

Addis Ababa University

School of Graduate Studies

Department of Community Health

Exploring Partnerships with *Civil Society Organizations* in Health Development: The

Case of *Iddirs* in Addis Ababa **By**

Garoma Kena (MD)

**A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS
ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTERS OF PUBLIC HEALTH**

May 2007

Addis Ababa, Ethiopia

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Declaration

I declare that this thesis is my original work and has not been presented for a degree in any university and all the sources of materials used for the thesis have duly been acknowledged.

Name Garoma Kena Denbeli

Signature _____

Date May 2007

Place Addis Ababa University

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Acronyms

ACORD	Agency for Cooperation in Research and Development
AIDS	Human Immune Deficiency Syndrome
BCC	Behavioural Change Communication
CBO	Community Based Organization
CSO	Civil Society Organization
FGD	Focus Group Discussion
FMoH	Federal Ministry of Health
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
HSDP	Health Sector Development Program
IEC	Information Education Communication
MoFED	Ministry of Finance and Economic Development
NGO	Non Governmental Organization
PASDEP	Plan for Accelerated and Sustainable Development to end Poverty
PLWHA	People Living With HIV/AIDS
SPSS	Statistical Package for Social Sciences
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing

ABSTRACT

Background: Health being the major development input, it was given due considerations in the millennium development goals to be achieved by 2015 by developing countries including Ethiopia. The health service coverage, utilization and quality in Ethiopia are poor and have not shown significant gains over time. The sector has been dominated by the public sector with limited involvement by other actors. The government could not handle the problem alone. Cognizant of these facts, the need to diversify actors in the health sector was given priority in the health policy as well as other policy documents. The *Iddir* is one of civil society organizations in Ethiopia that has recently gained some attention as potential partner in development, both by the government and non governmental organizations.

Objectives To explore partnership potentials between *Iddirs*, the government, and non-governmental organizations in the health sector.

Methods: Cross-sectional exploratory study was conducted from January to March, 2007 using both qualitative and quantitative methods of data collection. For the quantitative survey, a sample of 422 *Iddir* leaders were randomly selected from the *Iddirs* currently registered with the ten Sub Cities of Addis Ababa for interview. For the qualitative part, four focus group discussions were organized with *Iddir* leaders and *Iddir* members to explore their views on the importance and willingness of establishing partnerships between *Iddirs* and the government and non governmental organizations. Eleven in-depth interviews were also conducted with key informants drawn from non-governmental organizations working in partnerships with *Iddirs*

and relevant government agencies to explore their views on the significance and possibilities of establishing partnerships with *Iddirs* in health development.

Result: Out of the 422 *Iddirs* surveyed, 228 (54.0%) are currently engaged in health related activities in one way or another. The majority, 216 (51.2%), are involved in HIV/AIDS prevention, care and support activities. One hundred thirteen (26.8%) are offering some form of health care financing services to their members. Ninety-seven of them (22.9%) are also involved in environmental health activities. In the qualitative study, the need to establish partnerships with *Iddirs* has been emphasized by participants from governmental and non governmental organizations. *Iddirs* have also expressed their willingness to go in to such partnerships, although some are still suspicious in partnering with the government. Participants also expressed the need to build the capacity of *Iddirs* to be active development partners and improve their working environment.

Conclusion: In general, a number of opportunities and entry points exist to establish partnerships with *Iddirs* in public health efforts. The study has found that *Iddirs*, which were once providing only funeral services, are coming out as development actors and partners. Moreover, they are modifying their by-laws to include issues pertaining to pressing public health problems such as HIV/AIDS. There is also increasing recognition on the role of *Iddirs* in development by both the government and NGOs. The public health activities the *Iddirs* are currently engaged in can serve as potential entry points into partnerships with them for all concerned. However, a number of important contextual factors have been identified that need to be considered in initiating partnership working arrangements with *Iddirs*. Such initiative must accommodate their fears, concerns and suspicions if it has to prove effective.

Chapter One: Background

1.1 Introduction

Due to government and market failure in poverty alleviation and sustainable development, particularly in developing countries, there has been a re-thinking in development theory to find alternative actors beyond these two forces. The civil society organizations (CSOs) have long been identified as a third category of actors in development (Sitz 1995). This civil society approach seems to be an innovative opportunity for poverty alleviation and sustainable development by mobilizing local initiatives and resources in poor countries like Ethiopia.

Civil society organization includes different categories of organizations ranging from western type modern non-governmental organizations to grass root community based people's voluntary self-help organizations (Rooy 1998). The latter includes indigenous burial organizations such as *Iddirs* in Ethiopia.

The role of civil society organizations in mobilizing the community to participate in developmental activities has been argued to have comparative advantages as compared to other approaches such as the state in many ways. Some of the reasons forwarded were that they are very effective to reach the poor as these organizations are very often organized by the poor themselves and they are also said to tactically mobilize internal and external resources for equitable development (Rooy 1998).

The problem of the poor with respect to health has become a central issue in development. For the poor, health provides beyond just its intrinsic value to individuals. For poor people, health is also an important economic asset for their existence and livelihoods. Good health means better labour productivity, less time lost from work by the sick person and care givers, and improvement in over all conditions of the household. Illness of an individual in a poor household can significantly challenge the livelihood of the household through reduced or lost income due to less productivity and sale of livelihood assets and high health care costs leading the entire household in to more advanced poverty.

Achieving better health is of course recognized as an important prerequisite for developing countries to bring about economic development. Considering the role of health in reducing poverty and the range of investments required to achieve better health for poor people as an integral component of poverty reduction strategies, it has been recommended that health sectors develop a pro-poor approach which includes improving governance, strengthening the delivery and quality of health services, reaching highly vulnerable groups, developing more effective partnerships for health development, and designing equitable health financing mechanisms (OECD 2003).

The civil society approach therefore seems particularly very sound for poor countries where poverty eradication forms the core of their current development policies. In partnership with the public and private sector, civil society organizations have fundamental role, building up on the existing institutional framework and charting out other appropriate ways to intervene (Mangeni 2004).

In Ethiopia, varieties of such CSOs exist among which *Iddirs* are the most wide spread, prevalent in both urban and rural areas, and often transcending the divides of gender, generation, wealth, education, religion and ethnicity. These voluntary indigenous community based organizations (CBOs) were primarily established to provide mutual aids in burial matters at times of death but also address other community concerns at times (Pankhrust 1998).

It has been suggested that *Iddirs* can be mobilized to tackle pressing problems in public health such as HIV/AIDS, which needs full popular participation (Pankhrust and Haile Mariam 2002), and there have been emerging efforts by few NGOs to undertake joint partnership projects with *Iddirs* (Tsfaye 2002).

1.2 Statement of the problem

In the past, development policies and strategies of developing countries have been dominated by, either private sector led market driven or state led development strategy for health, economic growth and poverty eradication. However, third world countries like Ethiopia generally lack such modern organizations, which can provide the necessary services to the beneficiaries at the local level (Aredo 1998).

The health sector in Ethiopia has also suffered from the consequences of such policies. The effective health service coverage, utilization and quality in Ethiopia are poor and have not shown significant gains over time. The sector has been dominated by the public sector with limited involvement by other actors.

The government could not handle the problem alone so that the need to involve other actors in an attempt to diversify the sources in financing and mobilizing resources to increase access as well as improve quality, and utilization of services has been the major policy issue in the Health Sector Development Program (HSDP) and other policy documents (FMoH 2003, FMoH 2005).

Although much has been done in the last decade in improving the capacity of the public sector and in attracting more and more private investors to invest in the sector, the government still faces difficulties in putting in place the right organizations that can reach the local people, particularly the poor and the neglected segment of the community.

Even though, they were largely neglected in the past, *Iddirs* in Ethiopia, popular form of indigenous voluntary CSOs, have recently been points of interest by researchers, policy makers, and development actors in the country as third category of actors and partners in the country's development efforts.

Despite this renewed interest, to increasingly involve *Iddirs* in developmental activities including health, both by the government and NGOs, there is little articulation on how to translate this into action. Potential entry points and methodologies for more acceptable partnerships between *Iddirs*, the government as well as NGOs have not been identified well.

Furthermore, although most health activities are funded through formal organizations in Ethiopia, little is known about what the informal organizations have been doing and what their strengths and limitations are (Kloos 2000).

1.3 Significance of the study

The renewed interest in *Iddirs* as potential partners in development and the seemingly correct view shared by many that involving *Iddirs* in pressing developmental problems like health will be effective, needs more information on the activities already being undertaken by the *Iddirs* to build on what they have at hand and further explore potential areas for partnerships. To this end, the study documents what *Iddirs* are currently doing in the health sector, and explores potential opportunities and entry points into partnership with *Iddirs*. The information gained from this study is believed to serve as springboard for the government, NGOs, and other development actors for initiating partnership-working arrangements with *Iddirs*. The study is also expected to enrich the scarce literature pool and stimulate other researchers to do more job in the area.

Chapter Two: Literature review

2.1 What are *Iddirs*?

Iddirs are probably the most widespread and very popular traditional CBOs, rooted in the cultural life of Ethiopians (Zerihun 2003). Their origin is not clear and requires careful historical research but has been suggested to be associated with the growth of urban centers at the beginning of the 20th century (Tenagashaw 1973), as an alternative to tightly integrated social networks in the rural areas.

Basically, *Iddirs* are associations established by members who agree to contribute a fixed amount of money on periodic basis which is used to help defray burial costs when a spouse, a child or immediate relatives of a family passes away. The membership may be recruited based on family, friendship, neighborhoods, ethnicity, place of work, occupation etc.

The *Iddir* members are expected to take care of all practical matters relating to burial, including announcing the death of one of its members, pitching the *Iddir* tent in the courtyard of the house of the deceased, where the bereaved family will receive the respects and condolences from relatives and friends.

Iddir also lends out its communally owned cooking and service utensils during the three days of mourning after the funeral. The *Iddirs* also donate a fixed amount of cash to the family of the deceased to cover miscellaneous expenses related to the funeral and the mourning rituals. Monthly contributions are paid to a person elected as a cashier or a treasurer and there is a

secretary that keeps the roster of members. The periodic contribution that people pay varies from one *Iddir* to the other.

Iddir management is transparent, accountable and cheap. They have written rules, regulations, and are organized with a certain leadership structure that is known to both its membership, the public and to the authorities. Usually there is a well-known and respected *Iddir* chairperson (called the '*Iddir dagna*' or the *Iddir* judge) who presides over *Iddir* meetings.

Since their origin, *Iddirs* have undergone significant transformation and considerable degree of formalization primarily due to the use of currency, which is contributed by members according to specific bylaws for handling the burial functions that needed regular meetings, registry and document keeping for better financial management. *Iddirs* have proved to be very strong in recruiting and mobilizing community members for any sort of activity. Despite these, strong influences they have, their involvement in developmental activities have remained insignificant (Pankhrust and Haile Mariam 2002).

This has been explained by the ambiguous and often negative relations between them and the successive governments in the past, who tried to marginalize, co-opt or abuse *Iddirs* for their own political purposes or even ban them at times (Kohen and Kohen 1976). For these and other reasons, they were rather cautious about collaborating in development activities and tended to stick to their burial function only in an attempt to avoid interference by the government (Pankhrust and Haile Mariam 2002).

Although some have argued that, the potential for such organizations to form development partnership with the government and Non Governmental Organizations (NGOs) is rare as

they tend to avoid interference by external parties for fear of losing their autonomy (Rahamato 1999), *Iddirs* in particular do not seem to have been tested enough for that. Others still argue that, attempts can be made to introduce development objectives in their agenda without violating their institutional arrangements and traditional roles to gain the motivation and willingness of members in development efforts (Zeyohannes 2001).

More recently, *Iddirs* have gained some attention from the government as well as NGOs in Ethiopia, as potential partners in development (Asefa 2000), which can be attributed to the global paradigm shift in development theory that recognizes the role of civil society organizations as actors in development.

The idea to involve *Iddirs* in development in Addis Ababa emerged in 1972 when the Ministry of Community Development and Social Affairs called for a seminar to discuss on the issue even though not much had come out of that initiative beyond an attempt to keep the status quo rather than empowering *Iddirs* as development partners (Salole 1986; Koehn 1976).

During The Marxist regime in the 1970s and 1980s, the conditions became even harsher for *Iddirs* to participate in any developmental activity, as they were obliged to stick to their burial functions to avoid interference by the government (ACORD 2003).

Comparatively, the current government seemed to have shown a spark of interest in *Iddirs* as development partners. The invitation of *Iddir* members to participate in a workshop to discuss on the draft national law of the Ombudsman and Human Right organized by the

Committee of Legal Affairs in the House of Peoples Representatives and another workshop on proclamation 147/1998 on cooperative regulation organized by the cooperative unit of the Addis Ababa City Government (Asefa 2000) can be taken as important signs to this interest. More recently, the government in its plan for Accelerated and Sustainable Development to End Poverty (PASDEP), called for a push towards strengthening the role of *Iddirs* in sustained care and support services for PLWHA to reduce dependency on external resources (MoFED 2005).

There are also emerging attempts to form development partnerships with *Iddirs* by few international and local NGOs mostly in urban areas (Tesfaye 2002) although their performances were not well evaluated. A study by the Addis Ababa City Government Social and Labors Affairs Bureau indicated the existence of 4007 *Iddirs* in the city (Tadese 2002). Some have argued that the activities of *Iddirs* in development of the city is insignificant compared to what their magnitude would suggest (Petros 2001). However, this is not based on empirical evidence as researches are lacking in the area.

A study on the response and potential role of *Iddirs* in HIV/AIDS prevention and control has identified that they are engaged in activities like Information Education and Communication (IEC), giving support to people living with HIV/AIDS (PLWHA) and orphans due to the epidemic (Pankhrust and Haile Mariam 2002; Negash 2003).

The renewed interest in *Iddirs* as partners in development and the seemingly correct assumption shared by many that involving *Iddirs* in pressing developmental problems like health will be effective, needs more information on the activities already being undertaken

by *Iddirs* to build on what they have at hand and for further exploration of potential areas of partnerships. This is especially because it has been recommended that policy makers and development agencies work through existing indigenous community based organizations (CBOs) and build on their self-initiated activities instead of displacing them (UNAIDS 1999).

2.2 *Iddirs* as CSOs

The concept of Civil Society Organization is rather controversial, used by different people in different ways. Difficulty is observed in putting down precise definition of civil society and what constitutes civil society organizations. Particularly of interest is the problem encountered when concepts and definitions developed in a Western context are applied in non-Western settings.

The concept is debated in terms of two opposing arguments among scholars. For some, civil society must involve the contestation of the ideological hegemony of the state and roll back the overwhelming power and presence of the state through influencing public policy, striving for the larger public interest (Rahamato 2002; Abate 2004)

The other debate stems from the formality of such organizations. Some claim that both formal and informal organizations should be included in the framework of CSOs (Tesfaye 2002; Pankhrust and Hailemariam 2002) while others argue that the conceptualization of CSOs is impossible outside the formal organizational framework (Rahamato 2002).

In discussion of civil society organizations in Ethiopia, (Rahamato 2002), presented CSOs in terms of “a variety of autonomous, voluntary institutions which provide services to individuals and which articulate public interests”. Based on these criteria, he described CSOs in Ethiopia as consisting of NGOs, advocacy organizations, professional organizations, co-operatives, trade unions, religious organizations, and the independent free press.

Interestingly, Rahamato excludes informal (or traditional) organizations such as *Iddirs* as well as ethnic self-help or development associations from his definition of CSOs. Although *Iddirs* may well represent autonomous and voluntary associations, he excludes them from consideration on the grounds that there is little evidence that they are able to transcend the particular interests specific to them, i.e. they are often based on interests that are outside the domain of public policy. He argues that there is no enough evidence to indicate to what extent such organizations contribute to the large public interest and provide this as major rationale to justify his argument.

Pankhrust and Haile Mariam (2002) however, note that the formal/informal dichotomy in this regard may be too simplistic; and they argue that ‘despite all the constraints on such voluntary organizations, there is a fair amount of evidence on the nature of such associations’. They further indicate that even though their contribution has been limited, this should not be considered a sufficient reason to exclude them from the domain of civil society. Similarly, Teketel (2001) argues that the criteria of inclusion and exclusion into CSOs are misleading. He particularly notes that excluding informal CBOs and ethnic-based self-help associations from the domain of CSOs in the African context is rather controversial. He argues that such associations should be included.

If an organization to be labeled CSO, must be involved in public policy, should challenge the overwhelming power of the state, participate in issues of governance and democratization process; as argued, this may pose a big question on the position of even the modern NGOs (which are often considered as classical CSOs) operating in Ethiopia in the domain of CSOs. Because they have played not at all or very little role if any, with regard to the above criteria.

Therefore, it is more plausible that CBOs such as *Iddirs* in Ethiopia that form the social fabrics of the society must be included in the domain of CSOs. The following more general definition of CSOs is, therefore, employed in this study. “Groups formed for collective action outside the State and the Market” (Rooy 1998). Under this definition come different forms of organizations ranging from western international NGOs to grassroots people’s voluntary organizations. The latter category includes, among others, burial associations like the *Iddirs* in Ethiopia.

2.3 Why partnership for health?

Improving human health, reducing poverty and bringing about sustainable development can be better realized through joint partnership efforts of all development actors, as their full potential can be realized if they work in more strategic and coordinated ways. Such partnerships have become the cornerstones of public health actions. Partnering with the

community is necessary to create change and improve health. Inter-organizational, co-operative and synergistic working partnerships between government and CSOs have gained popularity in recent years as a mechanism to positively impact on the social, cultural and economic determinants of health (Gillies 1998; Huxham and Vangan 2000).

There are many reasons for working in partnerships: finding creative solutions that emerge from differing perspectives, improving working relationships between different actors, creating sense of ownership in development outputs, empowering communities with participation and inclusion, particularly of the poor and the neglected groups and individuals; and identifying holistic approaches to community issues.

Evidences suggest that partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private and non -government sectors do work. In particular, the stronger the representation of the community and the greater the community involvement in the practical activities of health promotion, the greater the impact and the more sustainable the gains (Gillies 1998).

The notion of government/CBO partnership is often used to denote the reciprocal arrangements between the government and the community to address social needs (Balloch and Taylor 2001). That is, governments realized the need to involve community in order to address social needs because the community is better equipped to identify services and create innovative responses to their unique problems.

The community is the necessary link between the state and its citizens and it is often the vehicle through which individual citizens' voices can be heard outside the formal political process. Similarly, the local community also needs the support of government, not just in financial terms, but also to provide guidance on organization, accountability, and most importantly, to reconnect unique community issues with the broader community as a whole. In this regard, it has been recommended that policy makers and development agencies work through existing CBOs and build on their self-initiated activities instead of displacing them (UNAIDS 1999).

Iddirs are the most widespread and very popular CSOs rooted in the cultural life of Ethiopians (Zerihun 2003). They are prevalent in both urban and rural community and often transcend the divides of gender, generation, wealth, education, religion and ethnicity (Pankhrust 1998).

They are part and parcel of the coping mechanisms and survival strategies of the people. Since *Iddirs* as organizations are embedded into the way of life and culture of the people, they are respected, valued and internalized by the people. They have proved to be very strong in recruiting and mobilizing community members for any sort of activity. Moreover, their organizational strength, the degree of autonomy they enjoy, their inclusiveness, particularly for the poor, and their huge social capital make them appropriate organizations for channeling development activities and funds. These and other reasons make *Iddirs* more valuable tools to ensure popular participation in all efforts of development in the country, including public health, compared to other organizations that are usually imposed on the community from outside.

Chapter Three: Objectives of the study

3.1 General objective

To explore partnership potentials between *Iddirs*, the government and non-governmental organizations in health development.

3.2 Specific objectives

1. To identify the current health related activities of *Iddirs* in Addis Ababa.
2. To explore potential opportunities and entry points for partnerships with *Iddirs* in the health sector for all concerned parties.
3. To explore willingness of *Iddirs* to work in partnership with other organizations.

Chapter Four: Methods and subjects

4.1 The study area

This study was conducted in Addis Ababa, the capital city of Ethiopia, with over three million total population; from February to March 2007. The city is sub-divided into 10 sub cities (districts), and 100 Kebeles (the smallest administrative units in the country)

4.2 The study population

The study participants for the quantitative survey have come from leaders of *Iddirs* that are currently registered by the ten sub-city administration offices of Addis Ababa and have active files with the city administration. For the focus group discussions, *Iddir* leaders and members were included from both registered and non-registered *Iddirs* in the city. The in-depth interviews were conducted with selected officials from NGOs that are currently working in partnerships with *Iddirs* and officials from relevant government agencies.

4.3 The study design

This is a cross-sectional exploratory study, which employed both quantitative and qualitative methods of data collection to triangulate the benefit of both methods.

4.4 Sample size and sampling techniques

A sample of 422 *Iddirs* from those currently registered by the Addis Ababa Sub City Administration Offices was calculated based on the assumption that 50% of the *Iddirs* in the city are currently undertaking some health related activities, with 95% confidence

interval and 5% margin of error by using sample size formula for single proportion and 10% added for non-response for the quantitative survey of health related activities currently being undertaken by the *Iddirs*.

$$n = (z_{\alpha/2})^2 (P) (1-P) / d^2 = 422$$

The calculated sample size was then proportionally allocated to the ten Sub-Cities based on the number of *Iddirs* currently registered by the Sub- City Administration offices. Participating *Iddirs* were randomly selected from each sub city until the required number is reached for each sub city. The leaders of the selected *Iddirs* were then approached and interviewed on issues regarding the activities of their *Iddir* in the health sector.

4.5 Sampling for the qualitative study

To get information on issues that cannot be fully explored by the survey interview method, a total of four focus group discussions and eleven in-depth interviews were conducted.

The focus group discussions were organized with six to eight carefully selected participants in each group drawn from *Iddir* leaders and members; both from registered and none registered *Iddirs*. Leaders of *Iddirs* and members who were suggested by others as being more active in the *Iddir*'s day-to-day activities and leaders of *Iddirs* identified as more communicative during the field survey were selected on purposive

basis. A total of twenty-six, seven females and nineteen male individuals were included in the four focus group discussions.

Important points raised during the focus group discussions, among others, included issues pertaining to the role *Iddirs* could play in the health sector, the challenges met in their efforts so far, the importance of working in partnership with other organizations, and willingness of *Iddirs* to establish partnerships with other organizations including the government.

In-depth interviews with eleven key-informants drawn from non-governmental organizations currently working with *Iddirs*, as well as concerned government officials, was also conducted to explore their views on the significance and possibilities of establishing partnerships with *Iddirs* in health and other development activities.

4.6 Data collectors and study instruments

Ten high school graduates were recruited and trained for collecting the survey data. The principal investigator moderated both the focus group discussions and the key informant interviews. A sociologist has participated in assisting the qualitative data collection.

Structured pre tested questionnaire was used to interview the target *Iddir* leaders for the quantitative survey; while semi structured discussion guide and interview checklists were used for the focus group discussions and key informant interviews respectively. All data collection instruments were prepared in Amharic.

4.7 Data quality control

To ensure the quality of data, all data collection instruments were originally prepared in the local language, Amaharic. Instruments for data collection were also tested in advance and all necessary adjustments were made before the actual data collection. Data collectors, supervisors and facilitators were also effectively trained to enable them acquire the basic skills required in data collection and supervision. Moreover, data quality was controlled as much as possible by cross checking the already filled questionnaire formats daily, and through frequent on-job supervision by the principal investigator.

4.8 Variables

The major variables dealt with, among others, included socio-demographic characteristics of the *Iddir* leaders; duration since establishment of the *Iddirs*; types of services being provided by the *Iddirs*; current health related activities of the *Iddirs*; development related plans; attitude towards working in partnerships; and willingness to form partnerships, with other organizations including the government.

4.9 Data processing and analysis

Data from quantitative survey, after cleaning and checking for completeness of the filled questionnaire formats, data were coded, and entered in to SPSS Version 11.0 Microsoft for

Windows computer program for analysis. Frequencies and percentages of the responses were calculated. While the qualitative data obtained from focus group discussions and key informant interviews were audio taped, transcribed, and translated in to English. Then the responses were categorized under relevant themes and features that are characteristics of the majority of the respondents were summarized and reported.

4.10 Ethical considerations

All ethical clearances were obtained and official letter was collected from the Faculty of Medicine, Addis Ababa University before the commencement of the study. The purpose of the study was fully clarified to all concerned in general and to the respondents in particular. Informed consent was obtained and voluntary response was sought from each respondent and confidentiality was assured. Half of the data collectors were purposely made to be females and female key informants were included to make the study gender balanced.

Chapter Five: The results of the study

5.1 Findings of the quantitative survey

5.2 Profiles of the *Iddirs* and socio-demographic characteristics of leaders

A total of 422 *Iddir* leaders have participated in the interview for the health related activity survey of *Iddirs* in Addis Ababa, making the response rate 100%. The participating *Iddirs* were of different types. Most of them were multi purpose community *Iddirs* accounting to 90.3 % of the participating *Iddirs*. The rest were contributed by variety of other types such as workplace *Iddirs*, women *Iddirs*, youth *Iddirs*, religion based *Iddirs*, family *Iddirs*, and other interest group *Iddirs*.

Table 1: Frequency distribution of the various categories of *Iddirs* surveyed, Addis Ababa, March 2007

<i>Type of Iddir</i>	<i>Frequency</i>	<i>Percent</i>
<i>Multi purpose community Iddirs</i>	381	90.3
<i>Women's Iddirs</i>	19	4.5
<i>Youth Iddirs</i>	10	2.4
<i>Work place Iddirs</i>	7	1.6
<i>Others¹</i>	5	1.2
<i>Total</i>	422	100

The mean time since establishment of the studied *Iddirs* was found to be 23±7 years. Youth and women *Iddirs* are found to be of recent making, existed for 1-4 years on the average. The average member size in one *Iddir* was 131 ranging from 28 to 600 while the average total beneficiaries in one *Iddir* was found to be 751 people.

The average monthly contribution by members in the surveyed *Iddir* was found to be 10 birr with a range from five to 25. Most of the *Iddirs* were not willing to disclose their total savings or such data were not readily available. Most *Iddirs* have already revised their bylaws to include development agendas. The revised bylaws in most cases included fighting HIV/AIDS as a major issue to be dealt with by the *Iddirs*.

Iddir leaders with differing names and functions such as ‘*Iddir dagna*’ (the *Iddir* judge), ‘*ye Iddir genzeb yazy*’(the *Iddir* treasurer), ‘*Ye Iddir sebsabi*’(the *Iddir* chairperson) were identified and interviewed for this survey. The *Iddir* leaders were predominantly found to be males in 92.3% of the cases. Leaders of women *Iddirs* were, however, all females. Almost half (47.8%) of the *Iddir* leaders interviewed were educated from grade 1-6 while 114 (27%) have no formal education. Small proportion of the *Iddir* leaders (3.1%) have obtained at least college level education. Table 1 below summarizes the major socio demographic variables of the *Iddirs* leaders interviewed.

Table 2: Socio-demographic characteristics of the *Iddir* leaders interviewed, Addis Ababa, March 2007(N=422)

Variables	Number	Percent
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¹ Others include religion based *Iddirs*, family and keen ship *Iddirs* and friendship *Iddirs*

Age		
15-49	28	6.6
50-64	251	59.5
>65	143	33.9
Sex		
Male	389	92.2
Female	33	7.8
Educational status		
No formal education	114	27.0
Grade 1-6	202	47.9
Grade 6-12	93	22.0
College diploma	9	2.1
University degree	4	1.0

5.3 Health related activities of the *Iddirs*

Most of the *Iddirs* 267(63.3%) were involved in other development activities in one way or another, including health at the time of the study. The rest were not engaged in other development activities but provide only funeral services. The most frequent reason for not participating in other development activities for those not engaged in such activities was found to be limited financial capacity.

The community development activities of the *Iddirs* are diverse and differ from one *Iddir* to the other. It ranges from construction of social utilities like road, water, community schools, churches and others, provision of support to the poor members, the elderly orphans and all members at times of problems including financial support at times of illness, saving and credit

activities, environmental sanitation, HIV/AIDS prevention, care and support activities, and crime prevention activities. Two hundred twenty eight (54.0%) of the *Iddirs* were engaged in health related activities at the time of the study.

Table 3: Public health activities of the *Iddirs* surveyed, Addis Ababa, March 2007 (N=422)

Public health activities	Number	Percent
HIV/AIDS prevention, care and support	216	51.2
Health care financing	113	26.8
Environmental sanitation	97	22.9
Others ²	27	6.4

Among the health related activities that were being undertaken by the *Iddirs* at the time of the study, the major ones were HIV/AIDS prevention, care and support, health care financing, environmental sanitation, advocacy and health education, care and support for orphans and old people. The major areas of engagement of the *Iddirs* in the health sector are described in more detail below.

5.3.1 HIV/AIDS Prevention, Care and Support

² Support for orphans, the elderly and disadvantaged groups of the community, construction of drinking water sources, schools, health facilities, and conflict resolution, prevention of harmful traditional practices and violence against women.

Well over half (51.2%) of the *Iddirs* have HIV/AIDS prevention, care and support as a major component of their health related activities. IEC/BCC was identified as a major area of intervention in HIV/AIDS prevention care and support, which was being undertaken by almost all (93.9%) of the *Iddirs* that were engaged in HIV/AIDS, related activities.

Health education sessions were often arranged during *Iddir* meetings in which non-members are also allowed to participate. At times, funeral ceremonies are used as a forum for transmitting HIV/AIDS related messages. Apart from these, some *Iddirs* also have separate planned monthly sessions for health education that are often organized in collaboration with NGOs and officials from the government health facilities.

The health education sessions also include advocacy for voluntary counseling and testing (VCT). Very few *Iddirs* (6.0%) of those engaged in HIV/AIDS related jobs were engaged in condom distribution. Most of the *Iddirs* engaged in condom distribution were found to be youth *Iddirs* and work place *Iddirs*.

Care and support for victims of HIV and orphans due to HIV/AIDS was found to be the second common area of intervention in HIV/AIDS by the *Iddirs* surveyed, which was being undertaken, by 159 (73.6%) of the *Iddirs* involved in HIV/AIDS related activities. The services offered under care and support include: home visit to AIDS patients, covering some of the medical expenses for AIDS victims at times of illness, exempting AIDS victims from paying the monthly contribution if they disclose their status and if they are not able to work, and at times allowing some of the money they had already paid to the *Iddirs* to the victims so that they can use it for their living till they die and care and support for AIDS orphans.

The kind of support provided to AIDS orphans included: covering school fees, covering part of the medical expenses, house rent, giving membership right in the *Iddir* in places of deceased parents and exempting from the monthly payment required from members. AIDS orphans are also given priority in securing credit money to run small businesses from the *Iddirs* if the service is available.

Table 4: HIV/AIDS prevention, care and support related interventions by *Iddirs*, Addis Ababa, March 2007. (N=216)

Interventions	Number	Percent
IEC/BCC	203	93.9
Advocacy for VCT	163	75.5
Care for PLWHA	67	31.0
Care for orphans due to HIV/AIDS	83	38.4
Condom distribution	13	6.0
Fund raising for AIDS victims	9	4.2

5.3.2 Health care insurance schemes

Among the *Iddirs* surveyed, slightly over a quarter (26.8%) were providing some form of health care insurance to their members and for the families of the members at times of illness including provisions of loans at times of illness. Among the activities of the *Iddirs* in this regard are refunding part of money paid for prescribed medications (63.7%), covering part of inpatient medical expenses (58.4%), and covering part of emergency medical expenses (51.3%).

Moreover, loans are also provided by 133 (31.5%) of the *Iddirs*, in most of cases, at times of severe illness requiring substantial amount of money that cannot be covered through out of pocket payment by the affected individual and other shocks. 42 (37.2%) of the *Iddirs* involved in financing medical care for their members have such loan arrangements in place. This is apart from loans and aids provided to members in cases of other catastrophic shocks like robbery, house fires and other property damages.

The package of benefits offered varied across *Iddirs*. Most *Iddirs*, however, offer more than one benefits depending on the situation. The amount of money paid out for such schemes was, however, not readily reported or the *Iddirs* were not willing to disclose the amount of financial reimbursement they make.

Table 5: kinds of benefits offered in the health care insurance schemes of the *Iddirs*, Addis Ababa, March 2007 (N=113)

Benefit	Frequency	percent
Compensation for drugs prescribed	72	63.7
Covering part of the inpatient expenses	66	58.4
Covering part of medical emergency services	58	51.3
Providing loans during illness	42	37.2

5.3.3 Environmental sanitation activities

The *Iddirs* have also reported to have been engaged in community sanitation activities. Ninety-seven (22.9%) of the *Iddirs* reported that they are doing some activities related to community sanitation. Sixty-one *Iddirs* which are all village based *Iddirs* reported that they contribute extra amount of money for solid waste disposals from houses. Some *Iddirs* also have sanitation campaigns for cleaning their surroundings at times of national celebration days such as the Ethiopian New Year, Ethiopian Easter, Ethiopian Christ-Mass and the like.

5.4 Findings of the qualitative study

5.4.1 FGD Results

In the focus group discussions to get the opinions of *Iddir* leaders and members regarding the involvement of their *Iddirs* in other development activities, besides giving funeral related services which were once the only and primary functions why *Iddirs* were formed, the majority of the participants expressed that *Iddirs* must participate in all efforts of development endeavors and should not only give funeral services.

They reported that *Iddirs* are currently diversifying their functions. But they also stressed that the funeral services *Iddirs* offer should not be stopped. They are also modifying their bylaws to include development agenda. A participant expressed the importance of helping each other at times of death in this manner; while he also stressed the need to support each other while alive.

Today's Iddirs are not like the past ones. In the past the job of Iddirs was to bury when people die and to mourn with the family. But now the job of the Iddir is very much widened. For example, in our Iddir we have agreed to help each other while alive, not only at times of death. This we have included in our bylaws. However, we should not stop helping each other at times of death. We can do both together.

Regarding the adequacy of the *Iddir's* participation in health related activities so far; the majority expressed their feeling that, although there is a good start in this regard, their participation is not adequate. Most of the focus group discussants think that more should be done in this regard. However, they also noted that support is needed from both the

government and NGOs for *Iddirs* to do more jobs. One participant explained the issue in this way:

Until now in our Iddir we have tried to do a lot of jobs. But when we see from the problems that exist, it is not enough. We now are giving education on HIV/AIDS. We have monthly program for HIV education. Besides, we give education at burial sites. As there is no money required for this, we are much into it. But to care for PLWHA and orphans due to AIDS, for example, although we have the will we do not have the capacity. Nevertheless, we did not sit down; we are doing everything we can. Therefore, I suggest government and NGOs should give support to the Iddirs.

Some of the *Iddir* leaders reported that their *Iddirs* are getting financial and technical support from NGOs in their community development work. For example, one *Iddir* leader reported that his *Iddir* is getting an important support in credit and saving services for poor women members from ACORD (an international NGO working to improve the involvement of CBOs in development activities).

ACORD is providing us training on how to control our money. I have participated in two workshops with other Iddirs that was called by ACORD. The organization is also providing loan to poor women in our Iddir. They are now leading a better life. Now we know how to control our expenses and income as we are given training.

Another participant reported that they have obtained financial grant from CARE-Ethiopia for provision of support for AIDS orphans and PLWHA. CARE also trains *Iddirs* on how to write project proposals that are required to be submitted before securing funds.

Concerning the issue of willingness to work in partnership with NGOs in the health sector and other development activities, most of the discussants expressed that their *Iddirs* are willing to form such partnership with NGOs.

Some *Iddir* leaders also reported that they are already working in partnership with NGOs particularly in the area of HIV/AIDS. Others reported that they have heard of *Iddirs* currently working with NGOs in development partnerships and that they are doing a very good job. But there seems to be lack of initiation from the side of the *Iddirs* to form such partnerships with NGOs unless the NGOs initiate the process themselves. One participant expressed it in this way:

I know few Iddirs working in partnership with NGOs both in health and other development activities. Our Iddir is also willing to work in such partnership if we were given the chance. But none of them came to work with us. In the future if they come we are very much willing.

Concerning formation of partnership with the government, few of the participants expressed their willingness to work in partnership with government organizations. While the majority of the leaders think that though they themselves are willing, some members may not be willing to form such partnership with the government. A participant explained the issue this way:

You know, in the past government and Iddirs were enemies with each other. Iddirs were confiscated; Iddir leaders were put into prison during the Durgue. The government at that time wants Iddirs only to run its political purpose. Of course, I am not saying there is such thing today. The fear among members today is from experience.

Other participants still think that members would be willing if the issue to work in collaboration is clearly health related or purely development related and not suspected by members as being a political agenda.

If it is not something political, I think members of the Iddirs will be willing to work with the government. For example, my Iddir is currently working with Addis Ababa HIV bureau and health bureau. They are sending health professionals to give education on HIV/AIDS for our members during Iddir meetings. We are working together without any problem.

The issue of registration process was also raised as one important point during the focus group discussion. It was reported that *Iddirs* are required to pay an initial amount of 150 Birr for registration and subsequent annual payment of 50 Birr to renew their licenses. Moreover, they are also required to provide written bylaws and support letter from the Kebele office they are operating in.

Although the majority of the participants do not think this amount to be difficult to pay, it has been noted that some *Iddirs*; which were registered before long ago at the time when there was no annual fee for license renewal, are currently being asked to pay the total sum for the years not paid for getting their licenses renewed. Many *Iddirs* are, therefore, requesting to be registered as new but this has been refused from the government side. A participant explained the issue bitterly:

We were registered before 20 years. Now when we go to the sub city we were asked to pay 1000 Birr to get our license. We asked them to register us as new because we do not have that amount of money. They

refused. We went back without getting registered. I say the government should do something.

5.4.2 Government's view on the role of *Iddirs* in development

To get an insight into how the government views *Iddirs*' contribution and participation in the development efforts the country is currently engaged in, indepth interviewes were conducted with relevant government officials.

The officials have expressed that the government views *Iddirs* as potential actors of development and that there is a belief from the government side that they have yet an untapped potential in the fight against poverty the country is currently engaged in, particularly in terms of the huge social capital they have.

A government official interviewed on this issue said:

As the Iddirs represent majority of the population, envolving them in development activities means mobilizing the whole community. Therefore, due attention is given to this issue, as they are believed to bear huge potential for the development of the country.

Another interviewed government officials have also emphasised the importance of establishing development partnership with *Iddirs* for better coordination of community resources to come up with best result.

Poor internal governance (non democratic leadership structure) within *Iddirs* and non educated leaders who are often elderly and resistant to change have been mentioned by government officials as weaknesses on the part of the *Iddirs* that need to be improved in order to realize effective partnership between them and the government.

Concerning support and encouragement from the government in involving *Iddirs* in development activities, the officials reported that the government is doing its level best. Poverty reduction and sustainable development program specially seems to have created a good forum for discussion between *Iddirs* and the government. Most of the supports by the government focus on administrative and capacity building issues. A government official from one of the sub-cities administration, interviewed on the issue said:

We have conducted series of meetings with Iddir concils in our subcity to discuss on issues of poverty reduction and other development issues. We encourage Iddirs to revise their old bylaws so that they include development agenda when they come for registration. Of course we do not force them but advise and encourage them to change their bylaws. It is not criteria to get registered however, we register even if they do not want to change. All of them are so far willing.

Regarding the availability of legal framework to involve the *Iddir* as well as other CBOs in development activities, it was reported that there is no explicit legal framework in the country on this issue.

Although there is no clear policy statement put down, considering the present situation of development and community participation needs, Iddirs and other similar CBOs as they have their base in the community; understanding that they are crucial forces for development, appropriate direction is arranged for them to enter into development.

5.4.3 Findings of the indepth interviews with NGO officials

Indepth interviews were conducted with officials from NGOs currently working in partenerships with *Iddirs* in an attempt to get an overview of the general situation of the partenerships currently in place and to get information on the lesons learned for the way forward.

The participants were selected both from international as well as local NGOs in Addis Ababa that have some form of partenership working arrengments with *Iddirs* in any sort of development activities including health. The duration of time since these NGOs established partenerships with *Iddirs* range from 2 to 7 years. Although all of them started to work with individual *Iddirs* at the begining, currently most of them are working in partenership with confederations of *Iddirs* which consistute up to 30 individual *Iddirs*. There are, however, NGOs still working with individual *Iddirs* due to capacity reasons.

The officials from the NGOs have reported that they have chosen to work in partenerships with the *Iddirs* due to their legitmate position in the society and their ability to mobilize the community for any sort of activity more than any other organization currently in place. The following points summarize the reasons as to why the NGOs have chosen *Iddirs* as potential partners in their development activities:

- *Iddirs* are the nearest associations to the community as they are established by the community themselves and are deep seated in the hearts of all individual members.

- They are the best route to reach each individual member and their families in the organization both the poor and the rich as well as male and female to ensure participation and empowerment.
- Their leaders are respected by the members which makes transference of messages more effective.
- *Iddirs* have huge social as well as material capital that can be effectively mobilized to solve collective community problems.
- They have strong social cohesion and commitment
- They are most appropriate to target the poor, women, elderly, young and marginalized segments of the society to ensure fair distribution of development outputs
- They have accumulated experience in managing communally owned resources for community benefits.
- They are cost effective in implementation of projects and programs as it cuts organizational costs.
- They are sustainable as they are established around a sustainable cause 'death' which makes them appropriate for smooth handing over of development outputs and efforts resulting in sustainability of the efforts possible.

The activities currently being run jointly by the NGOs and the *Iddirs* are diverse in scope and magnitude. They range from specific health issues like HIV/AIDS prevention and control to a wide ranging development issues.

The officials have reported that there is no specific requirement by the government that the NGOs must fulfil to establish partnership with *Iddirs*, apart from submitting project

proposals to the concerned authorities. Local NGOs getting fund from the government agencies such as Addis Ababa HIV/AIDS Prevention and Control Office (HAPCO) are, in addition, required to report the progress of the implementation of the projects.

The NGO officials were also asked about the weaknesses within and outside *Iddirs* that need to be improved for future similar partnerships. It was indicated that lack of technical capacity by most *Iddir* leaders to run joint projects with partner NGOs and occasional disagreements among leaders of *Iddirs* in confederation must be addressed. Failure of leaders and *Iddir* members to participate regularly in meetings in a required number has also been raised as a problem on *Iddir*'s side.

Regarding what needs to be improved from the NGOs side, participants have strongly recommended that NGOs, both international and local, should avoid the perception that *Iddirs* are not of value in the development efforts of the country. They have also indicated that the capacity of the government at lower levels, particularly the kebeles, are generally poor and needs to be improved to avoid unnecessary bureaucratic bottle-necks.

Chapter Six: Discussion, Conclusion and Recommendations

6.1 Discussion

Iddirs that were once providing only funeral related services are currently engaged in diversified health and development activities. This study has revealed that most of the studied *Iddirs* (63.3%) are currently engaged in some form of development related activities including public health efforts.

HIV/AIDS prevention, care and support activities is identified as one of the areas in public health that is given due attention by most *Iddirs*. This is evidenced by the fact that well over half (51.2%) of the studied *Iddirs* have at least one area of intervention in HIV/AIDS. This figure is significantly higher than what was found in a study by Social and Labour Affairs Bureau in 2002 in which case only 6% of the study samples had some HIV/AIDS related activities (Tadesse 2002), showing that there is increasing involvement in to the issue of HIV/AIDS by *Iddirs*. A more recent a study has found a similar scenario (Punkhurst et al, 2006)

This might be because *Iddirs* are basically established to offer funeral insurance to their members, which has a direct bearing to the expenses incurred on them due to increasing mortality from HIV/AIDS. It has been found in some studies that *Iddirs* have come under great financial strain due to increasing AIDS deaths, necessitating increased contributions from surviving members (Pankhurst and Haile Mariam 2002; Negash 2003).

Another possible explanation could be the availability of relatively adequate fund at national level from donors for HIV/AIDS prevention, care and support activities. This might have

stimulated *Iddirs* to engage more and more in HIV/AIDS in order to benefit from such funds. Most of the partner NGOs working with *Iddirs* have also concentrated their activities around HIV/AIDS than any other development issues possibly for the same reason i.e. availability of fund for HIV/AIDS. The fact that the initiations for working in partnerships with *Iddirs* have mostly come from the partner NGOs also indicates such donor driven strategies. The ongoing IEC/BCC efforts in the country might have also created awareness that is expected to contribute to such efforts by the *Iddirs*.

The range of activities in HIV/AIDS prevention, care and support the *Iddirs* are currently undertaking has also been widened. HIV/AIDS related intervention activities of *Iddirs* had mostly been limited to information campaign activities. For example *Iddirs* had not been assisting PLWHA or AIDS orphans until recently (Haile Mariam 2002). In this study, however it was found that 67 (31.0%) and 83 (38.4%) of the studied *Iddirs* that have HIV/AIDS related programs are supporting PLWHA and HIV/AIDS orphans respectively. These latter services particularly depend on whether members undergo VCT and disclose their sera status. They are also doing considerable job in advocacy for VCT which is indispensable component of HIV/AIDS prevention and care for PLWHA.

Moreover, it has been shown from the study that considerable proportion of the *Iddirs* (26.8%) are currently providing some form of health insurance to their members through their informal insurance schemes. This is considerably higher than the 15% figure found previously by Pankhurst and Haile Mariam (2004), while it is slightly lower than the figure of 30 % found by Dercon and et al (2004). Besides these, 42 (37.2%) of the *Iddirs* surveyed have also some form of loan arrangements for their members at times of illness.

In a community based study involving 40 villages found in various parts of Ethiopia, using households and health institution exit interviews, it was found that 21.5% and 16% of the respondents respectively were utilizing their *Iddirs* to finance part of their health care needs (Haile Mariam 2003) Ninety seven (22.9%) of the *Iddirs* surveyed are also involved in some form of environmental sanitation activities although most of these activities are on ad hoc basis.

Besides activities which have direct bearing to public health, *Iddirs* are also increasingly being engaged in other development activities. Most *Iddirs* have already modified their bylaws to include pressing public health agenda like HIV/AIDS as well as other development issue. Councils of *Iddirs* are currently established in all sub-cities of Addis Ababa. In addition *Iddirs* have recently made public their Anti Aids Network (<http://www.ethpress.gov.et/Herald/article.esp?categoryid=79andcategoryName=The+Battle..>.) which is believed to intensify their efforts against the pandemic.

It has also been observed from the current study that government has the view that *Iddirs* are important partners in the development of the country. However it was found that there is no explicit policy and legal framework in the country directly addressing the issue of *Iddirs* in particular and CBOs in general. Studies have indicated that absence of Legal framework within which CBOs operate in a country is an important constraining factor for establishing development partnerships between CBOs and government (International Bank for Reconstruction and Development 2005).

Some NGOs have already been engaged in development partnerships with *Iddirs*, especially in the fight against HIV/AIDS and extreme poverty. In all of the cases, the initiation to establish partnership was taken up by the partnering organizations; indicating the need to initiate the process of establishing development partnership with *Iddirs* by partnering organizations themselves.

Fears, concerns and willingness of the *Iddirs* to work in partnerships with government and NGOs have also been explored during the current study. It has been found from the focus group discussions that *Iddirs* are well aware of the importance of partnering with both the government and NGOs in all efforts of development including public health.

Nevertheless, while there was no problem found in partnering with NGOs, as some *Iddirs* are already engaged in development partnerships with NGOs, there seems to be suspicion in partnering with the government. There is fear by the *Iddirs* that the government might use them for its own political purposes. This might be explained by their past experiences with successive governments with which their relationships had mostly been negative.

6.2 Limitations of the study

The study has tried to triangulate the benefits of both quantitative and qualitative research methods that has helped to view the issue from different angles. Although focus group discussions and indepth interviews are well acknowledged for their ability to elicit a large amount of information in an efficient manner, the issue of generalizability of the acquired information will remain a concern. Moreover, although non registered *Iddirs* might be engaged in simmlar health and development activities, due to inaccebility reasons, the quantitative survey covered only those *Iddirs* that are currently registered by the government.

6.3 Conclusions

The findings of the study confirm that *Iddirs* which were once providing only funeral services are coming out as development actors and partners. Moreover, they are modifying their by-laws to include issues pertaining to pressing public health problems such as HIV/AIDS and other development agenda. There is also increasing recognition of the role of *Iddirs* in development by both the government and NGOs. The current poverty reduction and sustainable development program may progress the situation even further.

The public health activities which the *Iddirs* are currently engaged in can serve as potential entry points in to partnerships with the *Iddirs* for both the government and NGOs. Their HIV/AIDS prevention, care and support activities can be an important opportunity for the government and NGOs working in the area to work in partnership with such very popular CSOs to intensify the multi-sect oral efforts towards fighting the pandemic.

The issue of HIV/AIDS should specially be taken seriously as *Iddirs* are being seriously hit by the financial burden incurred onto them due to increasing HIV/AIDS related deaths among their members. The high level of stigma and discrimination in the community against HIV/AIDS victims may also limit the care and support activities already initiated by *Iddirs* as affected people may not disclose their status.

The health care financing schemes of *Iddirs* for their members can also serve as starting point to introduce community based health insurance schemes in the country as an alternative mechanism to finance health care. Due to increasing health care demand in the face of continuously shrinking finance for publicly provided services, the government is currently

actively searching for alternative mechanisms of financing health care in the country (FMoH 2003, FMoH 2005).

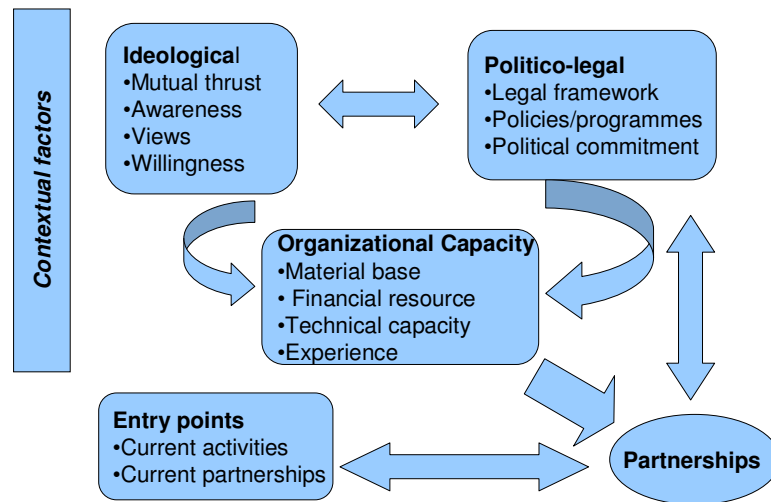
Although effective health care financing remains a universal problem in both developed and developing countries, the challenge is even more pronounced for poor countries as the revenue gained from taxation in these countries are often low (Abel-Smith, 1994). Increasing user charges, which have once gained popularity, are being criticized as worsening the situation especially for the poor (Claeson et al. 2001). Evidences suggest that health care costs can lead households into poverty and significantly diminish their chance to come out of poverty trap (Whitehead et al. 2001; WHO 2005).

Studies in Ethiopia and elsewhere in sub Saharan Africa have indicated that the majority of people are unable to afford the high costs incurred when seeking health care, and cannot cope with the negative effects of cost-recovery schemes. Therefore, moving away from out of pocket payments was suggested as an alternative (Save the Children UK 2005; McIntyre and Gilson 2005)

In partnership with the government and NGOs, *Iddir* based health insurance that was suggested in the past (Haile Mariam 2003) may prove effective in this regard. It is therefore recommended that the government and NGOs work closely with the *Iddirs* on the possibility of introducing *Iddir* based health insurance as a way to move away from out of pocket payments.

In general, a number of opportunities and entry points exist to establish partnerships with *Iddirs* in public health and all-rounded development efforts, hence, increase their participation in the fight against poverty and bring about the envisaged sustainable development. This study has also identified important contextual factors that need to be considered in initiating partnerships with *Iddirs*. Based on these contextual factors, the following conceptual framework for initiating partnership working arrangements with *Iddirs* has been developed as a final synthesis of the study.

Conceptual framework



6.4 Recommendations

For effectively engaging *Iddirs* in public health and development efforts, there is a need to work in partnership with them. Such partnership building should, however, be with full consent of all the members. Any move by the government to involve *Iddirs*, in any sort of development efforts must give due considerations to their past experience with successive governments and accommodate their fears, concerns and suspicions. It should be carefully planned and slowly implemented to avoid misinterpretations as political interference by the government. This requires continuous dialogue between partnering organizations, be it governmental or non governmental organizations, and the *Iddirs*. The agenda should also be brought to the wider public through mass-medias and public forums. Starting with the activities *Iddirs* have already taken up by themselves, such as HIV/AIDS prevention and health care financing, and building their capacity in terms of finance and technical skills may be taken in the initial step.

The ongoing effort to organize *Iddir* councils at the kebele level should be strengthened as development partnership between CBOs and the government is more effective at the local level. Kebele based *Iddirs* should also be encouraged as they are more conducive for participatory community development activities because they are geographically cohesive.

The success of transforming *Iddirs* into more appropriate development actors and partners, however, depends on how well they can handle joint development projects with their partners, which requires additional skills and managerial capacity. Both the government and NGOs

should work closely with *Iddirs* in building their capacities in both technical and financial aspects.

While provision of support to *Iddirs* is indispensable for building their capacities for more development works, it has to be in a systematic way to avoid ‘dependency syndrome’. Such tendency by *Iddirs* to seek fund for handouts may significantly compromise the good start once the fund stops as it may not be available in a sustainable manner. A better strategy could be creating conducive policy environment for *Iddirs* to get involved in income generating schemes to tackle the financial constraints that has limited and will continue to limit their involvement in development activities.

Moreover, the operating environment for *Iddirs* and other CBOs should also be improved if they have to engage in more pronounced development activities. There is a need to put in place explicit legal frameworks for CBOs in the country. There has to also be an institution that coordinates the development efforts of *Iddirs* and other CBOs.

Further research is also recommended to evaluate the success of the already in place partnerships and build on the lessons learned and best practices. Implementation of the recommended partnership may also require well designed, preferably multi disciplinary, participatory operational research.

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Annex I

CONSENT FORM

Hello, first of all I thank you a lot for sharing with me your precious time.

My name is -----I am a data collector for a study currently being under taken on the *Iddirs* in Addis Ababa in collaboration with Addis Ababa University. The purpose of this study is to explore the potential of *Iddirs* as partners in development besides offering their traditional burial services with particular emphasis on the health sector. So I am here with you today to ask you few questions, which are valuable for the study. Therefore I am respectfully requesting your voluntary response in advance. You are free not to answer any question you are not comfortable with. Whatever you say will be kept confidential and no name or any sort of personal identification will appear in the final report of this study. Your genuine answers are very important for the success of this study. Would you please express your willingness to respond to my questions?

Yes I am willing

No I am not willing

Thank you very much.

Annex II

QUESTIONNAIRE FOR INDEPENDENT INTERVIEW WITH *IDDIR*
LEADERS (ENGLISH VERSION)

NO	QUESTIONS	ANSWERS
1	Personal profile <i>of Iddir</i> leader Age Sex Educational background	_____ 1. Male 2. Female 1. No formal education 2. Grade 1-6 3. Grade 6-12 4. College diploma 5. University degree
2	Type of <i>Iddir</i>	1. Multi purpose <i>Iddir</i> 2. Women <i>Iddir</i> 3. Youth <i>Iddir</i> 4. Work place <i>Iddir</i> 5. Other (mention) _____
3	Duration since establishment of the <i>Iddir</i>	_____

4	Number of members of the <i>Iddir</i>	-----
5	Total beneficiaries of the <i>Iddir</i>	-----
6	Is the <i>Iddir</i> engaged in development activities? (if yes mention)	1. Yes 2. No ----- ----- ----- -----
7	If not engaged in development activities, why?	----- ----- ----- -----
8	Is the <i>Iddir</i> engaged in health related activities (mention)	----- ----- ----- -----

9	List activities of the <i>Iddir</i> in HIV/AIDS if any.	<hr/> <hr/> <hr/> <hr/>
10	Does your <i>Iddir</i> provide support to orphans due to HIV/AIDS? (mention if any)	<hr/> <hr/> <hr/> <hr/>
11	Does the <i>Iddir</i> provide financial support to its members at times of illness?(mention if any)	<hr/> <hr/> <hr/> <hr/>

12	Is the <i>Iddir</i> engaged in environmental sanitation activities? (mention if any)	<p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p>
13	How much money is contributed to the <i>Iddir</i> monthly?	<p>-----</p>
14	How much is the current financial saving of the <i>Iddir</i> ?	<p>-----</p>

Annex III

GUIDE FOR FOCUS GROUP DISCUSSION INVOLVING *IDDIR* LEADERS AND MEMBERS.

1. What is your opinion on the involvement of the *Iddirs* in health and other developmental activities besides providing burial services?
2. What is your opinion on establishing development partnership with the government?
3. What is your opinion on establishing partnership with NGOs?
4. In which health related activities do you think is it possible to form partnership with governmental and non-governmental organizations?
5. Is there any problem you think might result to the *Iddirs* from such partnerships? If so, what would you suggest as a solution?
6. What problems are there that hinder *Iddirs* from engaging into development activities more widely? What do you think should be done so that *Iddirs* be strongly involved in developmental activities?

Annex IV

INTERVIEW CHECKLISTS FOR SELECTED GOVERNMENT OFFICIALS

1. What is the general stand of the government on involving the *Iddirs* in health and other developmental activities?
2. Under which organizations in the country are *Iddirs* categorized?
3. Is there any policy guideline and framework regarding the *Iddirs'* and other community based organizations participation in developmental activities?
4. How does the government view establishing development partnership with the *Iddirs*?
5. Are there any supports so far provided to the *Iddirs* by the government?

6. What are the requirements for the *Iddirs* to undertake development projects?
7. The participation of *Iddirs* in developmental activities has been minimal, what do you think is the problem? What should be done for the future?
8. Which conditions must be corrected on *Iddirs* side for the government to work in partnership with them?
9. What are the potential areas to establish partnership with the *Iddirs in the health sector*?

Annex V

INTERVIEW GUIDE FOR NGOS CURRENTLY WORKING IN PARTNERSHIP WITH *IDDIRS*

1. How long did you work with the *Iddirs*?
2. Why did you choose to work with the *Iddirs*?
3. In which areas are you currently partnering with the *Iddirs*?
4. What are preconditions set by the government for you to work with the *Iddirs*?
5. What were the strength and limitations so far of your partnership?
6. Do you get any support from the government in your activities with the *Iddir*?
7. What do you think should be done for the future to improve the conditions?
8. What conditions should be improved on the NGOs side?
9. What conditions should be improved on the government's side?

Annex VI

QUESTIONNAIRE FOR INDEPENDENT INTERVIEW WITH
IDDIR LEADERS (AMHARIC VERSION)

• •	• • •	• • •	• •
1	<p>•••• ••• •••</p> <p>•••</p> <p>••</p> <p>•••••• •••</p>	<p>-----</p> <p>3. ••</p> <p>4. •••</p> <p>6. •••• ••••• •••••</p> <p>7. •1•-6• •••</p> <p>8. •6•-12• •••</p> <p>9. •••• ••••</p> <p>10. ••••••• •••</p>	
2	<p>•••• ••••</p>	<p>6. •••• •••• •••</p> <p>7. •••• •••</p> <p>8. •••• •••</p> <p>9. •••• ••/ ••• •• •••</p> <p>10. •• (••••)</p> <p>-----</p> <p>-</p>	
3	<p>••• ••••• •• ••• ••</p> <p>••••?</p>	<p>-----</p>	
4	<p>•••• ••• ••• •••? </p>	<p>-----</p>	
5	<p>•••• •••• •••••••</p> <p>••• ••• •••?</p>	<p>-----</p>	
6	<p>••• •••• •• ••</p>	<p>3. ••</p>	

12	<p>••• ••••• ••• •••</p> <p>•••••••• •••• •• •</p> <p>•••• ••••</p>	<p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p>	
13	<p>•••• ••• •••••••</p> <p>••••• ••• •• •••</p> <p>••?</p>	<p>-----</p>	
14	<p>••• ••• ••• •••••</p> <p>••• •• ••• ••?</p>	<p>-----</p>	

Annex VII

GUIDE FOR FOCUS GROUP DISCUSSION INVOLVING
 IDDIR LEADERS AND MEMBERS (Amaharic version).

ሃግጅ ስለሁሉም ተሳታፊዎች ማሳሰቢያ

1. ስለሁሉም ተሳታፊዎች ማሳሰቢያ ማሰጠት፤
2. ስለሁሉም ተሳታፊዎች ማሳሰቢያ ማሰጠት፤
3. ስለሁሉም ተሳታፊዎች ማሳሰቢያ ማሰጠት፤

4. S"Óefi© ŸMJ' < É"İ, < Ò` ›Ò''f SöÖ`
5. ¼MTf ›Ò''f SöÖ` •Éa< ; . . U" SÁ[Ó ›Kuf;
6. Éa< uMTf Y^ LÃ ueóf "ÇÄd}ñ U" U" <Óa< ›K<; <Óa‡" KTp[ö U" SÁ[Ó ›Kuf;

Annex VIII

INTERVIEW CHECKLISTS FOR SELECTED GOVERNMENT OFFICIALS (Amaharic version).

KS"ÓYf }Ö]-< ¾k•u SÖÄp

1. S"Óef •Éa< • ÁK" < ›ÖnLÃ ›kU U" ÄSeLM;
2. Éa< u›Ñ]~ " <eØ ŸK< TQu^f ~cØ u¾f—" < Y' ÄSÄvK<;
3. Éa" KKA< uQw[]cu< ¾}kkS< }TddÄ TQu^f" u}SKŸ} uMTf Y^ LÃ KTd}ö ¾"x pK=c=" ¾c^ Tkõ ›K;
4. S"Óef ŸÉa< Ò` ¼MTf ›Ò''f SöÖ" "Áf ÄSKŸ}ªM;
5. S"Óef KÉa< ¾T>ÁÄ`Ñ" < ÉÖö ›K;
6. Éa< yaËif k`è uMTf Y^ LÃ KSd}ö uS"Óef uŸ<M U" U" pÉS G<'< ÄÖupvªM;
7. ¾Éa< ¼MTf }d}ö ŸIØ^†" < ›"i' c=Ä ¾T>Öuk" < ÁIM ›ÄÄKU:: K'I <Óa‡ U"É" "†" <; K"Áö~ U" SÁ[Ó ›Kuf;
8. S"Óef ŸÉa< Ò` ¼MTf ›Ò''f ›"ÉðØ` Ÿ}ðKÑ uÉa< uŸ<M U" U" G<'< Se}ŸŸM ›Kv†~;
9. uÖ" < ²`ö S"Óef" É` ›Ò''f ðØ[" < K=Wu†" < ¾T> <K<v†" < Y^< ›K<;

Annex IX

INTERVIEW GUIDE FOR NGOS CURRENTLY WORKING IN
PARTNERSHIP WITH *IDDIRS* (Amaharic version).

S”ÓY□© LMJ’< É`İ, < ¼k •• SÖÄp

- a. j°Éa< Ò` ìeÿ >G<” U” ÁIM Ñ>²? W`□□M;
- b. j°Éa< Ò` SY^f” KU” S[x<G<;
- c. j°Éa< Ò` uSY^f LĂ ÁL<G<f uU” ²`ö ”<;
- d. Ÿ°Éa< Ò` KSY^f uS”ÓYf ¼T>Öupv<G< pÉS G<’@□-< U” U” “†”<;
- e. ¼ìeÿ>G<’< Ÿ°Éa< Ò` >Ò`□<G< U” U” Ö”ÿ^” ÄYT Ô•< >K<f;
- f. j°Éa< Ò` •••• uS”ÓYf ¼•••••••• ••• ••;
- g. K`Àòf }SXXĂ ¼MTf >Ò`f KSöÖ` □“ ¼}hK ”<Ö?f KTeS`Ñw Ÿ°Éa< >ÿvu= Se}ÿÿM >Kuf ¼T>K<f ’Ñ` >K;
- h. S”ÓY□© vMJ’< É`İ, <e Se}ÿÿM ÁKuf ’Ñ` >K;
- i. uS”ÓYf uÿ<Me ShhM ÁKv†”< G<’@□-< >K<;