relevant sector office by itself, carried out all its activities by itself, evaluated its outcomes by itself and only submitted its reports once in a quarter or a year to the relevant sector office. But after CVM started working on HIV/AIDS issues, we became a

member of the Zone HIV/AIDS Council and the secretariat has provided a very good opportunity for all those working on HIV/AIDS to be aware of one another's programmes, to supplement each other's activities, collaborate together, and review what has been done by everyone together.

The staff member goes on to describe the Community Care Coalition (CCC), a novel approach to advance coordination:

"If we want to start a new project, we first discuss it with the CCC, the WCYA office and HAPCO regarding who our targets are and how we will select them. After that, we have to discuss it with the woreda coordination committee and the technical committee after that. It may be educational support but we can only give support to 40 children out of one or two hundred who may need it; so we discuss our selection criteria with them and [they] decide who should receive support. This way, the support available is allocated fairly and we also ensure that there is no duplication of efforts and no double beneficiaries. This has been a great development ... but it is still in its early stages and there are a lot of things that need to be improved as we go on. There is also an NGO forum at the zone level which ... provides us with another opportunity to discuss what each one of us is doing, avoid duplication of efforts and collaborate with one another when possible".

The Kebelle Administration Head and Chair of the Kebelle CCC Committee described the origins of the CCC and some of the difficulties it currently faces:

"It has been about two years since the [kebele] CCC was set up. There are 15 people in the CCC committee composed of community leaders, the iddir leader, government and kebele administration leaders, religious leaders and so on. The CCC committee has been making a lot of efforts to mobilize the community and raise funds for the CCC. But we have not been very successful in this regard because people in the community here [in the town] have little capacity to start with.

He shared the view of an official in the Goba woreda Finance and Economy Office on how the now voluntary character of the CCC could be improved:

A system should be put in place to coordinate all the activities that are being undertaken by government and non-government actors and to set up an office that would handle this. If there was such an office with this specific responsibility, then that would not only facilitate coordination and make it mandatory for everyone to work together".

A CoP staff in Goba had a similar view:

"Just in our project alone, we have to work with the WCYA office, the LSA office, the education office, the health office and hospitals, among others. We try to do our best to involve them all in what we do but it is not easy. We call a meeting and only some come. ... But if there was a separate unit with the mandate to facilitate such coordination or at the very least a guideline, it would definitely make such coordination easier. The government has, for example, started to force all sector offices that have similar objectives to plan together and work together. So sector offices have started making joint plans and joint evaluations and one sector office is identified to lead this process and is made responsible for the coordination. It is exactly this that we are lacking when it comes to NGO-GO coordination."

The testimony indicates that coordination of efforts among Government and non-government social protection programs is still often a challenge. Joint planning and evaluation, which would make possible cycles of learning and improvement in the provision of services, appear to be what several informants are actively working towards in the CCC and other initiatives.

4. Discussion

4.1. Features and limitations of the study

In interpreting this study's findings, it is important to keep the following points in mind:

The study was commissioned by the Community of Practice and it uses the operational areas of four partners as study sites. These cannot be considered as representing conditions nationwide: none of the sites include rural villages where a large proportion of Ethiopia's population reside. As discussed above, the study's participants were in large proportion women. The question of how access to social protection varies between rural and urban areas and between men and women could therefore not be answered.

Furthermore, the CoP partners cannot be considered representative: we suspect that the quality of the programs they deliver is generally higher than those of most NGOs working with these groups in similar environments elsewhere in the country. To the extent that this is the case, the membership advantage which the study has documented in terms of access to social protection would be greater than what one would find with respect to most other NGOs.

Samples for the survey were selected from clients and non-clients of the CoP partners. In the event, 38% of the 304 respondents were clients. We estimate that a further 26.7% of non-clients of the CoP partners were clients of other NGOs, meaning that 54.6% of respondents were clients of one NGO or another. We suspect that this is a higher proportion than in the country as a whole. If it is, then, given the advantage members enjoy, the group averages we found, for example the number of programs MKG or PNHD accessed, would be greater than one would find for these groups elsewhere.

It is possible that part of the membership advantage is attributable to CoP partners selecting individuals for their programs who were the most likely to obtain social protection support, for example, because they were better educated and so better able to navigate the bureaucracy. We cannot exclude this possibility but note that age, gender and educational attainment were not significantly related to the number of programs respondents obtained support from (Table 9).

We suggest that the quantitative findings we report, e.g. the number of programs people obtain support from, are relevant to the study sites and their population i.e. the CoP partners, their clients, local government officials and community leaders. Likely of wider relevance are the trends and qualitative findings, for example the large gap between the number of programs people know of and the number they go on to access and obtain support from, the obstacles to access they encounter and the components of the membership advantage.

Our discussion of the study's findings is organized around the five key questions.

4.2. What are the social protection programs, provided by state and non-state actors, that are available and for which PLHIV and key groups are eligible?

The number and type of social protection programs that are in principle available and for which PLHIV and key groups are potentially eligible are largely similar across the four sites. Provision of Basic Social Services, Support to Vulnerable Children, Support to Persons with Disabilities, Employment Promotion, and Community-based Social Support are available in all four sites, while Urban Housing is available in three of the sites but absent in the company town of Fincha. Few of the participants in the study qualify for Support to Older Persons because of their age or for Social Insurance, which currently covers only public sector employees: the large majority of participants work in the informal sector, if they are employed.

The services offered by NGOs such as the CoP partners under these programs broaden the social protection available in government programs, although not uniformly across the sites. In two of the sites, Addis Ababa and Fincha, COP partners are implementing programs that facilitate access to healthcare by covering the medical care costs of their PLHIV and OVC clients, supplementing the government-financed medical fee waiver. The state-owned sugar factory in Fincha is also

providing medical care and monthly stipends to PLHIV among its employees. Though those receiving them complain that the stipends are inadequate to meet their basic needs, the program appears to be a unique corporate initiative in Ethiopia.

There are also programs run by CoP partners which provide other services to clients in particular target groups including MKG, PLHIV and PWD which are not available from Government programs, such as comprehensive medical care and forging links with judicial services.

4.3. To what extent are PLHIV and key groups actually accessing these social protection programs?

The method we employed to analyse the survey responses allows us to locate where the most important barriers in access to social protection are located. We found that respondents know of a relatively large number of the potentially available programs. Some know of programs that are not yet available in their area: in Goba, for example, more than half know of the Food Security Program which has yet to be rolled out there. This suggests that people are hearing about programs through other than official channels such as publicity campaigns.

Respondents believe they are eligible for somewhat fewer programs than they know of. By far the largest gap, however, is seen between the number of programs respondents believe they are entitled to and the number they attempt to access support from. A smaller gap is seen between the number they attempt to access and the number they succeed in obtaining support from.

PLHIV generally know of and obtain support from more programs than other groups. On average, PLHIV obtain support from 2.0 programs, PWD from 1.3 programs and MKG and PNHD from 0.9 programs. Broken down by site, respondents on average obtain support from 1.6 programs in Goba, 1.5 programs in Debre Elias, 1.2 programs in Addis Ababa-Bole and 0.6 programs in Fincha. These represent programs implemented by Government, community institutions and NGOs.

The factor having the greatest influence on the number of programs a respondent obtains support from is being a client of an organization's programs (often this involves membership in a facilitated group or association). This differential, which we refer to as the "membership advantage", is seen to vary among the groups; it is greatest for MKG and least for PLHIV. MKG who are non-members obtain support on average from 12% as many programs as a member; for PLHIV the proportion is 59%, for PWD and PNHD it is 33%.

Access to support appears to be very inequitably distributed. Among respondents, 37% receive no support whatsoever and 24% have support from one program. The proportion receiving no support is greatest among MKG (54%), least among PLHIV (11%) and intermediate in PWD (36%) and PNHD (48%).

Respondents who can only access to Government-led programs are on average receiving support from no more than 0.73 programs and possibly as few as 0.23 programs. This compares to 2.1 programs among respondents who could access both Government and CoP-run programs. More than 57% of those who could only access Government-run programs received no support; among MKG, the proportion was 85%.

In all groups, Employment Promotion, Provision of Basic Services, Urban Housing and Support to Vulnerable Children are among the five most accessed programs. The programs oriented to OVC, particular groups at risk of HIV, PLHIV and PWD are also among the most accessed.

The small number of respondents (3%) receiving support from Community-based Social Support is surprising. More than half (54%) know about these programs and 41% know of someone who has succeeded in obtaining support from them. Most of the attempts to access these programs occurred more than 5 years ago, much earlier than attempts to access other programs. None of the testimony of key informants and focus group participants sheds light on why so few find support from this source. The question bears further discussion with CoP partners and possibly further investigation.

4.4. What are the obstacles PLHIV and key groups face in accessing social protection programs?

The rate at which survey respondents have attempted to access social protection programs varies significantly among the four groups – greatest for PLHIV, least for MKG, intermediate for PWD and PNHD. Success rates also vary significantly –

greatest for PLHIV, least for PNHD, intermediate for PWD and MKG. In both attempt and success rates, clients of an organization's programs fare much better than non-clients.

Evidence from the survey, focus group discussions and key informant interviews provide complementary perspectives on the factors that affect these rates and that limit people's attempts to access social support programs and their success in these attempts.

4.4.1. Factors affecting access for all

Lack of information about the programs, their eligibility for them or how to approach them is the most common reason survey respondents give for not attempting to access them.

Some programs which respondents believe they are entitled to are not available locally or are practically inaccessible. The Food Security Program, for which there is a demonstrable need, is not currently being implemented in any of the four sites. Other programs, like the provision of medical care fee waivers in three sites, are so limited that focus group participants consider them unavailable.

Access to some programs is limited by what focus group participants and key informants consider unrealistic eligibility criteria. For example, livelihood strengthening and employment promotion is currently being provided in some sites only as part of OVC care and support programs and so is unavailable to men or women without children. Another frequently cited concern relates to individuals or households having to be among the "poorest of the poor", which is often the principal criterion for access to social protection programs. It is typically not well defined in operational terms, leading to subjectivity in its application. Moreover, the manner in which the criterion is being applied may be undermining the promotive goal of the Social Protection Policy: support has been withheld from some who have managed to accumulate productive assets that place them incrementally above the poorest of the poor, thereby penalizing initiative.

4.4.2. Factors contributing to the membership advantage in access

There are three reasons why clients of an NGO's or CoP partner's programs, who are often also members of a group or association the organization facilitates, are better able to access support from social protection programs than non-clients. First, clients have access to more programs than non-clients. A common example is Support to Vulnerable Children which is often provided as part of wider programs of support to PLHIV or OVC. These are implemented, in some areas exclusively, by NGOs such as the CoP partners.

Second, in areas where NGOs and Government may be providing services that are ostensibly similar, those provided by the NGO may be more attractive and accessible. Focus group participants described examples where both encouraged the formation of self-help groups but the NGO provided follow-up and training that help make the groups more functional and longer-lived.

Third, there is evidence that clients of an NGO's programs are more successful in accessing Government programs even in areas of social protection in which the NGO is not itself active. Analysis of the survey data indicates that in two sites, Goba and Addis Ababa-Bole, where Government is implementing four social protection programs without apparent NGO involvement, members more frequently seek support from these programs and succeed in obtaining it than non-members.

There are indications that this aspect of the membership advantage may in part be related to better access to information and to being part of a group or association of people facing common social challenges. This was evident from the experience of house maids in Debre Eliyas: membership in an association has given these previously marginalized women greater awareness of the health and economic risks they face and how to avoid them, information that allows them to access a range of services, and strength and confidence from joining with others in a similar situation.

4.4.3. Factors contributing to differences in access among the groups

The analysis of the survey data indicated that the four groups differ in the extent to which they have succeeded in accessing support from social protection programs. Evidence from participants in the focus groups and from key informants in all sites provides insight into the factors that contribute to these differences. It suggests that social protection programs have generally paid greater attention to the needs of PLHIV and OVC than to those of PWD and the elderly, among whom there are large unmet needs. Some Government informants refer to the efforts they are making to support sex workers but other groups at risk of violence and HIV, such as housemaids, are generally not mentioned.

Urban people and those who are members of a group or association are also said to have received relatively more attention than people from rural villages people and non-members of a group or association.

Several key informants emphasized that, while some groups may have received relatively more attention from social protection programs, the support provided is, for all, nowhere near what is needed both in terms of the numbers supported and the quality of the support provided.

While discrimination against PLHIV is generally seen to have declined in the past decade, evidence from focus group participants indicates that it persists and, together with self-stigma, prevents some PLHIV from attempting to access available programs or to make good use of the support they are able to obtain. However, stigma and discrimination are not sufficiently severe to reverse the relative advantage in access to social protection that PLHIV enjoy. This is not to minimize the other effects of stigma and discrimination they experience.

The generally acknowledged selective attention of social protection programs may be experienced as discrimination by the groups less attended to, such as PWD. The testimony of PWD focus group participants indicates that they have at times been met with negative stereotypes when approaching agencies, which further limit the support they are able to access and its quality. Their ideas on how support to them could be better provided have not been taken on, suggesting that opportunities for greater program effectiveness have been missed.

In the study areas, PNHD benefit from the least number of social protection programs, along with MKG – less than one per person. This could be taken to indicate that those with characteristics that make them particularly vulnerable – living with HIV or a disability – are, properly, receiving more attention. However, the low level of access also reflects in some degree the lower level of organization among PNHD: only 26% are clients of an NGO, including the CoP partners, the lowest of any group (see Table 2). As the testimony of PNHD at several points indicates, they have important unmet needs.

4.4.4. Structural factors that limit access

Discussion in focus groups in all sites indicates that participants rarely see the support that social protection agencies or NGOs provide as a right that they can claim. While some say that people who meet the eligibility criteria a program establishes may, in principle, have a right to support, the predominant view is that expecting to receive it or attempting to claim it as a matter of right would be ill-advised and detrimental to one's interest. However, some participants have forthrightly pursued, individually, support that they had reason to believe they were entitled to, though without success.

Staff of local government offices and CoP partners generally said that while people have a right to support if they meet a program's criteria and some see it as their duty to provide it, in a context of limited and uncertain provision, people lack the confidence to press for their rights. A local government officer characterized the predominant attitude as one of humility and gratitude for whatever support is received.

Key government informants described the implementation of the Citizens' Charter. Sector offices have been clarifying with their employees what services they will provide and discussing with other offices opportunities for coordination and greater efficiency. Each sector is also expected to confer with its clients on a continuing basis so that they know what they have a right to expect. Awareness is said to be growing though much remains to be done.

CoP and government staff recognized the potential of the Citizens' Charter to increase awareness of social protection programs and to improve accountability. However, staff of only 2 CoP partners and not one of the FGD participants had heard of the CC. As one CoP staff put it, people cannot press for accountability if they don't know what engagements have been made and what rights have been confirmed.

Clients surer of their rights and more confident that they will not be penalized if they claim them can contribute to improving access to and the quality of social protection even, or perhaps especially, in situations of severe resource constraint. They are likely those most aware of groups or needs not currently being addressed and of opportunities for making more effective use of the available support. Organizations seeking to promote livelihoods often operate with stereotypical understandings of a group's capacities and ignore their own attempts to innovate (Loevinsohn et al 2012).

4.5. How useful do PLHIV and key groups find the social protection programs they are able to access?

When respondents who had received support from social protection programs were asked, “Can you imagine what your life and that of your family would be like without the support you received from these programs?” more than 65% in each of the four groups responded “somewhat” or “a lot worse”. The percentage was highest among PLHIV, lowest among MKG. Educating their children – keeping them in school – stood out as the most frequently cited benefit for all groups.

PLHIV often mentioned providing more food and paying their health care costs as important benefits. Maintaining health and nutrition is crucial for PLHIV taking ART and frequently a major challenge. More than a third also cited increased savings and assets which their livelihoods are more secure.

MKG includes people at high risk of HIV for whom avoiding infection is critical. More than a quarter of MKG respondents cited avoiding infection and illness as a benefit of social protection. More than 36% also cited increased savings and assets which are important to OVC and those who support them seeking to avoid impoverishment. Unfortunately, the fact that MKG includes both those at high risk of HIV and at risk of impoverishment makes it difficult to assess how each group assesses the value of the social protection support they have received.

A number of women spoke of the skills and self-confidence gained from employment promotion support, and the benefits they derive from membership in a group or association. These include occupational and life skills, awareness of health and economic risks, ideas on how to avoid them and the solidarity which, as mentioned above, may make accessing other services and programs less daunting. Some of the testimony suggests that well-conceived and implemented social protection programs can have transformative effects, altering the risk structures they faced, as the Social Protection Policy envisages.

This potential has to be tempered by the recognition that many of the survey respondents and a majority of those who can access only Government social protection programs, receive no support whatsoever. This is likely to reflect the experience in areas of the country where membership in NGO programs is less widespread than in the study areas.

4.6. To what extent do the COP’s programs complement those of state social protection and how can that be improved for the benefit of PLHIV and key groups?

One of the sub-questions of the Key Question was whether CoP members are facilitating access to state programs e.g. by improving awareness and information. As the discussion above indicates, clients of an organization, including the CoP partners, are better able to access state programs than non-clients, even where the organisation does not provide services of this sort. Improved awareness and access to information contribute to this advantage, the evidence suggests.

For the most part, the relationships between NGOs and government departments appear to involve what can be seen as fairly basic coordination: avoiding duplication of effort, assisting in recruiting clients and exchanging information. The evidence informants on both sides provides suggests that broader collaboration, involving joint assessment of needs and opportunities, agreement on how the efforts of different organizations can complement each other and joint evaluation and learning is still very limited although some informants are clearly interested in moving in that direction.

Dorcas in Addis Ababa-Bole is following an innovative approach to expand the scope for collaboration. They have set up a steering committee for their projects composed of all stakeholders, including government sector offices, local government administrations and community leaders. The steering committee meets every six months and reviews activities in the period and the challenges encountered, then discusses how these problems can be solved and each other’s efforts better complemented.

In Debre Elias, a Community Care Coalition (CCC) has recently been established, governed by a committee composed of community, iddir and religious leaders, together with government officers and kebele administration leaders. It serves as a forum for discussing and coordinating initiatives proposed by NGOs and others, ensuring that limited resources are used equitably and reach those most in need. It is also intended to raise funds for locally initiated efforts however this has been constrained by the limited financial capacity of the community.

There are some important similarities and differences between our findings and those of the ILO study (ILO 2014). The level of access to social protection appears to be higher – reaching a larger proportion of PLHIV, with a larger number of programs – in the areas of Ethiopia we studied than in the four countries the ILO considered. However, it is not clear whether the ILO study included programs implemented by NGOs. People in the informal sector in Ethiopia appear to have easier access than in those countries and discrimination does not appear to be as significant an impediment to access in Ethiopia. On the other hand, lack of information about social protection programs and complicated bureaucratic procedures are common problems. Access to health care, other than provision of ART, is also a major, shared issue. In Ethiopia, we find that it is not only PLHIV who confront it.

5. Conclusions

Access to social protection programs is very unequal: 37% of respondents and more than half of MKG receive no support from social protection programs, of whatever source. Among respondents who are not clients of CoP partners or other NGOs, who can access only Government programs, at least 57% and more than 85% of MKG receive no social protection support. For all respondents, access to services such as Medical Fee Waivers is variable and arbitrary. The Food Security program, for which respondents express a keen need, is not being implemented in any of the sites.

While it is important to keep these large unmet needs in view, the achievements the study documents are nonetheless significant. PLHIV, once marginalized and still encountering stigma and discrimination, obtain support from more social support programs than other groups. Moreover, PLHIV that are not clients of the CoP partner's programs – so without the membership advantage – obtain support more frequently relative to clients than do non-clients of any other group. Programs are widely seen to pay greater attention to PLHIV and OVC than to other groups and more so than previously.

This is a partial and relative success but indicates what other groups might achieve through the concerted efforts of a range of actors. The evidence also suggests that the experience of these groups in relation to social protection programs has often been similar and that they have a shared interest in the development of more responsive, coherent and accountable programs. There is an unrealized potential to develop and administer programs that keep in mind the capabilities of groups such as PWD and the elderly and that take account of their ideas on how support can be more effectively provided.

The confidence, practical skills, and links to a range of services that some of the most marginalized people appear to have gained through membership in CoP-facilitated groups and associations appear to have transformed the risk environment they formerly confronted.

5.1. Recommendations for research

It is important to examine whether the pattern of selective attention which has worked to the disadvantage of groups such as PWD and the elderly is found in other parts of the country. The reasons for the low levels of access to Community-based Social Support need to be further investigated. The gaps in this study notably with respect to the access to social protection by men and people in rural villages should be filled in.

Research should document and help evaluate institutional innovations such as the CCC and others being explored by CoP partners which aim at improving coordination and advancing collaboration among the providers of social protection services.

5.2. Recommendations for policy

Unrealistic eligibility criteria and counterproductive program designs should be reconsidered. In some cases, programs are now excluding people with clear need for support; in others, clients' initiative is being penalized, thereby undermining the promotive objectives of the National Social Protection policy.

Government should explore means to extend the coverage of the food security program and health care waiver provision for which this study has revealed a large unmet demand.

State offices providing social protection services should be vigilant that their selective attention to certain groups does not leave others underserved. The study suggests that this may be occurring with respect to PWD, the elderly, young OVC, the childless poor and people who are not NGO clients. Means to bring these groups up to the level that those benefiting from attention have achieved should be explored.

The Government's Citizens' Charter should be fully implemented, including development of charters at the level of local offices providing social protection services. These are meant to spell out the standards of provision that clients have a right to expect. If widely publicized, these charters will help create an environment in which, more confident of their rights, clients can forthrightly contribute to the progressive refinement of social protection programs.

Institutional innovations like the Community Care Coalition and others such as those being explored by CoP partners should be promoted and encouraged. They offer means through which the social protection efforts of all providers can be coordinated and adapted to local conditions and opportunities. With effective leadership and the involvement of all stakeholders, including clients, more coherent and equitable provision of social protection can be delivered.

5.3. Recommendations for CoP partners and other NGOs

Discuss with clients and local partners the reason for the apparently very limited access to Community-Based Social Support and what can be done to improve on it.

Explore how groups and associations can provide benefits even to non-members, for example in facilitating access to state social protection programs.

Develop and refine coordination and collaborative initiatives with state and community actors providing social protection services.

Increase awareness among staff and clients of the Citizens' Charter and progress in its local implementation.

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