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Improving Children's Health and Nutrition Outcomes in Ethiopia

Brief on the qualitative midline evaluation of the Integrated Safety Net Programme in Amhara

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This brief summarizes the findings of the qualitative midline evaluation of the Integrated Safety Net Programme (ISNP) pilot in the Amhara region of Ethiopia. The ISNP pilot was launched in 2019 by UNICEF and the Government of Ethiopia in Libo Kemkem and Dewa Chefa *woredas* of the Amhara region. Its main goal is to promote transition to an integrated system of cash transfers and linkage to complementary basic services, including Community-Based Health Insurance (CBHI) and nutrition services among the Productive Safety Net Programme (PSNP) clients. By leveraging the impacts of income support, these complementary measures and services aim to promote positive changes in clients' nutrition and health-related knowledge, health-seeking attitudes and practices, and to improve their prospects for a sustainable exit from multidimensional poverty and food insecurity.

INTRODUCTION TO THE MIDLINE EVALUATION

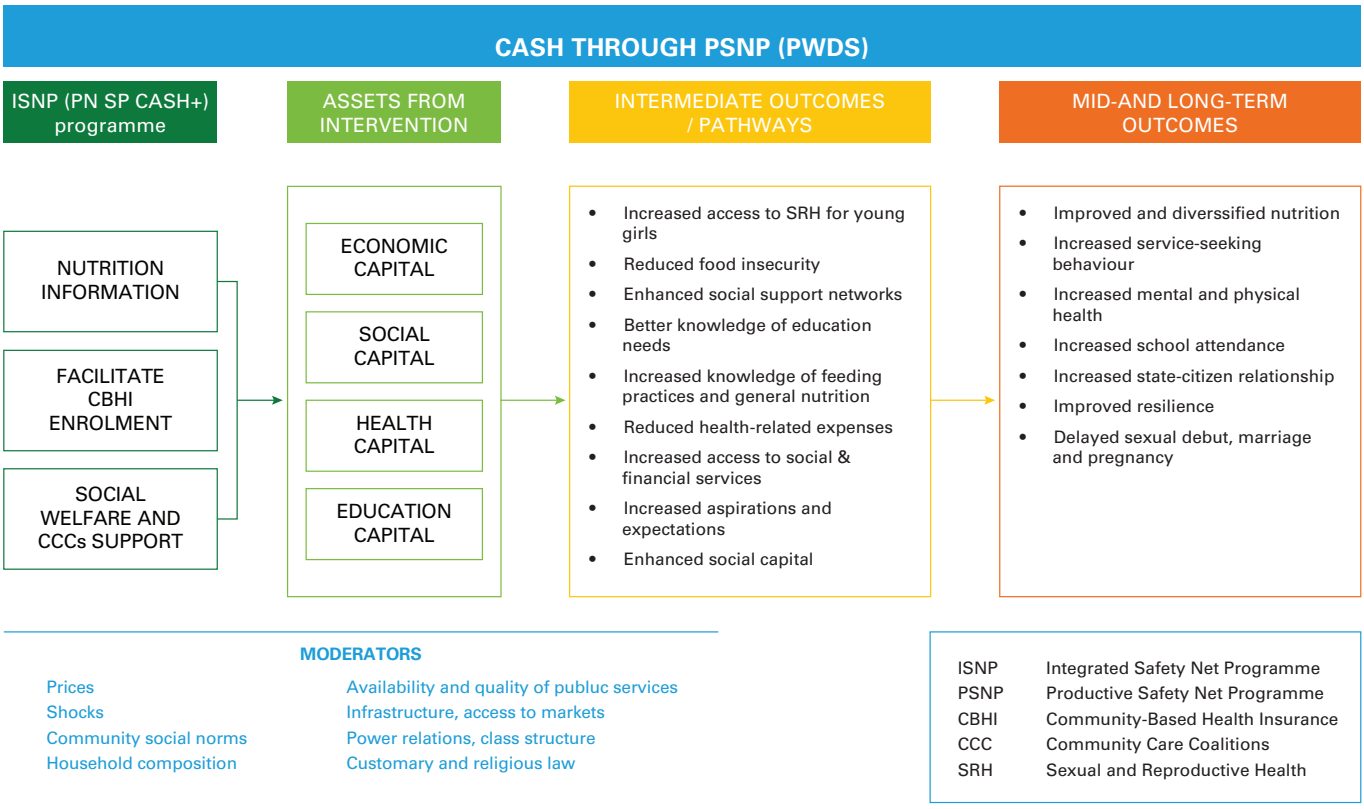
From 2018 to 2023, the UNICEF Office of Research – Innocenti, the University at Buffalo and Frontieri are conducting a mixed-methods, quasi-experimental impact evaluation of the ISNP pilot. The evaluation – by linking cash transfers with complementary interventions – assesses the impacts that the ISNP has on health-seeking behaviour, and health, nutrition and child protection outcomes among PSNP clients. The conceptual framework guiding the overall impact evaluation, which shows the pilot's various components, identifies relevant individual and household indicators, and suggests potential impact pathways, is illustrated in Figure 1.

A qualitative midline study was undertaken in January and February of 2020 to examine the progress of ISNP implementation 13 months after baseline. The study also documents early observable changes in the well-being of PSNP households as a result of the intervention.

Qualitative research was conducted in two treatment *woredas* – Libo Kemkem and Dewa Chefa – and one *kebele* in each *woreda*. The data collection involved 18 key informant interviews with government officials and the PSNP and ISNP staff at regional, *woreda* and *kebele* levels, and 32 in-depth interviews with female caregivers in PSNP households. This was complemented with six focus group discussions with pregnant and lactating women and caregivers of malnourished children under 5, and two focus groups with representatives of community care coalitions.

The findings of the study will inform necessary mid-course corrections of the ISNP to strengthen its design and delivery, and ultimately enhance its health and nutrition impacts among the target population.

Figure 1: ISNP conceptual framework



KEY FINDINGS

Overall programme delivery is on track. Various investments were made in the past year to build an institutional system for delivering integrated services to clients, resulting in reported gains in efficiency and better programme performance. These improvements included: deployment of social workers by the Ministry of Labour and Social Affairs (MoLSA) in all *kebeles*; engagement of cross-sectoral coordination committees to build closer institutional ties among key ministries at regional and *woreda* levels and various pilot components; improvements in implementation protocols and procedures (particularly for harmonizing PSNP and CBHI targeting of fee waivers to permanent direct support (PDS) clients); and capacity building of key ISNP and PSNP personnel and frontline staff to deliver a complex set of activities in typically resource-constrained settings. Although staff at *kebele* level continue to use the paper-based system for data collection and exchange, the electronic management information system (MIS) was rolled out at the *woreda* level, and core staff were trained in its use. The further roll-out of the digitized MIS at *kebele* level is expected to improve the efficiency and quality of cross-sectoral data use and management.

Enrolment of PSNP clients in CBHI has improved, especially among PDS households. Introduction of clear policy guidelines for allocation of CBHI fee waivers and common targeting criteria between the PSNP and CBHI programmes have resulted in universal free enrolment of PDS clients in the health insurance scheme. Participation in CBHI, particularly among PDS households, has led to a strong increase in demand for healthcare and better health-seeking behaviour. This has led to reported improvements in health outcomes and capacity to avoid catastrophic health expenditure, thereby boosting the impact of PSNP cash payments.

At the same time, the ISNP has not met the expected level of progress regarding CBHI enrolment of public work (PW) households. High premium costs, information gaps, common misconceptions about the value of insurance and high indirect costs of drugs were identified as key bottlenecks for PW client enrolment. Future efforts will be required to accelerate the expansion of CBHI coverage among

PW households and broader communities to ensure its overall sustainability and the state's ability to subsidize fee waivers for its poorest members.

There has been fair progress in transition of female caregivers into temporary direct support (TDS). Delivery of TDS in the past year has been strengthened, leading to timelier transition of female caregivers into TDS from the PW programme. Participation in TDS has brought critical benefits to caregivers and children. For example, reduced work burdens for mothers reportedly led to improvements in women's mental and physical well-being, and increased time available to care for children and themselves. Transition into TDS also improved women's capacity to comply with co-responsibilities and seek nutrition-related antenatal care.

These outcomes were particularly significant for caregivers of malnourished children, who reported more time available to access timely treatment and complementary support, with consequent improvements in care for their children. However, TDS procedures to identify and refer clients remain complex and somewhat arbitrary; roles and responsibilities of health extension workers, social workers and development agents continue to overlap in practice, and social and gender norms related to women's employment, mobility and use of healthcare and information gaps continue to pose barriers to TDS enrolment. This leads to vulnerable clients missing out on complementary benefits and entitlements.

Despite resource constraints, the uptake of co-responsibilities and behaviour change communication (BCC) has been progressing relatively well. Positive results in delivery of co-responsibilities were driven partly by improvements in TDS implementation (as a precondition to co-responsibilities), the active engagement of social workers and health extension workers in delivering messages about the importance of co-responsibilities, and more consistent use of case management to monitor clients' compliance. However, the BCC component, implemented through the existing PSNP 4 government delivery systems, has suffered from significant delays and irregular delivery. As ISNP did not conduct parallel BCC activities independently from the PSNP 4 structure, these problems in implementation have influenced the pilot's effectiveness. Shortcomings in implementation resulted in gaps in clients' awareness of sessions and participation of TDS and PW clients in these activities. Those who did take part (primarily pregnant and lactating women with children) reported positive changes in their health and nutrition knowledge, including dietary diversity and the value of healthy living environments, food intake and child-feeding practices. These positive changes underscore the importance of continued investments in strengthening BCC delivery. For some women with the authority and mobility to access healthcare, co-responsibilities have also improved their demand for antenatal and postnatal care, institutional delivery and child vaccinations.

CONCLUSION AND RECOMMENDATIONS

Overall, the midline data indicate progress in implementation of different programme components, particularly strengthened programmatic linkage between the PSNP and CBHI and more timely transition of eligible households into TDS. At this mid-course point, the pilot has improved households' knowledge and understanding of key issues related to their health and nutrition. This is expected to lead to sustainable changes in practices over time. Participation in TDS has reduced work burdens for mothers, improved women's mental and physical well-being, and increased time available to care for children and themselves.

Several programme-related pathways were identified to mediate these positive outcomes. First, social workers and health extension workers are critical intermediaries between clients and programme services. Home visits by social workers are particularly useful opportunities to build personal rapport with PSNP clients and to teach, advise and motivate them to adopt positive practices and sustain healthy behaviours. Linking informational health activities to healthcare visits through co-responsibilities has been a successful means of reaching vulnerable mothers and children and improving their health and nutrition outcomes. Second, there is evidence that cash transfers (despite the generally low value) work effectively in synergy with co-responsibilities and CBHI by alleviating the financial burdens associated with service access and enabling PW clients to enrol or renew their CBHI membership.

Nevertheless, shortcomings in the delivery of various components – including gaps in staffing (allocations and technical capacities) and logistical and budgetary constraints (remote and difficult terrain, lack of transportation) – affect the scale and magnitude of any positive changes. On the demand side, gaps in client understanding of ISNP entitlements, as well as discriminatory social and gender norms related to work, mobility and women's healthcare, constrain women's awareness, demand and access to integrated benefits (and ability to seek healthcare). These factors undermine opportunities to enhance and ultimately sustain ISNP impacts in future.

Key recommendations for improving ISNP performance and future impacts include the following actions:

- Continue to strengthen collaboration mechanisms – including establishment of focal points at the *kebele* level – to more effectively coordinate and monitor the work of frontline staff.
- Reduce overlaps (or gaps) in staff roles and responsibilities and continue to provide joint trainings to key personnel to strengthen the technical and functional skills necessary to deliver ISNP activities and improve their performance.
- Develop context-specific promotional campaigns to improve understanding of PW clients about the CBHI and how it works and encourage their enrolment into the scheme.
- Provide greater technical and financial resources for ISNP coordinators and frontline workers to enable them to engage in quality outreach, case management and monitoring of programme activities.
- Continue to deploy the digital MIS at the *kebele* level, and train staff in basic computer skills to use it effectively.

Finally, ISNP sustainability in the long term depends on several structural efforts, including the MoLSA taking stronger ownership of its responsibilities to oversee the welfare of PDS clients, ensuring permanent deployment of social workers, and maintaining government commitment and financial capacity to progressively scale up the pilot.

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