Improving Children’s Health and Nutrition Outcomes in Ethiopia

A qualitative mid-line evaluation of the Integrated Safety Net Programme in Amhara
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<th>Full Form</th>
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<tbody>
<tr>
<td>ANC</td>
<td>antenatal care</td>
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<td>BCC</td>
<td>behavioural change communication</td>
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<td>BoLSA</td>
<td>Bureau of Labour and Social Affairs</td>
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<tr>
<td>CBHI</td>
<td>community-based health insurance</td>
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<td>CCC</td>
<td>community care coalition</td>
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<tr>
<td>DA</td>
<td>development agent</td>
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<td>DS</td>
<td>direct support</td>
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<td>FGD</td>
<td>focus group discussion</td>
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<td>FLW</td>
<td>frontline worker</td>
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<td>HEW</td>
<td>health extension worker</td>
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<td>IDI</td>
<td>in-depth interview</td>
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<td>IEC</td>
<td>information, education and communication</td>
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<td>ISNP</td>
<td>Integrated Safety Net Programme</td>
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<td>KII</td>
<td>key informant interview</td>
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<td>MIS</td>
<td>management information system</td>
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<tr>
<td>MoA</td>
<td>Ministry of Agriculture</td>
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<td>MoE</td>
<td>Ministry of Education</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoLSA</td>
<td>Ministry of Labour and Social Affairs</td>
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<tr>
<td>PDS</td>
<td>permanent direct support</td>
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<tr>
<td>PLW</td>
<td>pregnant and lactating women</td>
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<td>PNC</td>
<td>postnatal care</td>
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<td>PSNP</td>
<td>Productive Safety Net Programme</td>
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<tr>
<td>PW</td>
<td>public work</td>
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<tr>
<td>SIDA</td>
<td>Swedish International Development Agency</td>
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<tr>
<td>SW</td>
<td>social worker</td>
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<td>TDS</td>
<td>temporary direct support</td>
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<td>WASH</td>
<td>water, sanitation and hygiene</td>
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<tr>
<td>WOLSA</td>
<td>Woreda Office of Labour and Social Affairs</td>
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Executive summary

Introduction to the midline evaluation

This report presents the findings of a qualitative midline evaluation of the Integrated Safety Net Programme (ISNP) pilot in the Amhara region of Ethiopia. The Government of Ethiopia and the UNICEF Ethiopia Country Office launched the ISNP pilot in 2019 to promote an integrated system of social cash transfers and linkage to basic services, including community-based health insurance (CBHI), to improve the well-being of Productive Safety Net Programme (PSNP) clients. The UNICEF Office of Research – Innocenti, the University at Buffalo and Frontieri are conducting a mixed-methods impact evaluation of the ISNP pilot from 2018 to 2023. The purpose of this quasi-experimental evaluation is to assess the impacts that the ISNP has on health, nutrition and child protection outcomes among PSNP clients.

The ISNP pilot is implemented by the Ministry of Labour and Social Affairs (MoLSA), with technical support from UNICEF and funding from the Swedish International Development Agency. The pilot is carried out in the Libo Kemkem and Dewa Chefa woredas (districts) of the Amhara region. The pilot delivers to PSNP clients an integrated package of cash transfers and complementary services, including linkage to CBHI and health and nutrition services. By leveraging the impacts of income support, these complementary measures and services are aimed at promoting positive changes in clients’ nutrition and health-related knowledge, health-seeking attitudes and practices, and improving their prospects for a sustainable exit from multidimensional poverty and food insecurity.

A qualitative midline study was undertaken in January and February of 2020 to examine the progress of ISNP implementation 13 months after baseline and document early observable changes in the well-being of PSNP households as a result of the intervention. The study 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 (IDIs) with female caregivers in PSNP households. This was complemented with six focus group discussions (FGDs) with pregnant and lactating women and caregivers of malnourished children under 5 years of age, and two FGDs with representatives of community care coalitions. This report is targeted at PSNP implementers and stakeholders, including government and development partners. 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.

Key findings

Progress in ISNP implementation

The study finds that good progress has been made in ISNP implementation. Programme delivery is generally on track and cross-sectoral collaboration and coordination between key regional and woreda-level agencies of the Ministry of Agriculture, MoLSA and Ministry of Health have improved since baseline, resulting in reported gains in efficiency and better programme performance. Various investments were made in the past year to build an institutional system for delivering integrated services to clients. These improvements included: deployment of social workers (SWs) by the 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); 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 management information system at kebele level is expected to improve the efficiency and quality of cross-sectoral data use and management.

As a result, service providers and respondents reported improved access to services among PSNP clients, with
some positive shifts in their health, nutrition and care outcomes. There is also evidence that quality, timeliness and fidelity of implementation vary across programme components and geographic location, with these being more irregular in Libo Kemkem as a result of political instability and operational challenges. At the same time, in Dewa Chefa, discriminatory gender-related community dynamics present obstacles for female PSNP clients to access and benefit fully from the ‘plus’ entitlements, such as behaviour change communication (BCC), health services and transition into temporary direct support (TDS).

**Enrolment of PSNP clients in CBHI**

Coordination between the PSNP and CBHI has improved significantly since the baseline. Introduction of clear policy guidelines for allocation of CBHI fee waivers and common targeting criteria have resulted in universal free enrolment of permanent direct support (PDS) clients in the health insurance scheme. Participation in CBHI, particularly among PDS clients, has led to a strong increase in demand for healthcare and better health-seeking behaviour. This led to reported improvements in health outcomes and capacity to avoid catastrophic health expenditure.

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.

**Transition of female caregivers into TDS**

There has been fair progress in the delivery of TDS in the past year, 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 (HEWs), SWs 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.

**Uptake of co-responsibilities and BCC**

Management of co-responsibilities and client compliance has been progressing well, driven partly by improvements in TDS delivery (as a precondition to co-responsibilities). The engagement of SWs and HEWs in delivering messages about the importance of co-responsibilities and more consistent use of case management to monitor and facilitate compliance contributed to these results.

However, the BCC component, implemented through the existing PSNP 4 government delivery systems, has suffered from significant delays, and irregular and incomplete 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) reported positive changes in their health and nutrition knowledge and practices, underscoring the importance of continued investments in strengthening BCC delivery.

The combination of BCC, individual counselling (from frontline workers) and access to services via co-responsibilities has led to greater knowledge about dietary diversity and the importance of healthy living environments, as well as improved diet, food intake and feeding practices. 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.
Several programme-related pathways mediate these positive outcomes. First, SWs and HEWs are critical intermediaries between clients and programme services. Home visits by SWs 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.

Second, linking informational sessions and advisory support to health centre visits has been a successful means of reaching vulnerable mothers and children and improving their health and nutrition outcomes. Finally, there is also evidence that cash transfers 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. At the same time, delays in PSNP transfers and their relatively small amount diminish clients’ ability to direct them towards utilization of services.

Conclusion and recommendations

Overall, the midline data provide a comprehensive picture of the ISNP pilot implementation and preliminary results. They also identify various challenges and bottlenecks that undermine programme efficiency and effectiveness. Key informants generally felt it was too early to determine sustaining impacts and programme benefits over time as changes in health and nutrition require sustained, long-term investments to materialize.

At this mid-course point, the pilot has effected positive changes in some 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. Nevertheless, shortcomings in the delivery of various components undermine the scale and magnitude of any positive changes. Shortcomings identified include gaps in staffing (allocations and technical capacities), logistical and budgetary constraints (remote and difficult terrain, lack of transportation). 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:

- 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 expand installation of the digital MIS at the kebele level, and train staff in basic computer skills to use it effectively.
- Deliver an awareness-raising campaign targeted at community members (men and boys in particular) to increase their understanding of the ISNP gender dimensions and improve women’s authority and agency to freely access their ISNP entitlements and uptake of services.

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 SWs and maintaining government commitment and financial capacity to progressively scale up the pilot. It is worth highlighting that IDIs and FGDs were not held with PSNP clients in the comparison areas to ascertain whether the preliminary improvements in outcomes observed in the treatment areas are also being experienced in the control areas.
Section 1
Introduction

This report presents the findings from a qualitative midline study of the Integrated Safety Net Programme (ISNP) pilot in the Amhara region of Ethiopia. The pilot was launched in 2019 by the Government of Ethiopia with funding from the Swedish International Development Agency (SIDA) and policy support from the UNICEF Ethiopia Country Office. The ISNP pilot is implemented within the framework of the Productive Safety Net Programme Phase 4 (PSNP 4), with a goal to continue to support the Government of Ethiopia in transitioning to an integrated social protection system. It specifically aims to test the value added of linking social transfer to community-based health insurance (CBHI) and other social services among PSNP clients to improve their well-being. The UNICEF Office of Research – Innocenti, the University at Buffalo and Frontieri are conducting a mixed-methods, quasi-experimental evaluation of the ISNP pilot from 2018 to 2023 (ISNP Evaluation Team, 2021).

The evaluation will assess the impacts that the ISNP – by integrating cash transfers with complementary interventions, and health insurance in particular – has on the well-being of PSNP households, including health, nutrition, schooling and child protection outcomes. A mixed-methods baseline study was conducted from December 2018 to February 2019 across four woredas (districts) (Libo Kemkem, Artuma Fursi, Dewa Chefa and Ebinat) in the Amhara region. This qualitative midline study collected data from January to February 2020 in the two treatment woredas of Libo Kemkem and Dewa Chefa. This qualitative midline wave examines the progress of implementation of the ISNP pilot 13 months after baseline, and documents early observable changes in the well-being of PSNP treatment households resulting from the intervention. The study is targeted at PSNP government stakeholders and development partners involved in social protection policy and programming. The evaluation results will inform necessary mid-course modifications of the ISNP and the future design of the PSNP 5.

This report is structured as follows. The remainder of Section 1 provides a background of the ISNP and an overview of the study’s objectives and methodology. Section 2 reports findings regarding overall progress of ISNP implementation, and Sections 3–11 present specific findings for each programme component. In Section 12 we summarize the key lessons and challenges emerging from the study, and in Section 13 we conclude with key takeaways and recommendations to inform ISNP pilot implementation.

1.1 Background

1.1.1 Social protection context in Ethiopia

The Government of Ethiopia and its development partners have made considerable progress in poverty reduction in the country. Between 2011 and 2016, a 9 per cent annual increase in GDP was accompanied by a 6 per cent reduction in the national poverty rate (CSA and UNICEF Ethiopia, 2020). However, 24 per cent of the national population remained in poverty in 2016 (26 per cent of rural populations compared to 15 per cent of urban populations). Children remain particularly vulnerable to poverty: according to the latest data, monetary child poverty declined only slightly from 35 per cent in 2000 to 29 per cent in 2016. Multidimensional child poverty has also decreased at a very slow rate (from 90 per cent in 2011 to 88 per cent in 2016) (CSA and UNICEF Ethiopia, 2020). Moreover, food insecurity is chronic in many rural areas, and often exacerbated by weather shocks such as droughts and floods.

The Government of Ethiopia and its development partners have been implementing various social protection programmes to address poverty and enhance resilience among vulnerable populations. The existing social protection system is comprised of diverse contributory and non-contributory interventions, such as the PSNP, the CBHI scheme, health and education fee waivers, and a formal social security scheme.

The PSNP is Ethiopia’s largest flagship social protection programme; it has been in operation since 2005 and covers 8 million people nationwide. It provides critical support through cash, food and complementary benefits to food-insecure and poor households in chronically food-insecure woredas. PSNP clients are categorized into two
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groups: 1) the public works (PW) programme, which provides monthly cash-based wages1 for adults working six months per year during the lean season; and 2) direct support (DS), which provides unconditional cash payments throughout the year to households with no able-bodied members. Most of these participants are classified as PDS recipients, including households with elderly members, people with chronic illness and/or disability and households headed by vulnerable females with severe labour constraints.

In Phase 4 of the PSNP (PSNP 4),2 an additional category was introduced: temporary direct support (TDS). This category allows adult pregnant and lactating women (PLW) to transition from PW to DS status, exempting them from work requirements during pregnancy and until their child is 12 months of age. Adult caregivers of malnourished children aged 6–59 months are similarly eligible for TDS. In 2017, the PSNP was extended to urban areas to address the multifaceted challenges of urban poverty.

CBHI is Ethiopia’s key health-financing measure aimed at protecting poor families from catastrophic health shocks and negative coping strategies that may be used to pay for health services. The scheme was first piloted in 13 rural woredas in 2010/2011 and has since been intensively scaled up to cover 770 out of 1,100 woredas nationwide, or 32 million households. CBHI is subsidized jointly by federal and regional/district governments, while communities themselves decide whether or not to join the scheme (Mebratie et al., 2015a). Premiums, registration fees and benefit packages vary across regions but are largely similar (Mebratie et al., 2015b). CBHI covers all preventive and primary curative health services (basic medical consultations, procedures and diagnostic tests) delivered within a health centre, as well as drugs from private pharmacies or vendors, based on the physician’s prescription. Currently, roughly 10 per cent of CBHI members in each community should be enrolled for free as part of the ‘indigent’ population.

While these programmes have been critical to improving food and economic security and access to healthcare for poor and marginalized families across Ethiopia (Berhane et al., 2014), they have had modest impacts on poverty and nutrition outcomes. A comprehensive evaluation of the PSNP over the years found that the programme contributes to enhanced capacity of poor households to mitigate seasonal and income stresses; however, their access and uptake of social services remains limited, particularly among vulnerable women and children. This is partly because these programmes have been fragmented in terms of their policy, institutional coordination and budget allocations, and have lacked a coherent and cross-sectoral approach to poverty reduction.

In recognition of these shortcomings, the government has begun the process for establishing a comprehensive and integrated social protection system based on coordinated multi-sectoral collaboration and linkage with basic social services. Such an approach is expected to more effectively harness potential synergies between social protection and complementary services as a means of enhancing the magnitude and sustainability of poverty reduction and food security and nutrition outcomes.

A national social protection policy and strategy adopted in 2016 provides an institutional framework to achieve these aims. To a certain extent, integrated service delivery is also recognized programmatically within PSNP 4 and PSNP 5. However, the social protection strategy has not produced the desired effects to date in terms of bringing together the different interventions in place in Ethiopia. Further policy measures are required to enable key ministries and other stakeholders to work more collaboratively and effectively on social protection programmes through shared commitment, sufficient budget funding and enhanced implementation capacities, systems and tools. UNICEF is supporting the Ministry of Labour and Social Affairs (MoLSA) and Ministry of Agriculture (MoA) to move the agenda forward.

1.1.2 Transitioning to an integrated safety net system through UNICEF pilots

UNICEF has been supporting the government in building an integrated safety net system of social transfers and linkage to complementary social services through several programme pilots. The previous two pilots, implemented within the framework of the PSNP, included the Tigray Social Cash Transfer Pilot Programme (2011–2014) and The Improved Nutrition through Integrated Basic Social Services with Social Cash Transfer (IN-SCT) pilot in the Oromia and Southern Nations Nationalities and People’s (SNNP) regions (2015–2018).

1 Only a small fraction of participants (1–4 per cent of PWs and PDS participants respectively) receive payments in kind or as a mix of cash and in kind.

2 The roll-out of Phase 5 of the PSNP started in early 2021.
The evaluation of the IN-SCT pilot found that the intervention had modest effects on child nutrition outcomes and highlighted areas for improving links between social protection and other social sectors. These recommendations involved a need for more generous and predictable cash transfers, more systematic development of the social welfare workforce, greater cross-sectoral coordination, data management and accountability mechanisms, and more reliable budgets. These lessons and recommendations from the IN-SCT pilot informed the new UNICEF initiative – the ISNP pilot (2018–2023) – in the Amhara region, which is the focus of this impact evaluation.

The ISNP pilot was initiated as a means of continuing to support the Government of Ethiopia in transitioning to an effective and efficient system of integrated service delivery to address the multidimensional needs of PSNP clients (particularly vulnerable women and children). While building on the strengths of the IN-SCT pilot, the ISNP introduces new programmatic elements to facilitate and test enrolment of PSNP households into CBHI and promote access to complementary services to improve health, nutrition and child protection outcomes. The new pilot also addresses the main shortcomings of the IN-SCT pilot by enhancing budgetary support to expand the social welfare workforce, strengthening the capacity of frontline agencies to deliver social services and improving data management related to PDS and TDS clients. The following section describes the ISNP intervention in more detail.

1.2 The Integrated Safety Net Programme

The ISNP pilot is implemented by MoLSA with technical support from UNICEF and funding from SIDA. The pilot is carried out in Libo Kemkem and Dewa Chefa woredas of the Amhara region. Building on the existing PSNP 4 framework, the ISNP delivers an integrated package of cash transfers and complementary services for PSNP clients, with a focus on CBHI and nutrition. To leverage the impacts of income support, these complementary measures and services are aimed at promoting positive changes in clients’ nutrition and health-related knowledge, health-seeking attitudes and practices, and improving their prospects for a sustainable exit from multidimensional poverty and food insecurity.

The ISNP pilot builds on the existing PSNP client structure and delivers interventions to households enrolled in the PW and DS, with a particular focus on PDS clients. While the majority of the programme’s components and activities are ongoing and delivered through the existing PSNP 4 system, the ISNP pilot adds value in two interrelated ways. First, the intervention introduces several design innovations, such as linking the PSNP clients to the CBHI scheme and education-related co-responsibilities. Second, the ISNP scales up and enhances the operational mechanisms and modalities introduced by the IN-SCT to improve the impact of the ‘cash plus’ approach and facilitate clients’ linkage to services in health, nutrition and education. These include the support to MoLSA and Bureau of Labour and Social Affairs (BoLSA) to confidently take responsibility of overseeing the PDS component, expanding the deployment and training of social welfare workers, expanding collaboration between frontline staff, improving the case management system and further transition to the digital management information system (MIS).

The ISNP pilot also works on improving partnerships between key ministries (i.e., the MoA, the Ministry of Health (MoH), MoLSA, the Ministry of Women’s and Children’s Affairs) and other relevant stakeholders through enhanced joint planning, coordination, implementation and proper resourcing of activities. The pilot will promote and test these ‘plus’ programme components and operational tools to determine their effectiveness in facilitating clients’ access to integrated services leading to improved health and nutrition outcomes. Details of programmatic components, activities and institutional arrangements are provided in Box 1.
Box 1: ISNP programmatic components, activities and services: What is delivered and by whom?

Access to CBHI for PW and DS clients

The ISNP promotes and facilitates enrolment of PSNP 4 clients into CBHI to improve their demand for and access to healthcare, to protect households from financial shocks and to prevent lapses into deeper poverty due to catastrophic health expenditures. PDS clients are provided free CBHI enrolment through fee waivers. PW clients are still fee paying and they are encouraged to enrol through promotional and information campaigns about the scheme and its benefits. Health extension workers (HEWs) with support from social workers (SWs) carry out promotional activities and registration of clients at community level. The ISNP works to establish institutional mechanisms to strengthen links and coordination between MoLSA, MoH and MoA to harmonize enrolment processes and enable the inclusion of PSNP clients in CBHI. A key objective of the pilot is to test the institutional linkage and associated health outcomes.

Transition into TDS

Under the PSNP 4 framework, the ISNP pilot facilitates transition of eligible women to TDS (including PLW and caretakers of malnourished children). The TDS feature is meant to protect women from health-related risks during pregnancy and lactation, and to safeguard the health and early development of their children by connecting them to health and nutrition services. Women in their fourth month of pregnancy are entitled to enrol into TDS and receive direct transfers for a period of six months without any work requirements. They are permitted to stay in the TDS until their child turns one year of age. Caretakers of malnourished children can transit into TDS as soon as their child’s nutrition status is confirmed and remain in support until the situation is improved. Frontline workers (FLWs), such as health and SWs and development agents (DAs), play a key role in TDS implementation. HEWs screen and refer eligible women to DAs, who in turn approve and manage exemptions. The ISNP works through the existing PSNP processes but invests efforts into strengthening protocols and capacities of key frontline personnel to appropriately transition clients to TDS as well as link them to health and nutrition services through co-responsibilities.

Co-responsibilities for TDS and PDS clients

Co-responsibilities are used to promote clients’ demand for and uptake of basic services. First, as part of the PSNP 4 framework, the ISNP promotes several co-responsibilities for TDS clients (also known as ‘soft conditionalities’) in health, nutrition and childcare practices. PLW with young children must commit to fulfilling their co-responsibilities during the six-month PW period, including attendance of four antenatal care (ANC) and two postnatal care (PNC) check-ups, attendance of growth-monitoring and promotion sessions, and attendance of behaviour change communications (BCC) sessions. Caregivers of malnourished children are required to attend growth-monitoring sessions and participate in therapeutic or targeted supplementary feeding, where available.

The ISNP has introduced a new type of co-responsibility for PDS clients, whereby children living in these households are required to attend school. While households are informed of their co-responsibilities and basic monitoring is undertaken by HEWs and SWs, there are no penalties in case of non-compliance. SWs encourage and support clients to fulfil co-responsibilities and benefit from basic services through case management. Co-responsibilities are implemented together with BCC interventions and case management as a package of complementary services aimed to promote investments in human capital development.
**BCC for TDS and PW clients**

BCC sessions are delivered through the PSNP system and include a package of co-responsibilities to enhance TDS clients’ knowledge about maternal and child health and child nutrition and promote utilization of services. PW households are also permitted to attend BCC sessions, and time dedicated to BCC can substitute for two days of work on PW sites. The BCC programme comprises several topics including maternal and child nutrition, gender provisions for PLW and caregivers of malnourished children (co-responsibilities), and water, sanitation and hygiene (WASH). BCC also includes cooking and feeding demonstrations for young children and delivering messages on cross-cutting themes such as gender equality, management of household resources and broader concepts of child protection. BCC sessions are coordinated by MoA staff with DAs, HEWs and SWs supporting the delivery of activities on the ground.

**Case management system for PDS clients**

The provision of case management support to PDS clients was introduced by the IN-SCT pilot. The ISNP focuses on an expanded and strengthened case management approach, with the establishment of protocols to refer and link particularly vulnerable clients (primarily PDS households) to essential services in health, nutrition, education and child protection, as well as additional social assistance benefits. SWs – under the guidance and support of Woreda Office of Labour and Social Affairs (WOLSA) – play a key role in this process; they are responsible for assessing, planning, delivering and monitoring the case management protocol required to meet clients’ various needs. Case management is facilitated by the digital MIS.

**Establishment of a unified and digital MIS**

Building on the original system established by the IN-SCT pilot, the ISNP continues to expand and strengthen the use of the digital MIS among MoLSA personnel. The main purpose of the MIS is to enable integrated data management across various programme components, and capture all relevant information about PDS households that can be used by multiple actors serving the same clients. The MIS is implemented and supervised by MoLSA (particularly at WOLSA level) and is used to facilitate the monitoring of case management, co-responsibilities and BCC attendance.

**Key agencies responsible for ISNP implementation**

In terms of the institutional set-up, the MoLSA plays a coordination role for implementation and monitoring of the ISNP pilot in collaboration with MoA, MoH, Ministry of Education (MoE) and other relevant sectors. The MoLSA and corresponding regional and woreda agencies are responsible for linkage to social services and support for PDS and TDS clients, including case management. While BoLSA provides technical assistance and supervision to the woreda level for ISNP, and monitors progress of the intervention, WOLSA manages the day-to-day planning, implementation and monitoring of the ISNP, including the supervision of SWs. MoA is responsible for the overall management and coordination of the PSNP 4 and provides support to MoLSA for implementation of the ISNP pilot, while MoH in partnership with MoLSA leads implementation of nutrition actions and CBHI linkage for ISNP.
1.3 Study objectives and key evaluation questions

1.3.1 A mixed-methods impact evaluation

A rigorous impact evaluation is being implemented from 2019 to 2023 to determine the impacts of the ISNP on the well-being of client households across health, nutrition and education outcome domains, and assess programme performance. This quasi-experimental, longitudinal and mixed-methods impact evaluation will assess the added value of the ‘cash plus’ components to inform PSNP policy and related initiatives. The focus of the evaluation is to test the ISNP clients’ access to CBHI and health and nutrition services, and the added value of FLWs in facilitating demand and uptake of complementary services.

The UNICEF Office of Research – Innocenti is leading the impact evaluation across three research waves, in collaboration with Frontieri, the University at Buffalo and UNICEF Ethiopia. The mixed-methods baseline data collection was conducted from December 2018 to February 2019 in four rural woredas of the Amhara region. Libo Kemkem and Dewa Chefa are sampled as treatment woredas (households receiving PSNP plus integrated PSNP/CBHI implementation activities) and Ebinat and Artuma Fursi are included as comparison woredas (households receiving the PSNP but not the integrated ‘plus’ components).

The baseline study compared the status of households already enrolled in standard PSNP activities with those households benefiting from the ISNP ‘plus’ measures, such as health insurance. In February 2020, a qualitative midline study was undertaken in treatment woredas to document progress in programme implementation since the baseline and to detect early observable changes in outcomes. A decision to have a stand-alone qualitative midline wave instead of a mixed-methods evaluation was warranted since no major impacts in clients’ well-being were expected at this time. The endline wave, combining quantitative and qualitative methods, is planned for early 2023.

The conceptual framework guiding the overall impact evaluation is illustrated in Figure 1, which shows the pilot’s various components, identifies relevant individual and household indicators, and suggests potential impact pathways. This framework draws from existing evaluations of the PSNP and related pilots, which suggest that cash transfers such as the PSNP have positive effects on food security, consumption and other aspects of well-being, but cash alone is often insufficient to achieve all health and nutrition-related outcomes of interest (Berhane et al., 2014, 2015; UNICEF et al., 2020). Thus, complementary programming such as linkage to existing services or additional, integral programme components (information/BCC, additional benefits or psychosocial support) may help to boost the impacts of cash, which alleviates binding income constraints but may not overcome other barriers to accessing services (Roelen et al., 2017; UNICEF et al., 2020).

The ISNP conceptual framework reflects a holistic approach, integrating services and programme components across sectors to address income and other determinants of health and nutrition. It also draws on the UNICEF nutrition framework, which recognizes that malnutrition among children is only partially explained by inadequate access to food, and is additionally determined by factors such as inadequate care for children and women, insufficient health services, hygiene and environment, and caregivers’ education (UNICEF, 2013; UNICEF et al., 2020). In this way, the ISNP pilot aims to target additional, underlying determinants of child malnutrition beyond income constraints (poverty). The ISNP also focuses on supply-side moderators illustrated in the conceptual framework – namely availability and quality of public services – by reinforcing training, staffing and improving information channels about existing services. More details about the conceptual framework and pathways of change are described in the ISNP baseline report (ISNP Evaluation Team, 2021).
1.3.2 Qualitative midline study

The qualitative midline data collection was conducted 13 months after baseline, providing a mid-course follow-up assessment with two primary aims: 1) to examine the progress of implementation of the integrated programme components (as indicated in the left-hand side of the framework referenced above); and 2) to provide preliminary evidence of early changes in core outcomes and pathways of change among PSNP clients related to impact evaluation objectives (with a focus on the intermediate, and some mid-term, outcomes presented in the conceptual framework).

The Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) criteria for intervention evaluations, namely efficiency, effectiveness and sustainability, are addressed in this midline evaluation (OECD & DAC Network on Development Evaluation, 2019). OECD-DAC evaluation criteria regarding relevance and coherence are beyond the remit of the study. The impact criterion (measurement of higher-order effects) will be addressed as part of the endline report using a combination of quantitative and qualitative data. This report covers three sets of issues and evaluation questions as follows:

1. **Programme efficiency:** The aim of the process evaluation component is to track implementation progress, and in particular to examine how well the programme and its components are managed and affect overall performance. It is focused primarily on operational efficiency and implementation of the processes and mechanisms used to deliver components and facilitate integration as well as the coherence between the ISNP and PSNP and with the health sector. It also aims to identify challenges, bottlenecks and areas for improvement in service delivery and outcomes. It assesses clients’ access and enjoyment of benefits and services and their perceptions and experiences of the programme in terms of its relevance, timeliness and quality. The qualitative midline wave assesses the fidelity of implementation and performance of different programme components, as indicated in Table 1.

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Figure 1: ISNP conceptual framework
Key questions related to efficiency include:

- How well is the intervention being implemented? Has the programme implemented components as intended? If not, why?
- Which institutional and operational bottlenecks affect the quality, timeliness and accuracy of programme delivery?
- What changes can be made to improve integrated implementation of the ISNP in future?

2. **Programme effectiveness**: The aim of the impact evaluation component is to assess early observable outcomes at the household and individual level, as well as pathways of change through which these changes have occurred since baseline. The midline research was conducted 13 months after baseline data were collected to allow adequate time for early effects (intermediary outcomes) to materialize. Key outcomes of interest include: (a) CBHI enrolment, reduced health-related expenses and an increase in health-seeking behaviour; (b) increased knowledge on child-feeding and dietary practices and a reduction in food insecurity; and (c) enhanced knowledge of, demand for and uptake of complementary support and social services (see intermediate outcomes in the conceptual framework).

We look for positive, negative and intended or unintended changes, identify their drivers and seek evidence of ISNP contribution to these changes. Qualitative data allow us to examine topics in more depth – particularly the role and contribution of design features (FLWs, TDS transition, MIS, etc.) – in mediating these programme outcomes as well as programme moderators such as supply-side barriers and facilitators (e.g., see moderators in the above-referenced conceptual framework).

Key questions related to effectiveness include:

- Did clients experience changes (positive/negative) in key outcomes since baseline?
- What changes have occurred as a result of the ISNP pilot and how?
- What other factors moderate these outcomes?

3. **Programme sustainability**: The aim of this component is to assess key informant perceptions about sustainability of the programme and its components in the long term. In particular, we assess the extent to which the programme’s benefits are likely to continue in future, and identify enabling institutional, financial and operational factors that will increase the potential for programme sustainability over time, as well as potential risks that may undermine the feasibility and commitment to programme sustainability.

Key questions related to sustainability include:

- Will support for the ISNP and its components be maintained over the medium term?
- Which key factors affect sustainability?

This report is targeted to PSNP implementers and stakeholders, including government and development partners, to inform programming by highlighting areas for improvement in the pilot and providing a set of recommendations to inform its future design and delivery. Lessons from the pilot and evaluation will be used specifically to advocate for strengthening PSNP 5 design and delivery, to scale up the integrated and coherent model, and to support broader policy learnings on the ‘cash plus’ approach.
Table 1: Programme components and midline evaluation focus

<table>
<thead>
<tr>
<th>Programme component</th>
<th>Focus of the assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolment into CBHI</td>
<td>Institutional and operational arrangements necessary for integration of the PSNP and CBHI, and barriers to PSNP client participation in CBHI</td>
</tr>
<tr>
<td>Implementation of ISNP components</td>
<td>Roles and responsibilities of the main actors delivering ISNP components, key tools used for integrated programming, progress against programme plans, and operational bottlenecks and challenges faced in implementation and monitoring</td>
</tr>
<tr>
<td>Transition of PW clients into TDS</td>
<td>Nature and effectiveness of implementation of transition procedures (identification and referral) from the service provider, as well as client perspectives and benefits from transition</td>
</tr>
<tr>
<td>Implementation of BCC, co-responsibilities and case management</td>
<td>Implementation of BCC, co-responsibilities and case management – in terms of fidelity to design and related operational bottlenecks and challenges – and their effects on client access to services and changes in knowledge and practices related to nutrition, hygiene, gender equality, child protection, etc.</td>
</tr>
<tr>
<td>Collaboration between ISNP FLWs and service providers</td>
<td>Mechanisms fostering collaboration between frontline agencies and service providers (to provide a comprehensive set of services to clients) and challenges to effective and sustainable service integration and provision</td>
</tr>
<tr>
<td>Utilization of an MIS</td>
<td>The functionality, procedures and responsibilities of data entry and management (operation by SWs and dedicated staff at the woreda level) and the potential for scale-up</td>
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1.4 Research design and methodology

1.4.1 Overall research design and methods

The overall impact evaluation adopts a *longitudinal* research design, meaning that the same cohort of households (both in the treatment and comparison communities) is tracked and interviewed at three different points in time (baseline, 13-month midline and 24-month endline waves). The qualitative cohorts are also ‘embedded’, meaning they are selected from larger cohorts of participants in the quantitative evaluation. Collecting data from the same households (and potentially the same individuals) at baseline and midline provides a rich picture of the lives of families, caregivers and children prior to the pilot, while illustrating how the ISNP alters well-being over time. The embedded sampling allows for greater integration of findings and interplay between quantitative and qualitative methods. The sampling framework is further discussed below and in Figure 2.

The qualitative midline evaluation does not measure impacts per se but rather it captures qualitatively the perceived changes experienced by the PSNP households as a result of their participation in the pilot. As such, our sample focuses only on treatment communities to understand what early changes have occurred based on clients’ perceptions, as well as identify pathways and reasons behind these changes (or lack thereof) that are attributable to the programme. The relatively small sample size, focused on treatment communities only, was also partly driven by budgetary constraints. The methods used for midline data collection include key informant interviews (KIs), in-depth interviews (IDIs) and focus group discussions (FGDs), which are described in detail in Section 1.4.3.
1.4.2 Sampling framework

We describe below the sampling process used to select study locations and participants for the research.

Study locations

The qualitative midline study took place in two treatment woredas: Libo Kemkem and Dewa Chefa. These locations were purposively selected by the government and UNICEF Ethiopia for implementation of the ISNP pilot due to their existing investment in the social welfare workforce, variations in their prevalence of CBHI enrolment (higher enrolment figures in Dewa Chefa compared to Libo Kemkem), UNICEF programmatic capacity to support implementation in these areas, and accessibility.

To carry out our midline data collection, we selected one kebele in each of the two treatment woredas: Shemo kebele in Libo Kemkem woreda, and Gula kebele in Dewa Chefa woreda. Kebele selection was based on a relatively large number of PSNP households per community (to enable inclusion of different client categories) and (relatively) good accessibility to research sites. In Libo Kemkem, researchers had to expand their fieldwork to nearby kebeles (Birkutie and Estefanos) to identify and meet the sampling criteria for inclusion of TDS clients in the IDIs and FGDs, as discussed below.

Our sample was relatively small scale due to budgetary and time constraints (as qualitative interviews are much more time-intensive than quantitative surveys), as well as the aforementioned goals of qualitative analysis to understand pathways of change in depth. While not representative of the broader population, the subsample reflects a diversity of geography, languages, sociocultural characteristics, religion, socio-economic development and CBHI enrolment. The midline research sites, sampling frame and stratification are consistent with the baseline.

Study participants

To conduct qualitative data collection, study participants were selected from a subsample of the larger quantitative evaluation sample. A stratified sample design was adopted to identify and select participants for the IDIs. Female caregivers from PW, TDS and PDS client groups were interviewed. The sample of TDS beneficiaries was further disaggregated to include:

- Households with pregnant women;
- Households with lactating women with a young child aged 1 year; and
- Households with caregivers with malnourished children.

FGDs were structured along the following criteria:

- Female caregivers from PW households;
- Caregivers with malnourished children; and
- Caregivers with children who are not malnourished.

A stratified sample enabled us to compare characteristics and programme outcomes between different categories of PSNP clients, including different lifecycle characteristics and trajectories as well as household composition. The majority of households and individuals who took part in the IDIs at midline also participated in the qualitative baseline research. The socio-economic characteristics of study participants in focus groups and IDIs varied depending on their PSNP client status. For example, while PDS clients were generally older and without young children (average age of 70 years), the PW clients mainly comprised adults aged 40 years on average, and all had children (four on average per family). TDS clients were slightly younger (aged 30 years on average) and had more children (six on average). Clients participated in the PSNP for four years on average.
1.4.3 Research methods and training activities

The methods used for midline data collection include: (1) KIIs (18 total); (2) IDIs with female caregivers from PW, PDS and TDS clients (32 total); (3) FGDs with PW and TDS households (six total); and (4) FGDs with community care coalitions (CCCs) (two total). Figure 2 provides an overview of the sampling framework and key informant/respondent categories involved in the research.

KIIs were conducted with staff involved with delivery of the ISNP pilot at regional levels, such as the BoLSA officer and Bureau of Health officer, and woreda-level personnel, including the ISNP coordinator, CBHI coordinator and PSNP coordinator. KIIs were also undertaken with FLWs at the kebele level, including HEWs, SWs and DAs. Interviews with key informants were primarily used to elicit feedback and recommendations on ISNP implementation processes and procedures, including success factors and challenges. IDIs were conducted with PW and PDS clients to determine the impacts of linking the PSNP and CBHI on the well-being of client households (focusing on children and caregiver nutrition, health and care practices, health-seeking and CBHI enrolment). These qualitative interviews also focused on client access, experiences and perceptions of programme components including access to fee waivers, BCC activities, co-responsibilities, TDS transition and case management referral systems.

IDIs were complemented by two sets of FGDs with PW and TDS clients to explore in more detail the attitudes and practices related to nutrition and child health, health-seeking behaviour and CBHI enrolment, and their ISNP pathways. Finally, another set of FGDs explored the roles and experiences of representatives from different community organizations working in social protection and cross-sectoral coordination. Across eight focus groups we interviewed a total of 64 people. Programme implementation was assessed only through the analysis of qualitative data; while programme monitoring data is a very important aspect of monitoring and evaluation, it was not envisioned as part of the impact evaluation and is therefore outside the remit of this report.

Interviewer training took place in Addis Ababa between 17 and 22 January 2020. The training was led by Frontieri with co-facilitation support from three members of the evaluation team from UNICEF – Innocenti and University at Buffalo. The training consisted of an introduction to the project, training on the study instruments and information on the ethical conduct of research, including informed consent. In total, eight qualitative researchers were trained. Data collection took place between 3 and 24 February 2020. Interviews were conducted in local languages, including Amharic and Oromo, and were audio-recorded for subsequent transcription.
1.5 Ethical guidelines and study registration

Ethical clearance for this study was provided by the Amhara Region Public Health Institute. The impact evaluation is registered in the Pan African Clinical Trial Registry (trial registration ID: PACTR201902876946874). Evaluators and interviewers involved in the study adhered to the ethical standards for evaluation prescribed by the United Nations Evaluation Group. Informed consent was obtained from all adult interviewees who participated in IDIs, FGDs and KIIIs, including: (1) information about the objectives and content of the study, (2) safeguards to ensure respondent privacy and data security, (3) voluntary participation, (4) the right to withdraw from the interview and/or refuse or skip any questions without consequences and (5) contact details of a source who can follow up complaints or provide further information on the study.

Intensive ethics training was provided to research assistants to ensure that they undertake data collection with independence, impartiality and accountability to participants and wider stakeholders. As IDIs included discussion of sensitive topics and issues, specific referral protocols to social services were available on hand in case respondents were seen to be vulnerable to the risk of violence or psychological abuse as a result of their participation in the study. The evaluation team was not involved in any aspect of the design and implementation of the ISNP pilot, and thus has an independent and impartial role in this evaluation.
1.6 Fieldwork challenges

Fieldwork generally proceeded smoothly and on schedule in both research sites. However, researchers encountered several challenges during data collection. First, interviews in Libo Kemkem were conducted during the CBHI enrolment campaign, which meant that several key informants were busy, and interviews had to be interrupted several times and instrument guides slightly revised to adjust to this schedule.

Second, researchers faced some challenges in identifying and locating respondents for IDIs who had also participated in the baseline survey. Because respondents in the embedded sample are living in scattered geographical areas, it was not always easy to identify them and determine their exact locations, even with full assistance and support of SWs. Thus, the team relied heavily on the assistance of locally knowledgeable persons, mainly PSNP supervisors who were familiar with households and their respective locations.

Databases were also rechecked to confirm individuals’ participation in the baseline study. As a result of life cycle changes (death, pregnancy, etc.) and scattered geographical locations, it was also difficult to identify respondents who could comply with the requirements of the embedded sample. It was particularly challenging to identify and recruit PLW in Shemo kebele to participate in IDIs and FGDs, which forced the team to expand the search to the nearby kebeles of Birkutie and Estefanos. In the end, the final sampling framework and size was slightly revised from the original plans (Figure 2). To fill the quota of pregnant women, our team recruited two more lactating mothers (a total of five lactating mothers were interviewed).

Finally, the homes of sampled respondents were located across a wide geographical area, most of which is not connected by road. Thus, the assessment team travelled on foot across difficult terrain and rough footpaths, which posed further challenges. Locating clients was difficult and would have required more days in the field had the team not been fortunate enough to obtain help from local assistants. Taking this as a lesson learned, we suggest the use of GPS for future similar assignments.

1.7 Analysis of qualitative data

Two data sets were used for the analysis: (1) verbatim transcripts from interviews conducted during the fieldwork; and (2) analytic summaries for each household included in the IDIs, summarizing key findings as well as field notes and contextual observations captured by researchers. Interviews were transcribed in the local language (Amharic) before translation into English.

The analysis of qualitative data was informed by the thematic analytical framework, which comprised two interrelated aspects. The first was a fluid thematic analysis, used to interpret, organize and structure the data into themes, and unpack the stories and important topics within the data. To do this, the research team initially conducted an in-depth review of the transcripts to become familiar with the data, develop an understanding of participants’ narratives and identify emerging themes in the data. They then developed a coding framework to identify patterns in key areas of interest. A code book was created using a priori themes from the interview guides, and supplemented with themes that emerged during data analysis (Lincoln and Denzin, 2000; Weber, 1990). Broad coding categories included health status and health-seeking behaviour, CBHI enrolment, child nutrition and feeding, pregnancy and lactation, educational enrolment, PSNP participation, co-responsibilities, BCC sessions, complementary services, food security and hygiene.

A second, more structured analytical approach was then used to analyse and code data to develop frequency counts to gain sense of the magnitude and scale of change. No software was used to code the data, but rather the coding was performed ‘manually’ in three steps: (1) assessing observed changes in the past year and coding as positive, negative or neutral; (2) mapping drivers behind the change in outcome as explicitly positive or negative; and (3) coding segments of the narrative for each outcome domain that make explicit or implicit links to the programme. Finally, quotes were selected that reflect key themes and findings and illustrate explicit evidence of observed changes. Initial coding structures were developed by the lead qualitative analyst and then shared with an additional two coders for recording purposes. In this way, the final coding structure was validated, ensuring consistency in the application of codes (MacQueen et al., 1998).
1.8 Evaluation limitations

Evaluators faced several limitations in this study. Given that it involved only qualitative research, the study’s focus lay in process evaluation, implementation progress and the exploration of perceived outcomes and potential impact pathways. Regarding programme efficiency criteria, the study examines operational efficiency in terms of how well the programme and its specific components are being implemented and fidelity to the original design. Due to data limitations (including unavailability of total programme cost data), we cannot determine how well the resources/inputs (funds, expertise, time) have been used – and if they have achieved results in a cost-effective way as compared to other feasible alternatives.

Finally, given the nature of qualitative research, it was possible to document only perceived changes experienced by a small sample of beneficiary respondents in two kebeles (wards) since baseline. As such, qualitative findings are indicative only, and findings cannot be generalized to other settings. During this study, we document the early observable effects reported by clients and key informants and analyse the mid-course progress towards objectives and intermediary results achieved by the ISNP to date. This study does not examine higher-order effects or broader contributions considered part of the impact criteria, as these will be captured within the endline study.

It is also worth mentioning that the study did not conduct interviews in the comparison areas to ascertain if the improvements in preliminary outcomes reported by the clients in the treatment areas are also being witnessed in the comparison areas. This could be the result of other contemporaneous interventions, general national changes or even spillovers. Collecting qualitative data from comparison areas will be considered in the next round of data collection.
Section 2
Integrated implementation of the ISNP pilot

As different agencies are responsible for implementation of the ISNP pilot, with some outside the purview of the PSNP, having good coordination and staff commitment towards integrated service delivery, as well as effective implementation systems (planning and data management) is a key in pilot delivery. The pilot tests the effectiveness of mechanisms in enabling programme stakeholders to work together and effectively deliver various interventions in a coherent and aligned manner. In this section we report findings on the progress of integrated service delivery, including staff understanding and commitment to the ISNP pilot, progress in overall programme implementation and coordination, and the key mechanisms used to facilitate harmonized project management.

2.1 Staff awareness and commitment to integrated programming

2.1.1 Staff understanding of the ISNP pilot and attitudes towards integration

Key informants generally demonstrated a solid understanding of the ISNP objectives and main components. There was widespread acknowledgement – particularly among woreda-level staff and FLWs – that single interventions, such as food or cash, are insufficient to support clients. Therefore, staff agreed that households must be linked to an integrated set of social services including health, nutrition and education to facilitate their graduation out of poverty.

The ISNP pilot was mainly associated with the promotion of health and nutrition services among PLW, transition into TDS and the enrolment of PDS households into CBHI through fee waivers. FLWs specifically referred to the programme’s new features, such as the engagement of SWs and implementation of home visits, continued follow-up, as well as SWs’ more systematic use of data management to identify and record clients’ needs, refer them to services and monitor their uptake of support.

Woreda-level respondents highlighted that systematic testing and generation of evidence about the added value of cash plus programming is the strategic purpose of the ISNP pilot. As the WOLSA officer from Libo Kemkem explained, positive results captured through routine monitoring have already enhanced political commitment and government ownership and involvement in the pilot: “The woreda administrators were not accepting the project. [They] … were also questioning what is WOLSA, who hired SWs, but after a while the outcomes of the project changed the perception of those woreda leaders.” These findings have important implications for the sustainability of the programme, as the ISNP coordinator from Libo Kemkem explained:

“We have presented two woreda reports that focused on changes as the result of the project. Due to this presentation, the government has promised to hire around 4,000 SWs and extend the structure up [from] grassroot levels, this is the big change.”

Key informants had positive attitudes towards integrated programming and cross-sectoral collaboration. Many expressed a deep understanding that working in isolation (silos) is not effective and cannot bring desirable change for poor communities; instead, as the PSNP coordinator from Dewa Chefa explained, a shift towards a systematized approach and cross-sectoral collaboration is required:

“It [ISNP] intends to integrate the components including agriculture, food security, livelihood enhancement, resilience to shocks, and nutrition to sustainably improve the livelihoods of the community […] If we take the issue of nutritional improvement, it needs the integration of health office, education office, WOLSA and the likes. The main point is that to reach where we wanted to reach, we need to integrate stakeholders. If we work in solidarity, we attain the goal of PSNP, which is graduation. As such, the purpose of the ISNP is to strengthen the integration between the sectors.”
The WOLSA officer from Libo Kemkem shared a similar sentiment about the importance of cross-sectoral networking for achieving results: “WOLSA can’t bring those changes alone; it is like clapping with one hand. We can’t bring change without food security office, women’s and children’s affairs, health and nutrition sector.”

FLWs indicated that even though they might be employed by different governmental agencies, they are still working for the same community, and must join forces on the ground to deliver support to clients. A collaborative approach is crucial for joint planning, identification of client needs and referrals to services. A member of CCC in Dewa Chefa explained how coordination between FLWs ultimately leads to more timely and improved service delivery: “If all are working together, they may bring solution for a problem, we may identify the right person to provide support, we may reach [clients] at a right time for any problem.”

Several respondents highlighted that integration and cross-sectoral collaboration have led to harmonization in targeting PSNP and CBHI fee-waiver clients. As a result, the CBHI coverage was extended and greater access to healthcare achieved for poor households:

“It’s been encouraging because the attitudes towards integrated programming and cross-sectoral collaboration are critical preconditions for effective programme delivery.

2.1.2 Progress in collaboration and drivers of integration

Next, we assessed perceived changes in the extent of integration and cross-sectoral collaboration since baseline, and identified drivers of integration. Overall, respondents were positive about the extent of cross-sectoral collaboration and reported improvements in horizontal integration since the ISNP roll-out, particularly at the kebele and woreda levels. A HEW from Dewa Chefa explained the positive change: “I work with SW in promoting CBHI, particularly for PDS clients. Before, we do not know each other, we work independently following the direction from woreda line [health] office. Since the last six or seven months we started to collaborate.” There was, however, less evidence of progress in vertical coordination between woreda- and kebele-level stakeholders.

At the kebele level, collaboration between SWs, HEWs and DAs has been identified as critical for effective service delivery. In both Libo Kemkem and Dewa Chefa, interactions between HEWs and SWs involving CBHI client registration and identification of clients for TDS and health and nutrition service referrals have been reported as examples of good practice. DAs and SWs collaborate effectively in retargeting PSNP clients, mainly PDS households, and addressing issues related to payment delivery.

Several testimonials explicitly credited the ISNP with breaking silos and reducing fragmentation across programme components and agencies (particularly the PSNP and CBHI) and systematically strengthening collaboration at woreda and kebele levels. A PSNP coordinator from Dewa Chefa described how the ISNP invested efforts in addressing attitudinal barriers to collaborative ways of working, and in improving awareness of different actors’ roles and responsibilities:

“As you know, every collaboration is essential. But the current level of collaboration has not come spontaneously and easily. In the past, the collaboration among various sectors was poor and was filled with many problems emanating from lack of awareness on the importance of working together [even among actors working in the same communities] [...] We have broken the negative attitudes towards collaboration and created understanding on the need for collaboration to effectively deliver what is expected from us. [...] These multi-sectoral collaborations since last year improved as a result of efforts undertaken in curbing the problems related to lack of awareness [...] We have learned that if we work together there is no hill we cannot go up.”
Cross-sectoral collaboration has also been driven by specific coordination platforms, such as technical committees and implementation mechanisms for joint planning and data sharing. A WOLSA officer and ISNP coordinator explained how joint field missions, after-action reviews and MIS are important means of facilitating horizontal and vertical collaboration, and provide opportunities to address bottlenecks in project management:

“In my perception, the inter-sector collaboration is very good … we go to [the] field every six months to provide support in collaboration. We are evaluating each other every three months so if there is a challenge that may affect our work, we jointly resolve it” (WOLSA officer, Libo Kemkem).

“The [MIS] software is installed this year, so the data is collected from each sector such as health, education, women and child affairs. To collect and enter such data it is a must to have collaboration, so MIS has great role in improving collaboration” (ISNP coordinator, Libo Kemkem).

Nevertheless, positive perceptions about integration are not universally shared. At the regional level, for example, collaboration has been described as insufficient and in need of improvement. Coordination focal points/platforms have been reported missing at the kebele level. In one instance, it was reported that since the early stages of the pilot, there was a reduction in collaboration between WOLSA and the Food Security and Agriculture Office, possibly due to increased capacity of WOLSA staff to conduct responsibilities more independently, with implications for programme sustainability.

2.2 Progress in integrated programme delivery

In this section, we report the perceptions and experiences of ISNP staff in overall implementation of the pilot. Sections 3–10 discuss the performance of specific programme components.

2.2.1 Overall progress in ISNP implementation

ISNP implementation is reportedly generally on track. Significant efforts have been made to strengthen delivery and coordination systems to ensure smooth implementation of different programme components (including those carried over from PSNP4) in the pilot’s first year. Regular reviews are carried out to assess implementation progress and address operational bottlenecks.

However, the fidelity and quality of implementation reportedly varies across the two research locations. In Dewa Chefa, several key informants reported that programme activities are timely and well implemented, and in some instances the ISNP has surpassed its targets. For example, a WOLSA officer at Dewa Chefa stated that goals related to the deployment of SWs to all pilot locations, and free enrolment of PDS clients into CBHI, have been achieved earlier than expected: “We are progressing more than what was planned … all PDS clients [were] to be covered by CBHI fee waiver within two years … we have already achieved this … [the] ISNP planned to fill the position of SW in each kebele within two years; however, we have achieved this in less than two years.”

In contrast, implementation in Libo Kemkem has been described by woreda coordinating staff and FLWs as irregular and inconsistent in quality. Operational and logistical challenges (such as vast and difficult terrain and transportation issues), shortages of budget (for fuel, transport, field worker pay, etc.) and political instability were cited as key factors that have hindered implementation at the village level. According to the PSNP coordinator in Libo Kemkem, these issues have restricted staff field visits and reduced opportunities for regular monitoring and follow-up, thereby ultimately affecting programme performance: “Capacity must be created, a comprehensive awareness programme should be developed, and the work can be done effectively if it is evaluated every quarter of the year. But … there are times when it stops and continues. Therefore, it is not possible to say that the entire programme is being implemented correctly.”

Respondents highlighted the variations in quality, timeliness and fidelity of implementation across programme components. For example, the programme experienced delays in establishment of the MIS; however, it ultimately increased efficiency in targeting clients for CBHI fee waivers and improving payment regularity and predictability. Positive drivers (enablers) of implementation include strong political commitment, staffing improvements (both in numbers and capacity) and increases in budgets and material inputs. But many bottlenecks remain, which need to be addressed to strengthen implementation efficiency. These challenges are discussed in Section 13.
In this section, we assess the relevance and efficiency of the key operational mechanisms and institutional structures – training, coordination committees and joint project management activities – used for integrated programming.

2.2.2.1 Training activities

Many respondents spoke about the role of training in facilitating positive change, as it improved awareness and support for the ISNP and the role of SWs. ISNP-related training for members of technical committees, woreda officials (WOLSA staff) and FLWs has created awareness about the programme’s objectives and the roles and responsibilities of different stakeholders (most notably SWs), while promoting commitment to collaboration.

Training was also provided on specific programme components such as CBHI, BCC, case management and transition into TDS, as well as specific topics of relevance to the ISNP pilot, such as gender equality. In some cases, respondents highlighted that the trainings resulted in observed changes in their and/or staff skills and capacity to undertake and deliver specific activities:

“When the CBHI [was] introduced at kebele level, beneficiaries were selected based on relationship [nepotism]. We have been giving training [to FLWs] by using some portion of the budget to create awareness about CBHI. After the training they 100 per cent believe that they [were] making mistakes before, then they try to identify the indigent ones and replace those beneficiaries who are benefited based on relationship” (WOLSA officer, Libo Kemkem).

Some key informants were not satisfied with the quality and frequency of training. Several respondents reported that training was insufficient (typically missing a follow-up or refreshments), and not well designed or executed, especially at kebele level, often due to budgetary constraints. Another key challenge highlighted is the gaps in the process used to identify and recruit trainees:

“Each department must be trained by its own competent staff. For example, the basic problem we have in this woreda [is that] we plan to give training but then we will not even be given three days for the training, so we send them back within a half day. I can’t say this is a proper training, it is more like a random talk, so I say it will make it better if the training is given professionally” (PSNP coordinator, Libo Kemkem).

More careful planning is required to ensure that relevant personnel are selected to take part in the training and refresher trainings to ensure adequate capacity transfer and continued learning. Going forward, ISNP personnel suggested a thorough review of the trainings delivered to date and their capacity outcomes, as well as identification of capacity gaps and future training requirements.

2.2.2.2 Coordination committees

At baseline, the ISNP had already established steering and technical committees at woreda level to reduce fragmentation between programmes and key agencies, and to facilitate coordinated planning, budgeting and evaluation. Both woreda-level committees were retained as important institutional structures/platforms and their capacities strengthened at midline.

The technical committee at woreda level is composed of technical experts from sectors involved in ISNP pilot implementation, including woreda-level representatives from the Departments of Social and Labour Affairs, Agriculture and Food Security, Women and Children's Affairs, Nutrition, Education, and Health. A WOLSA officer chairs the technical committee, which meets regularly (reportedly every three months in Libo Kemkem and monthly in Dewa Chefa) to discuss the progress of the pilot, evaluate results and identify operational and strategic bottlenecks, which are regularly reported to the steering committee.

The steering committee is chaired by the woreda administration head (chief administrator), and involves head staff from the same departments as the technical committee, with additional participation of the PSNP coordinator and CBHI team leader. WOLSA acts as committee secretary. As a high-level policy platform, the steering committee is involved in the strategic planning and oversight of the ISNP pilot and
budgets, programme monitoring and facilitation of cross-sectoral coordination of key stakeholders at the *woreda* level.

**When asked to evaluate the committees’ performance, regional and *woreda*-level key informants generally had positive feedback.** While the steering committee plays an effective role in mobilizing policy commitment and support for the ISNP pilot, and promotes collaboration across sectors at the *woreda* level, the technical committee provides more active and hands-on support with programme implementation. The members of the steering committee are more senior (composed of cabinet members) and therefore more time-constrained with regard to regular meetings:

“In this [technical] committee, we plan our activities together, monitor the implementations, we organize the reports together, and in general, we do all activities in connection to PSNP together. [The] technical committee has done a lot in this aspect. It solved problems related to collaboration” (PSNP coordinator, Dewa Chefa).

### 2.2.2.3 Joint project management activities

**Joint workplans, regular performance reviews and inter-sectoral meetings are key tools for integrated programming and collaboration.** At the *kebele* level, FLWs jointly plan their annual action plans. This is perceived as a valuable entry point for coordinated planning and joint discussions around expected targets, budgets and training needs. Detailed plans are then sent for approval to the *woreda* office. Joint planning is also actively used by the technical committee to design activities, coordinate work and build commitment for the pilot, as illustrated by the ISNP coordinator in Libo Kemkem: “Yes, we can’t conduct joint meetings without involving woreda leaders [and] agriculture, health, and women and child affairs heads at [the] regional and woreda level. This makes them committed.”

**Different types of inter-sectoral meetings, including vertical and horizontal exchange of information aid cross-sectoral programme implementation.** These include monthly meetings by the technical committee, joint reviews mainly at the *woreda* level (typically undertaken quarterly) to evaluate progress and field visits by *woreda* staff and UNICEF to monitor community-level work performed by FLWs:

“We have a meeting every month, keep minutes and have field missions every six months to evaluate whether the service is given or not. We are going to kebele level and work with education, health, food security, women and child affairs, WOLSA. We have joint checklist, so we are working in collaboration” (WOLSA officer, Libo Kemkem).

**While multi-sectoral reviews enable ISNP staff to adjust delivery and build institutional ties, some staff expressed concerns that meetings and joint reviews are not regularly conducted.** At *kebele* level, time limitations and work burdens are obstacles to more frequent staff meetings. At *woreda* level, officials face logistical and budgetary constraints that reduce their ability to regularly visit the field and monitor activities and outcomes.

### 2.3 Roles and responsibilities

The ISNP pilot engages a diverse range of actors from various sectors to deliver its targets. Some personnel, such as PSNP coordinators and DAs, were part of the PSNP structure before the pilot, while others, including SWs and MIS officers, have been newly introduced by the ISNP in pilot communities with a view to their permanent deployment. CBHI coordinators and HEWs, traditionally part of the health sector, have also recently joined the ISNP team to further the pilot’s health and nutrition goals. The ISNP also involves government administrative staff, such as the *kebele* manager and administrator and CCCs, to support the implementation of certain components and pilot activities.

Given the complex and cross-agency nature of ISNP integrated programming, it is critical that the roles and responsibilities of key actors are clearly defined and understood, and staffing allocations are adequate to achieve effective delivery. In this section, we present the responses of principal ISNP actors when asked to describe their own roles and responsibilities, and their understanding of the roles and duties performed by their colleagues. We
focus mainly on FLWs (SWs, HEWs and DAs), given their prominent role in the provision of integrated services for ISNP clients. We also provide a brief assessment of the programme’s human resources structure (for details about staffing bottlenecks see Section 13).

2.3.1 Roles and responsibilities of key personnel

Frontline workers

In Table 3 we present an overview of key responsibilities for each FLW across PSNP- and ISNP-related components. This is based on a review of the prescribed roles and responsibilities in the Programme Implementation Manuals and respondents’ perspectives from our qualitative research. There is 1 SW operating in each kebele, 24 are deployed in Libo Kemkem and 21 are in Dewa Chefa. SWs continue to be temporarily deployed by the BoLSA and managed by WOLSA, and their salaries are currently paid by UNICEF funds. While their official focus is to provide case management for PDS clients, SWs support many different aspects of the ISNP, including programme administration and facilitation of integrated service delivery. Our research demonstrates that SWs also cater to the needs of TDS clients, particularly with regard to the implementation of co-responsibilities and assisting their transition into TDS.

Allocation of HEWs in research sites is more limited. Two HEWs operate in Shemo kebele and three operate in Gula kebele. Their main responsibility is to deliver health packages to communities. However, they are also tasked with responsibilities related to the ISNP health and nutrition components, including: CBHI promotion, registration and renewal; delivery of BCC sessions; monitoring of health-related co-responsibilities; and management of TDS protocols.

Four DAs operate across Shemo and Gula kebeles. These areas also have four agricultural specialists: two are responsible for natural resource management, one for animal husbandry and another for crop production. Our DA interview was with a long-standing staff member of the PSNP, and most of his responsibilities are related to the management of PW activities and provision of livelihood support for PW clients. However, DAs also play an important supporting role for the ISNP with regard to the TDS transition process and coordination of the BCC programme.

Other personnel

CBHI coordinators are employed at the woreda level within the Bureau of Health. Their main responsibility is to coordinate CBHI enrolment activities. As our HEW respondent explained, the coordinator supports FLWs in CBHI programme promotion and co-facilitation of awareness-creation sessions. They also oversee the process of CBHI client enrolment, including access to fee waivers for the poorest individuals. They also liaise with the CBHI board, health centres and drug suppliers to ensure that enrolment and health provision run smoothly.

The regional ISNP coordinator is located in Bahir Dar and is responsible for overseeing coordination of all activities in the selected ISNP pilot woredas. This includes providing support for FLW activities and monitoring their work as needed, preparing annual budgets and workplans, and reviewing the project outcomes quarterly. The coordinator is in close contact with the UNICEF office to ensure that funds are released in a timely manner and distributed to woreda ISNP teams, and monitors and checks expenditure against the objectives. The coordinator also reported being tasked with coordinating monthly reporting from the woreda and sharing this progress with regional and national policy stakeholders.

The PSNP coordinator works at the woreda level and is reportedly responsible for management and oversight of PSNP 4 activities, including PW projects, transition of clients into TDS, the (re)targeting process and chairing the appeal committee. They hold responsibility for coordinating BCC trainings and ensuring implementation of co-responsibilities and explained that they were involved in ensuring that referrals to complementary services run effectively and vulnerable clients have access to timely support.

Finally, the WOLSA officer leads and coordinates stakeholders, assessing whether the project activities have progressed properly, monitoring access of PDS clients to fee waivers, and overseeing and supervising SWs’ case

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4 Gula kebele has been split into two administrative areas: Gula Ketemo and Gula Tsige. Two HEWs operate in Gula Ketemo and one operates in Gula Tsige.
management for PDS clients. They work in collaboration with woredas to identify and enrol PSNP clients into CBHI with fee waivers.

2.3.2 Staffing issues

Our assessment of respondents’ knowledge and experience of their roles and responsibilities (Table 3) indicates several gaps in the human resource structure and staffing allocations, with important implications for FLW capacity to deliver on ISNP commitments.

First, while staff roles and responsibilities are relatively well defined, and improvements were made to properly delineate responsibilities among FLWs, overlaps in staff mandates and duties are apparent. This is particularly evident with regard to shared responsibility among HEWs, DAs and SWs in the management of the TDS transition protocols (screening and referring eligible women for TDS). This leads to inefficiencies in overall performance and delays in women’s access to TDS. At the woreda level, overlaps were identified in the mandate and key responsibilities of ISNP and PSNP coordinators, who both claimed responsibility for coordinating, operating, monitoring and controlling the ISNP.

Second, on a positive note, there have been considerable efforts to strengthen awareness of different actors’ roles and responsibilities since baseline. For example, initially there was a significant lack of understanding among staff and the community regarding the role of SWs within the pilot, as well as a resistance to accept their involvement in the community. However, training was used effectively to build familiarity with SWs over time, leading to greater acceptance and support for them by both staff and communities. Further work is required to clarify the role of the CBHI coordinator, particularly concerning their involvement (or lack thereof) in the promotion of CBHI at the community level.

Third, for some staff, including HEWs and DAs, ISNP duties are added to their regular work activities. This reportedly creates a sense of competing priorities between projects and responsibilities, and reduced time available for ISNP-related tasks. According to several key informants, dual HEW roles in the ISNP – particularly CBHI promotion and enrolment duties, and general health promotion – result in significant work overload. This situation is exacerbated by the absence of an official staffing structure with a focal point for CBHI promotion at the kebele level. As we did not have insight into official staff terms of reference, we were unable to ascertain which (if any) of the expected tasks are missing, or if some tasks reported in this list are outside their core responsibilities.
Table 2: FLW main tasks and supporting roles

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<th>SW</th>
<th>HEW</th>
<th>DA</th>
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<tbody>
<tr>
<td><strong>Core duties</strong></td>
<td>Case management for PDS clients; conducts home visits and needs assessments; develops basic case management plans; undertakes referrals and follow-up</td>
<td>Delivers primary health packages to communities ('health days'), vaccination campaigns and provides family planning services; provides ante/postnatal check-ups, growth monitoring and treatments for malnourished children</td>
<td>Manages PW projects, supervises clients’ participation in PW activities, payment of transfers and provision of livelihoods trainings; oversees the (re)targeting of PSNP clients and identifies clients for programme graduation</td>
</tr>
<tr>
<td><strong>Basic PSNP-related duties</strong></td>
<td>Supports DAs in organizing PW activities and (re)targeting; informs clients about paydays; manages problems with payments</td>
<td>N/A</td>
<td>As above</td>
</tr>
<tr>
<td><strong>CBHI delivery</strong></td>
<td>Supports HEWs with CBHI promotion and enrolment process (focusing on PDS clients)</td>
<td>Promotes CBHI and oversees the registration and renewal process (taking photos for ID cards) in collaboration with SWs</td>
<td>Supports the HEW and SW by identifying and referring clients for CBHI renewal</td>
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<tr>
<td><strong>BCC activities</strong></td>
<td>Supports HEWs and DAs with BCC activities (focusing on child protection messages and the importance of education)</td>
<td>Delivers BCC sessions on maternal and child health, child feeding, hygiene and sanitation and latrine construction; delivers food demonstrations</td>
<td>Coordinates the BCC programme and delivers sessions on livelihoods, natural resources management and financial literacy</td>
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<tr>
<td><strong>Co-responsibilities</strong></td>
<td>Informs clients of co-responsibilities and oversees their compliance; provides follow-up support in case of non-compliance</td>
<td>Monitors the implementation of co-responsibilities in healthcare, child-feeding and hygiene practices; identifies reasons for non-compliance and follow-up support (in collaboration with SWs)</td>
<td>Monitors participation of PW clients in BCC sessions</td>
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<tr>
<td><strong>Transition from PW to TDS</strong></td>
<td>Supports HEWs in screening and identifying PLW and refers them for TDS; screens children with nutrition problems and facilitates access to TDS, follow-up support and treatments; encourages TDS clients to visit health centres</td>
<td>Screens PLW and malnourished children that qualify for TDS and refers them to the DA (often via a SW) to facilitate their transition; identifies PLW during home visits (in collaboration with SWs) and refers them for ANC/PNC; monitors changes in the nutritional status of children and refers accordingly</td>
<td>Screens TDS clients (in collaboration with the HEW and SW); manages referrals into TDS</td>
</tr>
<tr>
<td><strong>MIS</strong></td>
<td>Collects and manages statistics, project-related data and referrals to services; reports data to MIS officer for inclusion in the MIS</td>
<td>Maintains a checklist of the type of support clients receive and compliance with co-responsibilities, their CBHI enrolment status and access to fee waivers; submits data to SWs</td>
<td>Prepares data inputs on PW delivery and reports to Woreda Bureau of Agriculture and Food Security</td>
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Section 3
CBHI component

In this section, we report findings on changes in CBHI enrolment at midline, as well as people’s understanding and experience of CBHI membership, and main opportunities and barriers that clients face in joining the health insurance scheme. We also report on clients and service providers’ perceptions about how participation in CBHI affects changes in their health-seeking practices and access to services, household expenditure and coping practices.

3.1 Enrolment progress

3.1.1 Enrolment of PDS clients

3.1.1.1 Access to fee waivers

There has been an overall improvement in the enrolment of PDS clients into CBHI since baseline. According to the quantitative data, at baseline 51 per cent of PDS clients and 65 per cent of PW clients reported being enrolled in CBHI (ISNP Evaluation Team, 2021). During the past year, the ISNP expanded access to fee waivers for PDS clients, which led to an increased rate of enrolment in this group. In both research sites, key informants reported that 100 per cent of the PDS households were enrolled in the health scheme through premium waivers. As the ISNP coordinator illustrated, in Dewa Chefa, the number enrolled has nearly quadrupled since the project began: “Prior to the pilot, the CBHI was rolled out without having a specific target. But now PDS [clients] are the first priority. [Dewa Chefa] woreda has 1,680 PDS beneficiaries, which are beneficiaries of the fee waiver. But prior to this there were only 450 PDS CBHI beneficiaries.”

This progress was confirmed with the majority of PDS clients who reported receiving the fee waiver and becoming enrolled in the past year (in both woredas). In some instances, fee waivers were provided to vulnerable TDS clients (although this is not intended by the official programme design), once PDS enrolment targets have been achieved. Both PLWs and caregivers of malnourished children reported enrolling into CBHI for free, thanks to the fee waiver. While this expanded targeting of fee waivers to TDS clients is a positive outcome, it is not clear what exact criteria and procedures are used to identify and select PW and TDS clients for this benefit. The identification of vulnerable non-PDS PSNP clients is facilitated by SWs and HEWs who identify and vouch for eligible families and recommend them to the evaluation committee, which in turn assesses their income alongside a range of other vulnerability indicators such as labour constraints, age, chronic illness and disability. However, programme beneficiaries described the selection process as relatively ad hoc, with many very vulnerable non-PDS clients still unable to receive waivers, and others instigating the process themselves, as illustrated by the following quotes:

“I told [the SW] I had nothing and that I wanted to be a beneficiary … [She] took the case and discussed it with the agricultural and the HEWs as well as the kebele administrators and they permitted it” (Caregiver of malnourished child, Libo Kemkem).

“I was informed that my name has been included [for a fee waiver] but previously I pay out of my pocket for health service” (Pregnant woman respondent, Libo Kemkem).

3.1.1.2 Drivers of enrolment of PDS clients

Several ISNP-related drivers contributed to increased enrolment of PDS clients. First, the introduction of clear guidance by the MoA and MoLSA to promote explicit integration of the PSNP and CBHI programmes and protocols led to the improved commitment of project staff to provision of free health insurance to the poorest clients. MoLSA was mandated with implementing DS, which was seen as a positive factor in managing and enabling integration. Notably, at the time of writing the report, the MoH was not a formal signatory of the PSNP 4 Memorandum of Understanding (MoU). Since there was no formal agreement or expectations about the MoH or Bureau of Health in collaborating and integrating CBHI procedures with the ISNP/PSNP, this added
to the challenges of cross-institutional coordination. However, these were effectively addressed in operational terms and regional-level cross-sectoral coordination strengthened since the MoH became a formal signatory of the MoU.

**Second, community campaigns were organized to build awareness among the staff, local administration and village elites to ensure political buy-in for CBHI programme expansion and integration with the PSNP.** This is how the ISNP coordinator in Libo Kemkem described a shift in the staff’s understanding about the rationale for linking PDS clients to the fee waivers, and a more nuanced approach that considers the ways in which cash transfers are spent:

"Formerly there was an assumption that PSNP beneficiaries cannot be fee-waiver beneficiaries, but we believe that PSNP clients are indigent people [...] so if they use the cash we provide for medical treatment, they can’t survive, they can’t eat food, so that we agree with Bureau of Health and prepared the same criteria for inclusion in the PSNP and CBHI, which makes the PDS clients entitled to fee waiver."

**Third, the ISNP – with policy and budgetary support from UNICEF – actively promoted cross-sectoral collaboration between the PSNP, BoLSA and the Bureau of Health as a first step in harmonizing cash transfers and health insurance programme procedures.** The qualitative baseline research revealed a strong divergence between the PSNP and CBHI targeting systems and eligibility criteria used to identify and select households for the fee waiver. In its first year of implementation, the ISNP thus focused on creating common targeting and improving the accuracy of data registries/MIS to eliminate pre-existing targeting errors and ensure that the correct candidates have access to CBHI fee waivers. The CBHI coordinator in Libo Kemkem explained how the ISNP pilot addressed challenges and errors in targeting of fee waivers:

"At first our register for CBHI was problematic so we had to take the registry from other programmes like from the PSNP … we found that our data had so many problems … even some people using the free service while they are rich. But after this programme started, we have integrated [targeting] well and [are] working with different bodies like BoLSA, the health office and PSNP."

**Last, capacity building and strengthened coordination of FLWs helped to improve procedures for allocation of fee waivers.** Expanded deployment of SWs in particular allowed for more frequent home visits and case management for PDS clients, and better use of needs assessments and data management. As these testimonials show, the FLWs, and SWs in particular, made CBHI more accessible to the poorest and marginalized PSNP clients:

"Including the whole family in CBHI for free is a change that occurred when the ISNP was started. Previously, it was difficult to implement this because no one was willing to give attention, follow their cases and register them. Especially the weak used to suffer a lot. But now, the SWs and HEWs go house to house, identify them, register their children. Similar process takes place during CBHI renewal" (ISNP coordinator, Libo Kemkem).

"Currently the criteria for CBHI fee waiver and PSNP is the same. [...] But before the establishment of woreda social and labour affairs, the majority of the PSNP beneficiaries did not receive their benefit properly. [...] However, after our employment, we are monitoring and evaluating whether the beneficiaries are receiving the benefit properly or not" (SW, Dewa Chefa).

3.1.2 Enrolment of PW clients

The pilot has not met the expected level of progress regarding the enrolment of PW clients. The premium costs are the key reason preventing poor households from enrolling in the CBHI. Premiums vary by household size. In rural woredas, under the old pricing framework, households with up to five members were expected to pay Br240; households with six or seven members paid Br290, and households with eight members or more paid Br340 annually to join CBHI (Amhara Region Bureau of Health, 2017). To put these costs into perspective, the average amount of benefit received by PW clients over 12 months was Br3,805. There was a common perception that PSNP payments are not large enough to cover both the basic family expenditures for food and other essentials as well as insurance premiums. A SW from Libo Kemkem explained: “All safety net users are not using CBHI because … they say what will be left for us to feed ourselves if we pay for CBHI.” These
perceptions are somewhat surprising considering that the average total amount of PSNP payment received by the PW household is about Br4,000.

PW clients also highlighted that PSNP payments are frequently delayed, leaving many vulnerable families with significant gaps in their insurance coverage: “I wish I had money to go and renew it … We will be renewing when we get money [from the PSNP]; until then I will stay at home even if the disease takes my life” (Caregiver of malnourished child, Libo Kemkem).

Notably, at the time of writing of the report, the cost of premiums increased substantively, partly as a strategy to increase the financial sustainability of the scheme and raise funds for the fee-waiver benefits. For example, for households with up to five members, the premium increased by 45.8 per cent from Br240 to Br350; for households with six or seven members, the premium increased by 69 per cent from Br290 to Br490; and for households with eight or more members, the premium increased by 105.9 per cent from Br340 to Br700 per annum (Amhara Region Bureau of Health, 2017). Several respondents in Dewa Chefa (PLW and one PW) confirmed that increase in insurance premiums made the insurance difficult or impossible to renew, particularly as the value of transfers received by PW and DS clients remained unchanged: “Before, we were paying 340 birr. But now they say we should pay 700 birr. We have not renewed. We left it because we do not have money for that” (PW respondent, Dewa Chefa).

The recent hikes in premiums are likely to slow down further the expansion of CBHI coverage among PW clients. As the ISNP coordinator at Libo Kemkem pointed out, this may have implications for the overall sustainability of the CBHI programme, as well as the state’s ability to subsidize fee waivers for its poorest members:

“The overall CBHI enrolment should be high in pilot woredas as compared to non-pilot woredas. Because if the overall CBHI enrolment is increasing, we can get money that should be used to pay [fee waivers] for PDS clients. Our last programme monitoring report indicates there is no improvement of CBHI enrolment, because [there is an] awareness problem.”

To gauge how households value health insurance, respondents were asked about the maximum amount of money they would be willing to pay to buy a premium for an entire household for one year. The majority of PW respondents stated they would be willing to pay annually between Br50 and Br100 per family for the CBHI,7 which is well below the premium costs (based on the old prices, the lowest premium for households with 1–5 members was Br240 and is now Br350). The frequent disruption in the supply of medicines to government health facilities, which forces clients to pay full price for medications in private pharmacies, is another factor that erodes their willingness to trust and enrol in the CBHI programme. Many ISNP clients enrolled in CBHI explained that health facilities did not have the required medications and instead wrote prescriptions for private pharmacies. These are paid out of pocket, and insurance reimbursement is often delayed or left unpaid. On weekends, when health centres are closed, patients must pay full price for medications, as they cannot obtain CBHI prescriptions. Accessing medications from private pharmacies may also expose clients to incur indirect costs (transportation) and opportunity costs (time otherwise spent working):

“Although medications can be bought from private pharmacy, the insurance will not cover all the expenses. For example, if a person goes to Addis Zemen to buy a medicine [for] 100 birr, there is a cost of 20 birr for transportation and there might be other costs as well … the insurance will cover only the money for the medication” (SW, Libo Kemkem).

Some have dropped their CBHI membership due to these costs, incurred debt to pay for private prescriptions or reported halving their medication dose in order to afford it:

“If I have to pay for drugs to private clinics whenever my children fall sick, why should I pay for CBHI premium? I did not pay for CBHI renewal and I am not a member of CBHI anymore” (Lactating woman respondent, Libo Kemkem).

7 According to the quantitative baseline data, on average, the maximum amount PW households are willing to pay for a full year cover- age for the entire household is about Br144 with a corresponding amount of Br98 in PDS households.
“Medical supplies are very expensive, and costs can’t be predicted. Only the professional knows them and when the prescription is given to you, you don’t know how much it might cost you” (CBHI coordinator, Libo Kemkem).

There was, however, a small minority of people who placed a significant value on CBHI membership despite the costs of premiums or drugs. In both woredas, some fee-paying clients said they were willing to enrol even if it meant spending their entire PSNP income, working harder to earn income or seeking loans. Even extremely poor clients sometimes reported that they would try to pay a reduced amount if they could not obtain a waiver:

“We tried our best to get CBHI, I even worked as daily labourer to be able to pay the payment including loan from others” (Caregiver of malnourished child, Libo Kemkem).

Interviews with key informants and clients uncovered a range of other bottlenecks beyond costs that diminish demand for CBHI and enrolment in the scheme (particularly among those required to pay fees). First, various attitudinal barriers stand in the way of client willingness to enrol in CBHI, even among those with the financial capacity to do so. Even though the ISNP and CBHI programmes have improved community awareness about the insurance (see Section 3.2); however, negative attitudes towards CBHI remain. Some individuals may fear that an ability to pay the premium could disqualify them from participation in the ISNP. This is how a SW in Libo Kemkem described it: “Some people think that if they can afford to pay for health insurance, others will think they are rich and they will get out of the ISNP”

Others simply do not value insurance for risks that may not materialize in the future. “There were people who believe that if they are not sick, being a member of CBHI is not relevant” (ISNP coordinator, Libo Kemkem).

In other instances, people have misconceptions about the CBHI programme, which indicates that awareness-raising efforts are required to correct them:

“The main barrier is lack of awareness. People think they will not become ill and there is an attitude that planning for future illness is like calling for a bad fortune … these kinds of attitudes are huge barriers” (CBHI coordinator, Libo Kemkem).

“In [2012], the communities were saying that the CBHI was another way of collecting money for the renaissance dam. The communities were suspicious” (CBHI coordinator, Dewa Chefa).

“We need to work strongly on the attitudes of the community. The community think it is for free. That is why the community is not willing to pay for the CBHI” (DA, Dewa Chefa).

3.2 Procedures used to promote and enrol clients into CBHI

In this section, we describe the process and mechanisms used by ISNP staff (including CBHI-employed personnel) to promote CBHI in communities and identify and register clients. In addition to enhancing the knowledge of PSNP households about the benefits of health insurance, the information, education and communication (IEC) campaigns are used to encourage PW and TDS clients to enrol in CBHI and raise awareness of PDS clients about their eligibility for a fee waiver.

3.2.1 Promotion of CBHI

A broad set of actors is involved in the promotion of CBHI and dissemination of information to prospective clients. The CBHI coordinator in Libo Kemkem explained that the kebele manager and administrators, HEWs and SWs are trained by CBHI staff to jointly organize and implement sensitization activities. At the kebele level, CBHI promotion is largely initiated by SWs and HEWs, who speak with clients about benefits, premium payments/waivers and a renewal schedule during home visits and BCC sessions (see info on BCC below).

Other stakeholders, including CCC members, community leaders, DAs, and all executive bodies and health centres in the kebele are also engaged in providing CBHI information to community members. In Dewa Chefa, religious and community leaders were reportedly trained to disseminate CBHI information to communities, given their high level of local authority and involvement in the community.
Different entry points and formal and informal communication channels are used to circulate information about the CBHI benefits and process of enrolment. According to the PSNP coordinator in Dewa Chefa, there is an annual *woreda* conference organized to raise awareness of the importance of CBHI among community and government administrations. CBHI staff also organize regular *woreda*-level awareness campaigns in health centres and disseminate printed educational materials, leaflets and brochures to visitors.

At the *kebele* level, the insurance scheme is frequently explained in community and church meetings by FLWs, as well as after PW activities by DAs. As the following quote illustrates, given that not all PSNP clients are mobile or able to attend PW sites, home visits by HEWs and SWs are critical and most effective mechanisms in promoting CBHI membership:

> “Most of the users are the poor and the helpless who cannot access the kebele centre or even cannot go to the church. So, the SWs go to their house to discuss … let them know everything about health insurance and take a photo to register them and issue CBHI membership ID card” (DA, Libo Kemkem).

Finally, word-of-mouth – particularly positive testimonies from community members who have benefited from the CBHI – is an important IEC channel. This is how the DA in Dewa Chefa described the process: “I know that people hear from one another and become motivated to join CBHI membership. If one of the neighbours enrolled … others learn about the advantage.”

Indeed, community awareness-raising and visual promo-campaigns are often built around such testimonies, which can be effective in motivating others to join. The CBHI coordinator from Libo Kemkem explained: “We made a large awareness-creation campaign supported with photographs as evidence … one mother got healthcare treatment that cost up to 2,200 birr and we have used this as a promotion for the programme.”

In addition to these oral campaigns (at times supported by simple visual aids), printed educational materials and TV/radio broadcasts are also used. Printed brochures and flyers are generally distributed by the *woreda* and regional-level stakeholders to more educated audiences due to illiteracy issues and operational challenges (e.g., lack of printers, paper) at the local level. Face-to-face information sessions are most commonly used to address the literacy and training needs of farmers. Regional TV and radio broadcasts also primarily reach urban populations with access to electronic media, which impedes widespread broadcasting of CBHI information, as well as resultant programme enrolment, in poor areas.

**Several supply-side challenges have hindered effectiveness of promotional activities with implications for expansion of CBHI coverage.** Shortages of FLWs restrict effective implementation of promotional activities, thereby reducing the potential to expand enrolment. HEWs and the CBHI coordinator complained of being overburdened with CBHI duties and had restricted time to invest in promotional activities. As the HEW from Libo Kemkem explained, CBHI-related tasks are added to their usual job activities, leading to work fatigue and stress: “CBHI is actually good for the community but we are suffering a lot, the job requires independent employee, and we didn’t get any benefit through CBHI only problems, increasing our work burden.”

The operational budget required by CBHI staff to implement promotional and supervision activities is also reportedly too limited. To date, UNICEF has provided Br800,000–1,000,000 for working capital (operational activities). This has been used to support mobilization activities, supervision, targeting and training costs at various levels, but it is not clear how these funds are distributed across WOLSA and the Bureau of Health team responsible for CBHI implementation:

> “CBHI has no budget for operating costs, while you should have costs to show results. It [CBHI] depends on health office for such costs […] There has to be increased support and supervision that reveal any existing gaps. The staff turnover is high as the wage and work burden are not matching; that should be addressed through better incentives. The attention provided to WOLSA is by far higher than CBHI. They are provided with laptops and desktop computers, but we are not provided with computers” (CBHI coordinator, Dewa Chefa).

In both locations, FLWs and CBHI staff suggested committing more funds and recruiting an independent employee at the *kebele* level to focus on strengthening CBHI promotion to expand enrolment in CBHI among the fee-paying clients. **The effects of the promotional campaigns on clients were mixed.** Beneficiaries who were
exposed to the face-to-face IEC campaigns and advice received from FLWs reported that they were effective in improving their awareness and knowledge of the scheme. For example, the PLW client in Dewa Chefa reported that exposure to information motivated her family to enrol into the CBHI: “It was with the help of DA that my husband was convinced to buy premium of CBHI. Before, he had negative attitudes towards CBHI because he did not know the value of [it].”

While many respondents in both woredas were aware of CBHI and its benefits, this was not the universally shared experience. Some ISNP respondents, including PDS clients, confirmed that they had no knowledge about how the CBHI functions due to a lack of communication with FLWs: “I don’t know anything about how it functions” (PDS recipient, Libo Kemkem). Some instead had to rely on information shared by neighbours. While this still did not prevent them from enrolling into CBHI, these gaps in information still may undermine their proper and full enjoyment of entitlements.

In sum, the IEC sessions are critical mechanisms for encouraging and enabling PSNP clients in enrolling, both as fee-paying and non-premium members. At the same time, greater awareness and attitudinal shifts in support of CBHI do not necessarily translate into greater uptake of health insurance among the PW clients. The premium costs remain the key prohibitive factor for this group. Further efforts are also needed to improve the coverage and quality of IEC activities to ensure their reach all clients on time and with positive effects.

### 3.2.2 Identification and registration

**Identification**

As noted above, a key ISNP objective is the identification of PDS clients (and other vulnerable PSNP households eligible for fee waivers) and their registration in the CBHI programme. The BoLSA is responsible for compiling lists of PDS households/individuals, which are then shared with HEWs and SWs, who facilitate their inclusion in the programme. Given their close interaction with communities and intimate knowledge of client profiles and needs, SWs play an important role in identifying PDS clients who are automatically eligible for the fee waivers but may be excluded from receiving the benefit due to lack of information, administrative gaps and targeting errors.

In terms of the non-PDS clients, in both research sites, it was reported that the kebele-level evaluation committee is responsible for screening and identification of very vulnerable TDS and PW clients for fee waivers. The committee includes the kebele administration, kebele manager, SW, HEW, DA and two community representatives. The CBHI coordinator from Dewa Chefa outlined several stages of the selection and targeting process for non-PDS clients:

“There are many procedures when they are selected. First it will be presented for public opinion at churches. Then kebele representatives will evaluate it and they will pass through this procedure. The HEW fills forms of the selected people and then the forms are submitted to the woreda CBHI office for approval.”

According to the CBHI coordinator from Libo Kemkem, kebele-level committees also address targeting-related complaints from the community. However, elite capture of fee waivers was also reported to be a problem: “There are people who are rich and entitled [to] fee waiver based on [their] relationships so that those people who have resources … become fee-waiver beneficiaries” Lactating woman respondent, Libo Kemkem.

**Registration**

The clients need to take additional steps once offered a fee waiver to register in the scheme. The same applies to PW and TDS clients. HEWs are responsible for the initial registration of eligible clients for the fee waiver and those who pay the premiums. They also facilitate the renewal of their membership. HEWs are closely assisted by SWs, who inform clients about the process and assist with administration tasks. The PSNP coordinator deducts insurance premiums from PSNP transfers and HEWs renew client membership upon submission of the payment. The enrolment forms, supporting documents and payments are then sent to the woreda-level CBHI office, where the CBHI book/insurance ID card is stamped and prepared for clients. Copies of payment receipts are kept at the woreda and kebele CBHI offices.
While the collection of premiums (including renewal of membership) is scheduled at the beginning of each year and lasts for two months, registration of PDS clients into CBHI occurs on a rolling basis. After the registration or renewal process, clients explained that the HEW or SW would then deliver ID cards from house to house to PDS clients in case of their inability to travel due to disability or age: “We become a member of CBHI on this year. [The] SW supported me, and she finished all the process … [she] stamped … my photo and give me CBHI card” (Lactating woman respondent, Libo Kemkem).

Several key informants underscored improvements in the procedures used to register and enrol clients in CBHI, including reduced waiting times for ID cards and their use. Usually there is a 1–2 month waiting period between enrolment, issuance of the ID card and permission to use the insurance:

“The guideline by the MoH on the implementation of CBHI states that new members should stay for at least a year with the programme to get the benefits, but since they were very poor and in trouble, we didn’t wait that long. Therefore, I can say that this system has saved many people” (CBHI coordinator, Libo Kemkem).

“Newly CBHI registered beneficiaries are given ID cards after two months of their enrolment as per the rule of the Amhara CBHI programme. But in Dewa Chefa woreda they get ID cards after only one month, as per the decision of the steering committee” (CBHI coordinator, Dewa Chefa).

Many respondents also cited the importance of reminders from SWs, HEWs, DAs and kebele leaders about CBHI renewal dates, as well as their assistance in the renewal process, both of which led to fewer lapses in membership.

Notwithstanding these positive aspects, there are challenges with the registration procedures as well as access to health service. First, further efforts are required to boost staff capacity (CBHI knowledge and administrative skills for registration), clarify roles and responsibilities of key personnel (CBHI coordinator), and promote staff commitment to their duties: “[HEWs] face low capacity to accomplish the CBHI tasks such as collecting information about the clients, taking clients photos, and the like” (PSNP coordinator, Dewa Chefa).

Second, some respondents found the enrolment process confusing and faced difficulty with registration. Respondents in Dewa Chefa had logistical problems while trying to obtain photos of themselves for their ID cards. An inability to find a photo booth or pay for photos sometimes occurred after premium payment was taken, leaving people out of pocket and still without insurance. Others said they simply did not receive a card after applying.

Respondents in both woredas also complained about the lack of clarity about the procedures used to obtain medicines and claim reimbursement for the cost of drugs, resulting in client confusion and dissatisfaction with the overall service. One respondent in Libo Kemkem alleged that health professionals refused to provide clients with information about recouping the cost of private healthcare and prescriptions:

“We are not educated, so when they give us a piece of paper [for reimbursement for private care] we don’t know where to go … when we ask them where is the health insurance office, where will the money be processed? They don’t tell us … because they don’t want our money to be returned, and because of this, many ignorant people have lost their money. Many people say that you should not enter health insurance because it is useless, but everyone would understand it if it were taught well” (PW respondent, Libo Kemkem).

“The procedure is we go and get checked, we will be given a card number, we take that card number and buy the medication and go home. After that we take that number and receipt and go to what is called the health insurance bank, not the health centre, and then they rewrite or copy the paper and give us the payment. But people just go home with the medicine and when they go and ask for the money after long time, the payment time passes and they will not get reimbursed for medicines … they always give education for the community, but they don’t listen and don’t know the procedure and then they say they were refused … those other than the SW also educate but people do not pay attention … But if they still spoke repeatedly, everyone would understand and follow the procedure” (PW respondent, Libo Kemkem).
Overall, it appears that the process used to register clients into the CBHI scheme functions well, with SWs and HEWs in particular playing an important role in assisting PDS clients with administrative procedures. Nonetheless, there are supply-side barriers that affect the capacity of service providers to deliver the CBHI component effectively and achieve maximum coverage; according to KIIs, these could be addressed through further training, better incentives to encourage staff and regular monitoring of their performance.

### 3.3 Reported outcomes

Although it is too early to gauge the ISNP pilot’s impact on health outcomes, there are important positive indications of its influence across several intermediary outcome domains. There is suggestive evidence that ISNP client participation in CBHI has led to: increased access to healthcare, an increase in health-seeking behaviour and enhanced satisfaction with the benefits of healthcare; mitigation of negative coping strategies; psychosocial benefits; and greater trust in the local government. In this section, we briefly discuss evidence of progress in each of these areas.

#### 3.3.1 Increased access to healthcare, health-seeking behaviour and satisfaction

Respondents from PSNP households who joined the scheme had considerable praise for CBHI across all client groups and in both woredas. The insurance was cited as an important and more equitable means of accessing timely, adequate healthcare – previously out of reach for many poor families – and a way to address a multitude of illnesses among vulnerable children. For many parents, CBHI was explicitly mentioned as life-saving and the only means by which they could seek emergency healthcare for their children.

A majority of respondents explained that CBHI membership improved their health-seeking behaviour by directly alleviating the burden of payment for health services. A significant increase in health-seeking behaviour and demand for healthcare, and higher frequency of health visits among PSNP clients, was reported by both key informants and respondents, including both DS and PW households. However, indirect expenditure (on drugs, medicine and transportation) continues to undermine uptake of healthcare among CBHI clients:

> “[My] son … gets sick. I took him to health centre, and they treat him by CBHI card … with different medications … now he improves his health. He plays … Before CBHI, if people [did] not lend me money, I cannot take [my children to the] health facility. I [would] stay home and sorrow on the condition” (Lactating woman respondent, Libo Kemkem).

> “Regarding health, the attitude of the community is improving. Now people will not come on stretchers because they get treated early […] These changes happened because of the CBHI because now they will not have to spend money from their pockets and that has benefited them” (CBHI coordinator, Libo Kemkem).

Positive changes in health-seeking behaviour were observed even among PDS clients. This is important, given that PDS clients – due to their age, poor health, restricted mobility and financial difficulties – face even greater barriers to accessing health services than other clients. Resultant timely access to medical support was shown to directly improve patients’ health prognoses and outcomes: “If we were not CBHI member, we may die. I have no money to pay medical treatment. But now … we will go to health centre immediately. Our health also improved” (PDS respondent, Libo Kemkem).

#### 3.3.2 Mitigation of negative coping strategies

By reducing (or eliminating) direct costs for healthcare, participation in CBHI helps to mitigate negative coping strategies, such as decreasing food intake, incurring debt or foregoing healthcare altogether. Both clients and key informants reported that CBHI membership helps poor households to avoid catastrophic health expenditure and protects them from falling deeper into poverty and/or debt: “If I am getting sick [in the past], I was asking [for] loan to pay for medical treatment from rich person. But now if I am getting sick, I may get medical...

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8 It should be noted that our data collection was carried out when most indigent CBHI members had only recently enrolled in CBHI, therefore these outcomes are most likely provided by more experienced CBHI members.
CBHI enrolment also allows PSNP payments to be redirected towards other essentials that may otherwise have been sacrificed for healthcare, such as food and clothing, thereby leading to greater economic security and boosting the impact of the cash payments. However, the indirect costs of drugs and transport continue to pose financial problems:

“The money that we spend on healthcare is now spared because if there was no CBHI, we would have spent everything we got on healthcare … and die when ill. But now, because we are members in CBHI, we get treated for free when we become ill, and we can spend the money on other needs like food, clothes and others” (PDS respondent, Libo Kemkem).

“I use the money for soap and other purpose like I feed my children instead of expending for health facility” (Lactating woman respondent, Libo Kemkem).

3.3.3 Other indirect benefits

The broader benefits of CBHI enrolment go beyond health and financial benefits and are potentially enjoyed by the larger community beyond those individuals and households with access to insurance. For example, greater economic security improves people’s consumption and translates into important psychological benefits, including reduced stress and anxiety and enhanced aspiration for the future. In some cases, insurance reportedly improved women’s autonomy and enabled them to seek healthcare for children without relying on their husbands for cash:

“Through enrolment, people save their money. Those who are poor also get relief from worrying about their family health situation. Therefore, CBHI has great importance” (DA, Dewa Chefa).

“There were a lot of people who [had] lost their hope, begging God to die, but now they [have] hope that they have [a better] future life” (WOLSA officer, Libo Kemkem).

According to the CBHI coordinator in Libo Kemkem, improved and more transparent fee-waiver targeting has also reportedly led to greater trust in the local government and increased social capital in Libo Kemkem:

“Previously, there was a quota by the MoH for the very poor to be helped but that quota usually [was] occupied inappropriately and randomly by family and friends of those in administrative places. We then examined these based on the guidelines from UNICEF and cooperated with food safety … people become happy and thankful for the government. They say that this administration is concerned about the poor.”

3.4 Perceptions of CBHI programme sustainability

In this section, we discuss basic perceptions held by ISNP staff about the long-term sustainability of the CBHI programme component.

There is a clear consensus among ISNP staff that the future of the CBHI is dependent on expansion of coverage of fee-paying clients and the scheme’s financial viability. Currently, CBHI is financed through premiums and the government subsidy (30 per cent from the woreda and 70 per cent from the region). Increasing the enrolment of fee-paying clients is critical to ensure the programme’s future, as well as to maintain and expand coverage of fee waivers to all poor households in each woreda (including PSNP households and the indigent population). The current government subsidy covers fee waivers for only a handful of poor clients, and the ISNP and CBHI coordinators in Dewa Chefa and Libo Kemkem explained that significant budget increases are necessary to reach full coverage:

“In [the] Amhara region an estimated 26 per cent of the population is poor. In the woreda this percentage may be higher, but only 10 per cent of the population (3,651) is assisted by CBHI fee waivers. Had we had resources we could have assisted more than the 10 per cent of the population” (CBHI coordinator,
The perceptions of key informants varied, however, regarding how to ensure expansion of the fiscal space in the medium term to increase fee-waiver coverage. While some suggested that subsidies should be increased (options included both increasing the existing government subsidy and/or finding external donors), others were more convinced that CBHI should be entirely financed through premiums. To avoid dependency, the government’s subsidy should eventually be phased out:

“UNICEF is concerned about sustainability if it intervenes in direct assistance. We can enrol more people over the 10 per cent for CBHI with external assistance for premium payments, such as from UNICEF, but the concern is sustainability […] To overcome this challenge, we are requesting the region [regional government] to increase the quota for the fee waiver, but their response is to correct through retargeting to replace those that graduate, and also to correct inclusion errors” (CBHI coordinator, Dewa Chefa).

“If the number of members who can pay is not increased, the small amount of subsidy given by the government would not be enough to cover PDS clients. Therefore, we are doing awareness creation and promotion in the community to reduce the burden of the government to subsidize PDS clients … We are planning to include more people in CBHI by finding sources to cover their fees and to help at least 15–20 per cent of the extremely poor” (CBHI coordinator, Libo Kemkem).

These sustainability concerns need to be considered in a broader national context. UNICEF has been using the ISNP grant to focus at the federal level to influence policy. CBHI is now in 770 of 1,100 woredas that exist nationwide, with 32 million people enrolled (compared to 22.5 million in 2019), of which 6.7 million are indigents (receiving fee waivers) (compared to 5.1 million in 2019). The overall picture is quite positive and, for now, shows government commitment to the scheme, which is a key precondition for its sustainability.
Section 4
Behaviour change and communication component

In this section, we report the results of the midline assessment regarding progress in BCC implementation since baseline, perceived changes in client well-being outcomes resulting from BCC attendance, and operational and demand-side bottlenecks identified in BCC delivery that undermine the overall results.

4.1 Implementation progress

Overall BCC intervention suffers from weak and inconsistent delivery (related to the overall capacity of the PSNP administration/institutions). No progress was recorded in BCC implementation since baseline, when it was described as irregular and of low quality. Key informants in both research sites reported that BCC activities are not implemented as expected. In Dewa Chefa, a HEW explained that Gula kebele activities were discontinued shortly after their launch due to low demand and attendance by the community: “We tried to start it last year as a pilot. But BCC is not fully implemented. We cannot say that BCC is effective here, in our area. […] At the woreda level we can say it is at a start-up phase” (PSNP coordinator, Dewa Chefa).

In Shemo kebele, Libo Kemkem, BCC is rarely delivered according to the manual and implementation quality has significant shortcomings. The ISNP coordinator in Libo Kemkem explained: “I don’t think I have seen any changes to the BCC due to the ISNP […] BCC training was intended to be given approximately six times a year […] But these were not made accessible to the users.”

Staffing issues and budget constraints are the main supply-side factors affecting the quality and consistency of BCC implementation. In Dewa Chefa, for example, language barriers prevent core FLWs from delivering training. Neither the DA nor HEW in Dewa Chefa speak the local dialect of Afaan Oromo, an issue that necessitates an interpreter and leads to a laborious communication process. The DA said that this may explain why sessions have only been delivered once since the start of the programme, and there is low demand from communities. Moreover, the Dewa Chefa PSNP coordinator explained that BCC modules are designed in Amharic, which is not accessible to all FLWs. Therefore, BCC must involve the slow process of using translators, and modules cannot be used properly to facilitate teaching.

In both research sites, irregular and limited budgets reduce staff capacity to implement BCC activities properly; for example, there is a reported inability to hire proper facilities, and training duration has been reduced to cut costs. Lack of operational funds for refreshments and small gifts for trainees may also explain why participants are not incentivized to attend.

Weak delivery is reflected in relatively limited client awareness and participation in BCC sessions, though there is some variability across research locations and client categories. In Libo Kemkem, results were mixed in terms of awareness of BCC and attendance. For example, the PLW FGD respondents in Shemo kebele reported no knowledge of BCC sessions: “BCC sessions are not provided neither in a church nor at work sites. Therefore, we never attended it. No one told us about the benefits and the dangers.” However, IDIs with female caregivers in the same area explained that TDS (and even some PDS and PW) clients did indeed attend them. This is how the TDS clients described the experience:

“Pregnant and lactating mothers get called and trained … health professionals, SWs and DAs all gather around at a conference and teach us … how to breastfeed, how to feed [young children] and on vaccination … It is often delivered verbally. For example, now that the health institutions teach us about health, the [DAs] educate us about agriculture and the safety net employers teach us about the PW. So even if they all come together, they focus on their own respective areas … We discuss about health, nutrition, development, how to raise our children and feed them well, how to keep the kids get strong so that we would get back to work sooner, and how to be strong mothers” (PW respondent, Libo Kemkem).
Improving Children’s Health and Nutrition Outcomes in Ethiopia

“The [HEWs and SW] teach us about ANC, about skilled delivery and other things … they teach us and we teach our neighbours” (Pregnant woman respondent, Libo Kemkem).

“They [HEWs] organize coffee ceremony every month and we discussed about health” (Lactating woman respondent, Libo Kemkem).

In Dewa Chefa, most female respondents (particularly TDS clients) reported being unaware of BCC sessions or rarely attending. Nonetheless, there is evidence of PSNP clients, particularly TDS households, being exposed to important nutrition- and health-related messaging and advice from HEWs and SWs during health centre visits and home visits. Clients in both woredas cited exposure to sporadic group health (and nutrition) trainings and advisory sessions in the past year, wherein information is shared orally. This indicates that even if PSNP clients are not attending PSNP-run BCC sessions (or may not explicitly associate these with the PSNP or the pilot), they might still benefit from exposure to health and nutrition information delivered by HEWs and SWs. As noted by an interviewer in Dewa Chefa: “[Participants] link BCC sessions with health centre activities; they do not have awareness [of these] as ISNP activities.”

Female clients, particularly in Dewa Chefa, reportedly face significant barriers to their attendance. Gender and social norms related to women’s mobility and autonomy to leave home and their domestic roles restrict their participation in BCCs. These discriminatory gender norms appear to be prevalent and deeply rooted in Dewa Chefa. This is how the DA in Dewa Chefa explained the issue: “The attitude of men towards women is still problematic. Many husbands still are not willing to send their wives to PW and meetings or trainings. […] If they participate[d] together, they [could] have been changed. If experts visit the client’s home and create awareness on gender equality, [it is a] good [way] to bring change.”

In some cases, women’s participation in BCC can provoke unintended harmful effects when husbands’ permission is not obtained, as the following anecdotal testimony illustrates: “Sometimes husbands beat their wives if they attend BCC without permission … one woman told us that” (DA, Dewa Chefa). Women in Libo Kemkem also complained of missing BCC sessions due to time constraints and significant work burdens: “I never participated because I spend all my day taking care of my child; therefore, I didn’t get the chance to attend such events” (Caregiver of malnourished child, Libo Kemkem).

In some cases, key informants reported that BCC sessions try to reach beyond the traditional target population of women (i.e., mothers) to also involve husbands in these discussions, as a means of ensuring their buy-in for changes in household care practices and broader shifts in gender norms. But it appears that male response is limited. A HEW from Dewa Chefa explained how engagement of men in the BCC can have a gender transformative result:

“We also call husbands. But very few husbands who have positive attitude come and attend the BCC sessions, because women and men have no equal roles in this area. Many husbands are not willing to send their wives to meetings here […] They do not believe in gender equality. […] However, some well-informed husbands come and take training with their wives. Once they come and attend the training, they become happy” (HEW, Dewa Chefa).

Relatively limited BCC attendance is concerning, given the target population’s low nutrition status and topical knowledge: at baseline, only 3 per cent of children consumed minimum acceptable diets, and 60 per cent of caregivers demonstrated inadequate knowledge about dietary diversity (ISNP Evaluation Team, 2021). Importantly, gaps in BCC delivery not only hinder its effectiveness to promote and facilitate sustained behavioural changes in nutrition- and health-related practices but also undermine the added value of co-responsibilities.
4.2 BCC core characteristics

In this section, we examine the main characteristics of the BCC intervention, including how the sessions are supposed to be delivered as per the PSNP programme guidelines, which modalities are used to impart information, their frequency and the profile of participants.

4.2.1 Delivery

As mentioned in the introduction, FLWs play an important role in planning, organizing and delivering BCC sessions. According to programme guidelines, DAs hold overall responsibility for coordinating the BCC sessions, while HEWs organize and oversee delivery of the training programme. BCC is supported by SWs, with the assistance of community volunteers and the kebele administration. Each actor focuses on their area of expertise to deliver specific module/topic. For example, the HEW teaches participants about diet and nutrition, vaccination, health insurance and the importance of home hygiene and clean water. The school director covers issues related to education, while the SW teaches clients about co-responsibilities, child protection issues and general aspects of ISNP administration (e.g., payment schedules). The DA provides information on livelihoods and food production issues, as well as financial literacy and savings.

It was reported in both locations that training was organized by woreda staff to strengthen FLW capacity to deliver BCC content: “We train them in two cycles, in the form of theatre or action. We are not directly responsible to train the PSNP clients” (PSNP coordinator, Dewa Chefa). However, we could not gauge directly the relevance and quality of the training, or the extent to which it actually strengthened capacity to deliver the BCC programme to communities. Only two respondents (Libo Kemkem ISNP coordinator and Dewa Chefa PSNP coordinator) were able to correctly specify the exact number and focus of modules.

Some key informants said that BCC delivers messages on topics outside of the formal BCC guidelines (e.g., PSNP payments, financial literacy, money management and other related matters believed to be of importance to the community), indicating that in practice, BCC content is flexibly interpreted and tailored to local circumstances. We were also unable to determine the extent and nature of related ongoing support from the woreda in terms of logistics, technical advice or monitoring and follow-up for FLWs.

4.2.2 Topics and themes

According to the programme guidelines, the BCC component is structured around seven modules. Our fieldwork confirms that BCC sessions cover a broad range of topics related to nutrition and maternal and child health across these thematic areas as intended, with maternal nutrition and care during pregnancy being a core topic. Respondents with non-malnourished children receive advice on child and infant nutrition and feeding practices, including information about the importance of breastfeeding, complementary food and dietary diversity: “Pregnant and lactating mothers get called and trained. Then she goes and get training on how to breastfeed, how to feed … The HEWs teach us very well … health professionals, SWs, and DAs all gather around at a conference and teaching us” (PW respondent, Libo Kemkem).

This is an important finding, as it means that BCC modules are adequately tailored to the needs of target populations. Indeed, according to a HEW in Libo Kemkem, BCC seeks to address the specific needs of women and children depending on their stage of pregnancy and lactation. Women are separated into groups wherein pregnant women are taught about nutrition and the importance of health check-ups, lactating mothers with children under 6 months are advised to breastfeed and keep their personal hygiene, and lactating mothers with children over 6 months are advised to undertake complementary feeding.

In Libo Kemkem, a HEW and the WOLSA officer mentioned that BCC sessions involve a cooking demonstration to teach women about dietary diversity and feeding practices through concrete examples of food selection and meal preparation: “The HEW shows the cooking demonstration at BCC session how to prepare mixed powder [from different grains] and feed their child. In the earliest time, a farmer may have papaya at his backyard but not eat, they may sell at market but now the HEW shows practically how to eat those things like papaya and not to sell” (WOLSA officer, Libo Kemkem).

More broadly, information and advice on topics such as land management, food production and nutrition were reportedly provided by DAs, primarily in PW sites at the end of the working day. Although not all female respondents
were aware of DA involvement in providing agricultural information (particularly in Dewa Chefa), many could cite their activities, such as providing advice on planting specific crops and sowing techniques, maintaining soil health and avoiding erosion.

There is also evidence from interviews that sessions are used to inform participants of their co-responsibilities including health visits for PNC and ANC, as well as screen and identify PLW eligible for transition into TDS:

“We are informing the lactating and pregnant mothers about their rest period, about child feeding, all this is done at BCC sessions […] also a follow-up about getting healthcare check-up from HEW and how many check-ups they should follow, about giving birth at health centre, all this training is given at BCC sessions” (CCC, Libo Kemkem).

Information is also imparted on personal and home hygiene and water and sanitation health, given their close links to nutrition- and health-related outcomes. The information about the importance of using soap, handwashing and latrine use is often imparted during BCC sessions and home visits. Finally, respondents also cited additional BCC training information including the importance of family planning, vaccinations, health insurance, child protection and non-health topics such as the importance of education, the risks involved with child marriage, and savings. While these topics are not part of the official BCC guidelines, they are important areas of information for clients.

4.2.3 Timing and frequency of delivery

Programme guidelines specify that clients are expected to participate in six sessions (one per month) over the course of six months during the PW season. An assessment of staff understanding regarding the expected and actual timing and frequency of these sessions suggests significant divergence from the design provisions. Only a few key informants could accurately quote the BCC duration. One FLW in Libo Kemkem was unaware of the profile of clients and expected frequency of training. These findings are worrisome, given that these staff hold direct responsibility for coordination of BCC interventions. Further capacity efforts are required to enable key staff to deliver this component of the ISNP properly.

As the following testimonies from PSNP clients illustrate, many BCC sessions (and trainings) appeared to be ad hoc and irregular in their timing and frequency. They appear to range from once a month to several weekly sessions with very few mentioning specific timing or dates:

“The HEWs organize both lactating and pregnant mother every month on 12th and teach us” (Pregnant woman respondent, Libo Kemkem).

“They gather us three times per month … the SWs, DAs and kebele leader … they teach us about child feeding” (Lactating woman respondent, Libo Kemkem).

“I have also [a monthly women’s] conference … for two hours per month” (PW respondent, Dewa Chefa).

4.2.4 Communication channels

BCC sessions (or advisory and counselling sessions) are delivered through a variety of channels and platforms. BCC sessions held at PW sites after work were those most frequently cited overall. They appear to be those most reliably attended – indicating that this is currently a relatively dependable means of reaching a significant portion of PSNP clients in Libo Kemkem:

“I have taken various training courses on improved cooking stove, maternal health and home management. They give the trainings at the PW, not every day but some of the days. For example, when it is a holiday, they tell us to attend because they will teach us and we attend … The SWs, DAs, kebele leadership [and] HEWs … lead the discussion” (PW respondent, Libo Kemkem).

Information is also delivered at community forums and meetings, church gatherings and pay points. HEWs and SWs use home visits as opportunities to teach, advise and motivate people to adopt positive practices and sustain healthy behaviours, while health centres were most frequently cited as information points for PLW, which could be linked to their compliance with co-responsibilities.
The fact that different locations are used to deliver training beyond the PW sites suggests that BCC delivery diverges from expected plans. On a positive note, it appears that clients are exposed to messaging from multiple points, which increases their opportunities to access information. This is particularly important for women who do not work at PW sites due to gender barriers and would miss receiving information through this channel. However, this makes it much harder to follow up and monitor the relevance and quality of information received, and whether it produces expected changes in knowledge and behaviour. For example, although several key informants (SW in Libo Kemkem and PSNP coordinator in Dewa Chefa) reported that attendance and adherence to advisory support is followed closely through home visits and routine monitoring (e.g., BCC attendance record kept in MIS), only one PSNP client confirmed this statement.

4.2.5 Profile of BCC participants

Attendance of BCC sessions is a mandatory requirement for TDS clients who are required to attend the sessions as part of their co-responsibilities. While attendance for PW clients is not mandatory, those who participate in BCC sessions are temporarily exempted from PW (participation in three sessions is counted as one day of public work). PDS clients are not required to attend.

When asked to describe the profile of participants meant to attend BCC sessions, key informants had mixed views and experiences. For some FLWs, BCC is considered an activity for all community members (not only PSNP clients). As a HEW explained, this broad audience is often justified as health and nutrition being the responsibility of the whole family and community, and sustained changes in practices depend on community-wide attitudinal and normative shifts: “We are providing training to bring behavioural change for all, whether they are PSNP beneficiaries or not […] We may divide the community based on village just to get acceptance or easily understand the changes” (HEW, Libo Kemkem).

Others stressed that all PSNP client categories should and are encouraged to attend, including PW, TDS and even PDS clients. A PSNP coordinator in Libo Kemkem explained the rationale for opening BCC sessions to all types of clients: “We recommend that all of them [attend] BCC, whether it’s PDS, TDS or PW … In particular, it is recommended that TDS take the training but if they do not take it, their payment is not reduced. PDS clients are not just older people, they may have chronic illnesses, and these people may still be in reproductive age so they can benefit greatly from taking this BCC training.” Nonetheless, interviews with clients confirmed that PW and PLW are typically involved in trainings, with a caveat that in Dewa Chefa it is mainly men from these households who attend informational sessions at PW sites:

“From those who attend the training, the majority are public workers and they help us to send messages to DS users so that they will come and attend the BCC training” (DA, Libo Kemkem).

One PDS client in Libo Kemkem confirmed that training was provided to PDS clients in a “training centre,” though “they never teach regularly.” However, PDS clients in Dewa Chefa reported not participating in any informational sessions due to their lack of interaction with the community as a result of being elderly or infirm.
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4.3 Reported outcomes

In this section, we present preliminary evidence of the contribution of BCC and associated advisory support (including activities delivered beyond the ISNP pilot) and co-responsibilities to improving clients’ intermediary nutrition and health outcomes. Respondents (particularly key informants) generally felt it was too early to determine impacts, as changes in health and nutrition require sustained, long-term investments to materialize. A PSNP coordinator from Dewa Chefa cautioned against high expectations at midline point: “Those who participate in BCC sessions, they indicate that they are benefited from the sessions. But the programme itself is found at its early age, just starting, and it is too early to talk about the impact of the programme. On top of that, the programme is on and off and we cannot say it has brought changes.”

Shortcomings in BCC delivery, and relatively limited and irregular participation of target groups, undermine the scale and magnitude of positive changes. That said, those participants who benefited from advisory support reported positive changes on several aspects of their well-being. Overall, there is evidence that the combined effects of trainings, individual support and access to services via co-responsibilities have led to changes in knowledge, attitudes and in some cases even behaviours and practices.

4.3.1 Effects on maternal and child food security and nutrition

Client responses to receiving nutritional information from HEWs were overwhelmingly positive and manifested primarily through improved changes in infant-feeding practices. Lactating women in Libo Kemkem reported now feeding their newborns colostrum, an important source of nutrients and antibodies, and those who can afford purchasing more nutritious foods are diversifying children’s diets. Importantly, exclusive breastfeeding is now generally viewed as the norm until children are 6 months old, rather than previous practices of supplementing with (potentially unclean) water or food. BCC sessions were also said to increase knowledge about child nutrition beyond infancy, leading to adoption of better feeding practices:

“It has brought change regarding their feeding practice that they are feeding in proper way, that is great progress … we teach them how to feed porridge after six months” (HEW, Dewa Chefa).

“[HEWs] informed me that after 6 months of age to feed foods prepared from different crops to make the baby fat. So … I have prepared powder from 12 different types of crop” (Lactating woman respondent, Dewa Chefa).

There is also new suggestive evidence of enhanced knowledge of dietary diversity and improved food consumption among both mothers and children. In some cases, this is the reported result of changes in food production practices, such as increased skill in the production of nutritious food, and retaining food production for self-consumption; income from the sale of food has also increased in some cases, enabling clients to improve their diets and food intake:

“There is a big change in this regard … now the beneficiary knows that they have to eat three times a day. We have been involved on awareness creation to feed what they have at home properly … to improve food diversity … now people are consuming the available food at home [rather than selling it all at the market]” (WOLSA officer, Libo Kemkem).

“Yes, there is a change [from DA informational sessions]. We feed and teach our children properly; for example, when we hear them teach to grow fruit, we … tell our children … so now our children are motivated they have started nurturing fruits and watering them” (PW respondent, Libo Kemkem).

However, the majority of respondents explained that this knowledge cannot be implemented without money for agricultural inputs such as fertilizer and seeds, as well as structural agricultural changes including access to irrigation. As a result, much farmland remains unused, underscoring the importance of linking PSNP clients to livelihood support and training.

4.3.2 Effects on WASH practices

Hygiene education has led to improvement in both knowledge and action among the recipients of advisory support, particularly in Libo Kemkem, where both latrine and soap usage have increased. This
has also reportedly resulted in improved health outcomes for children and adults through better food and home hygiene, handwashing and sanitation usage:

“It has benefited both me and my children. There are people who do not keep their hygiene or eat food without cooking it well. But after I got the trainings [from HEWs], I wash dishes frequently and I keep everything, including toilets, hygienic. We have hand washing facility at the gate of the toilet … now we are all healthy … both the training and the follow-up have benefited us very well” (Lactating woman respondent, Libo Kemkem).

“Formerly people [were] using ash to wash hands but now, due to the recommendation of the HEW, now we are using soap” (PDS respondent, Libo Kemkem).

Learned hygiene practices have in some cases also spread through osmosis in the community: “I am keeping my personal hygiene, even my friend tries to keep her personal hygiene by following [imitating] me” (PLW, Libo Kemkem). In cases where learned toilet usage has replaced open defecation, this should also logically decrease contamination of water sources and result in better community health.

4.3.3 Effects on maternal and child health practices

Provision of health-related information (through BCC training complemented by advice provided during home visits) has resulted in a better understanding of maternal and child health and greater fulfilment of co-responsibilities among many ISNP clients. In both woredas, respondents reported an improvement in women seeking ANC and PNC and institutional delivery, as well as following vaccination schedules for infants and young children:

“[PLWs] get training on how to breastfeed, how to feed and on vaccinations [from HEWs] … and they follow that very well. When a mother is exempted from work, she doesn’t just sit down, she goes and attend these trainings” (PW respondent, Libo Kemkem).

“Attributed to the positive effects of BCC session, the participation of pregnancy check-ups is currently increased. Many pregnant women [have] started to seek pre- and post-pregnancy check-ups” (HEW, Dewa Chefa).

General discomfort with the idea of giving birth in health centres has also begun to dissipate in some areas of Dewa Chefa due to changes in attitudes towards maternal healthcare.10

“Look how much lack of knowledge [was] affecting us! … We thought that once you delivered baby, it is not important to go to health centre … particularly my distrustful attitude towards delivering at health centre has been completely changed [due to HEW BCC sessions in the health centre]. In the past, we were hindered by lack of knowledge, but we [have now] learned and we deliver at health centres. Now we trust health centre. … In the future I will not bear my children at home” (Lactating woman respondent, Dewa Chefa).

A respondent in Gula Tsige, Dewa Chefa explained that BCC facilitators encouraged health centre deliveries and had managed to overcome some religious/cultural aversion to treatment from male health workers, resulting in more institutionalized births:

“We have participated in it [BCC]. We … told them that we are not willing to be supported by male nurses at health centres; we prefer female nurses or midwives. They told us that sharia law has already allowed it and finally we accepted to be served by male nurses/midwives” (Lactating woman respondent, Dewa Chefa).

Another respondent in Gula Tsige explained that health centres have not only hired female (as opposed to male) midwives to assuage such concerns, but also offered food and clothing to encourage institutional births, with a resultant increase in health centre deliveries. This illustrates complementary efforts which can boost the effectiveness of BCC, wherein programme staff have directly addressed sociocultural barriers to improve

10 However, some respondents in Dewa Chefa (Gula Tsige) explained that their cultural/religious beliefs still prevented them from seeking institutional delivery.
maternal care and addressed supply-side barriers to women’s access to health services.

**Related improvements in health outcomes for children were also reported, including higher levels of immunization, better nutrition due to healthier feeding practices and higher rates of health centre births** (where emergency deliveries and complications may be resolved with better health outcomes for mothers and infants). As the following experience shared by a lactating mother attests, the BCC sessions can be credited with improvements in better health-seeking behaviour for mothers and children: “He [her child] got all the vaccinations ... I got information from the HEWs about child immunization [through BCC sessions, and as a result] ... my health-seeking behaviour has improved for my child and myself” (Lactating woman respondent, Libo Kemkem).

### 4.3.4 Unintended effects on gender and family planning

As a result of information provided through BCC sessions and visits to HEWs (who also supply contraceptives) at health posts, the use of family planning services has also increased, leading to more preferred birth spacing. This can potentially lead to better maternal and child health (and presumably better nutrition outcomes, as respondents equated large families with insufficient food):

“[BCC sessions] benefited me so much. For example, I could have had up to six children by now if it wasn’t for family planning” (Lactating woman respondent, Libo Kemkem).

Finally, although BCC does not attempt to comprehensively address unequal and discriminatory gender norms and roles, key informants did observe some changes in gender attitudes, particularly regarding women’s work burdens among those families who attend the BCC sessions. As evidenced in the following testimonials, exposure to sensitization efforts, as well as engagement of men in the trainings, may have contributed to these important gender shifts:

“[BCC sessions] benefited me so much. For example, I could have had up to six children by now if it wasn’t for family planning” (Lactating woman respondent, Libo Kemkem).

“We are also observing some changes caused by the training we provide ... Changes are visible. Most importantly we work on gender equality or on reducing the burden of women. We are observing changes in attitudes of the men counterparts” (DA, Dewa Chefa).
Section 5
Co-responsibilities component

In this section, we explore progress in implementation of co-responsibilities, clients’ levels of understanding and compliance, and effects of co-responsibilities on access to and uptake of complementary services.

5.1 Implementation progress

Overall, the implementation of co-responsibilities has been relatively on track since the baseline. It appears that the ISNP has strengthened the compliance of clients with co-responsibilities, particularly with regard to education. Positive changes in the implementation of co-responsibilities have been associated with improvements in the process of transitioning PW clients into TDS, engagement of FLWs in managing referrals, delivering messages about the importance of social services and improved monitoring of compliance through deployment of SWs.

5.1.1 Staff awareness of co-responsibilities

The majority of woreda- and kebele-level key informants, particularly in Libo Kemkem, displayed good (and improved) awareness of the various co-responsibilities expected of TDS and PDS clients. Joint staff training has contributed to this. In some instances, co-responsibilities related to childcare are more loosely defined and interpreted and may diverge from formal programme guidelines, as the following quote from HEW illustrates: “If the mother is lactating, she is required to properly feed food, take her child to do growth monitoring, keep personal hygiene of the child” (HEW, Dewa Chefa). While growth monitoring is a mandatory co-responsibility, child-feeding and hygiene practices are not.

The majority of key informants understood that these requirements are soft conditionalities for TDS clients, and should not involve penalties (although some respondents reported that non-compliance does indeed incur penalties):

“Taking a BCC training course is mandatory, although it has no punishment if she does not take the training. She will not be punished if she gets absent, but she will be pressured to participate. The other is she is expected to attend prenatal and postpartum care and these are mandatory. Because it would be difficult if she cannot do these. This is a soft conditionality that the Integrated Safety Net Programme reserves for them” (ISNP coordinator Libo Kemkem).

Most key informants reported that clients are responsible for ensuring their children are enrolled in school and attend regularly. However, views were mixed regarding which client categories this included. In Libo Kemkem, one SW explained that PDS clients were the key client group encouraged to send their children to school:

“In this regard, our focus is among PDS. We tell them that they should send their children to school, not to somewhere else where they will be maids. We also teach them that they are getting 12-month payment support because they are expected to send their children” (SW, Libo Kemkem).

However, a DA in Dewa Chefa said all categories are targeted, revealing gaps in the interpretation of the programme protocols: “Regarding sending children to schools, it is expected from all client categories.”

The PSNP coordinator is responsible for overseeing co-responsibility implementation, including posting and maintaining client lists, providing training about their rights and responsibilities, raising awareness and reporting. FLWs, including SWs and HEWs, support this process by informing clients of their co-responsibilities (listed on cards), and providing referrals and advisory support related to health services (in the case of HEWs) and education (in the case of SWs). SWs monitor the compliance with education co-responsibilities among PDS clients, as the WOLSA officer in Libo Kemkem explained: “The SW checks every day whether they are attending class or not, if they not coming, she has to go [to] household … and ask why the children are absent from school.”
5.1.2 PSNP client awareness of co-responsibilities and compliance

Most respondents in both woredas could not specify exactly what their health co-responsibilities were. Although the ISNP co-responsibilities are listed on the back of each programme ID card, many clients are illiterate and therefore cannot reference them. Several PLW in Libo Kemkem, and some respondents in all Dewa Chefa client groups, said they were entirely unaware of any co-responsibilities. This indicates a problem in FLW communication of the programme’s expectations:

“All I need to do is take care of my child. No one told me to do anything to get the payment” (Caregiver of malnourished child, Libo Kemkem).

“Nobody told me about the co-responsibilities, and I do not know about it. I did not attend any training” (Pregnant woman respondent, Dewa Chefa).

At the same time, many respondents referenced participating in tasks that could be linked to co-responsibilities (ANC/PNC, children’s education, BCC) due to requests from actors such as the HEWs, kebele administration, the local representative of women’s affairs and ‘the government’. Importantly, most sought to participate in as many of the co-responsibility areas as they could, regardless of whether they understood them to be an obligatory part of the ISNP:

“The coordinators at the ISNP don’t require anything. But the health professionals [HEWs] who followed us from the beginning tell us to bring our children every month and give them the vaccines. At that time, they also check up on us for postnatal problems … so I take [my baby] there and he gets vaccinated, and they give me injections too” (Lactating woman respondent, Libo Kemkem).

“[I attended two ANC appointments but] I am not required [to] as a PSNP client” (Pregnant woman respondent, Dewa Chefa).

Many could also clearly explain the importance of these activities (e.g., vaccination, growth monitoring, ANC/PNC), thereby exhibiting knowledge received from SWs, HEWs, DAs and kebele administrators. However, there were several PLW clients with a better understanding of the programme’s components and expectations. For example, one client in Dewa Chefa explained that after transitioning to TDS, attending ANC/PNC appointments becomes a responsibility that replaces PW: “Regarding prenatal check-ups, I was attending the health centre start[ing] from three months of my pregnancy. I attended five times or more for check-ups … As a member of PSNP it is expected … to attend check-ups” (Pregnant woman respondent, Dewa Chefa).

Notably, female clients face barriers to compliance with co-responsibilities and uptake of health services in particular. Religious beliefs and gender norms upheld mainly by Muslim communities regarding women’s reproductive health (including male pressure) prevent women from freely accessing reproductive healthcare in public facilities. This outcome was documented frequently in Dewa Chefa research localities. This is how the PSNP coordinator in Dewa Chefa described attitudinal constraints: “As I have told you, these [gender attitudes] are strongly influenced by the culture of the community. The community culture is still not appreciating the culture of visiting health support services. Despite some improvement, our community is still living in complex attitudinal problems.”

A TDS client in Dewa Chefa explained that religious members of the community often reject ANC/PNC from health facilities due to a worry that HEWs would ‘force’ women to use family planning – an issue that could benefit from further research, as these women do still receive nutrition information and vaccines from HEWs, and this fear may lead them to cease contact: “We do not have a culture of seeking ANC here in our area. The health worker may force you to use family planning. According to our religion, the use of family planning devices is not allowed. At the same time, my husband also does not like the use of family planning.”

Respondents showed a slightly better level of knowledge and uptake of education co-responsibilities. SWs, HEWs, DAs and kebele administrators provide information and encouragement, and SW home visits are the primary communication channel. In Dewa Chefa, PLW respondents even cited SWs providing school materials to clients to encourage their attendance, which was verified by the Libo Kemkem WOLSA officer. In some cases, other actors such as teachers, DAs and kebele administrators pressure parents to follow education co-responsibilities. A PW client in Libo Kemkem explained the role of teachers in encouraging school attendance:
“Even the teacher always take attendance at school and if the child misses two days of class, he will come to household and ask the reason why the child is absent.”

**IDIs confirmed that all PSNP client categories are exposed to education co-responsibilities. Although this is not in accordance with ISNP guidelines, it is a positive outcome for children.** Finally, there are clients who held beliefs that failure to comply with school co-responsibilities carries financial penalties or repercussions for clients:

‘‘[With regard to co-responsibilities, pregnant mothers are] advised [by HEWs] to attend follow-up treatment [and] take the vaccination and treatments she is given … If they do not fulfil the responsibilities, they will get upset and will get left out of the programme … [and] a person must take the [BCC] lessons to get the payment” (PW respondent, Libo Kemkem).

‘‘[The] kebele administration enforces us to send our children to school. They even penalize us up to 300 birr” (Pregnant woman respondent, Dewa Chefa).

5.2 Reported outcomes

As mentioned in Section 4, the combination of co-responsibilities and the provision of health-related information (through BCC sessions and HEW and SW home visits) has reportedly led to some improvements in women’s demand for ANC, PNC and institutional delivery, as well as better care of infants. Despite the small gains, this finding is important given that, at baseline, health-seeking rates among this group were low with fewer than 50 per cent of pregnant women attending ANC appointments:

‘‘Knowing these additional [co]-responsibilities [through BCC trainings] helped us in improving our tendency to go to a health facility, and we have benefited” (Pregnant woman respondent, Libo Kemkem).

‘‘If the mother is pregnant … she follows up going to health centre every month, she takes medications regularly … She then gives birth … by going to health centre. These are the things expected from a mother when given a leave [through TDS]” (Pregnant woman respondent, Libo Kemkem).

**Co-responsibilities have been associated with increased school enrolment and reduced child labour.**

The efforts of various actors have proven effective in facilitating attitudinal shifts towards education, increasing enrolment and retention of students. All client groups in Libo Kemkem reported that co-responsibilities and information from FLWs improved community awareness of the value of education, thereby creating a local cultural shift. As a result, there was said to be greater school enrolment and more emphasis on pursuing education until employment. PLW and caregivers of malnourished children in Dewa Chefa reported sending their children to school as a direct result of FLWs imparting information about the importance of schooling, as well as new understanding of their co-responsibilities. But this positive outcome was mainly reported among TDS clients, and not among PDS clients:

‘‘From this [BCC] I learned that I have to support my children to continue their education until they complete and get employed; I strongly work towards this” (Lactating woman respondent, Dewa Chefa).

‘‘DAs told me to bring my son and send [him] to school … he was working with rich person to get money. But they told me that the government is providing the benefit to send your children to school, enforced me to bring my son and I did it” (PW respondent, Libo Kemkem).

There is also evidence that cash transfers work effectively in synergy with the co-responsibilities. **PSNP payments were identified as a critical factor enabling clients to afford the clothing and materials needed to send their children to school rather than work.** This has the compound outcome of increased and prolonged education, as well as protection from child labour (including the additional vulnerability that respondents associated with children working in a wealthier person’s home):
“Before I join safety net, I support my family with my daily work money that hardly covers the price of foods because the price has skyrocketed. After joining, I was able to buy them exercise books and clothes; they are in grade one now” (Lactating woman respondent, Libo Kemkem).

“There is a change, we are receiving money and she has attended school, if the benefit is not given … I don’t have any capacity, she may [have to] drop out from school and become a housemaid for another household” (Lactating woman respondent, Libo Kemkem).

However, other clients complained that PSNP payments do not go far enough in assisting the poorest families with anything beyond basic food provision. This often leaves the most vulnerable without any means of obtaining healthcare (e.g., covering indirect costs) or an education: “The money we obtain from PSNP cannot go beyond filling their stomach. It is not enough to buy clothes and schooling materials” (Lactating woman respondent, Libo Kemkem).

Transport costs, poor (or lack of) roads and the distance to health centres also reduce access to services. Because of the distance to their health centre, respondents in Dewa Chefa explained that ANC/PNC check-ups are rare in the area. PLW described a common experience for women in accessing healthcare: “[It may take half a day for pregnant women to reach a health centre, due to a very steep slope], hence it is very difficult to visit health centre for ANC and PNC check-ups. Similarly, it is also difficult to carry baby and take to health centre for vaccination” (PLW, Dewa Chefa). Negative coping strategies (e.g., incurring debt to pay for transport, using PSNP money allocated for food, walking long distances in precarious conditions or foregoing healthcare altogether) can have devastating effects.

1.
Section 6
TDS transition component

In this section, we track progress in the implementation of transition of clients into TDS, key enablers and bottlenecks, as well as perceived outcomes for women and children as a result of their participation in TDS. Where data are available, we report results separately for different groups of TDS clients, namely PLW and caregivers of malnourished children.

6.1 Implementation progress

The majority of key informants reported improvement in the process of transitioning PW clients to TDS compared to baseline, when the TDS protocol was not fully operationalized. Although there have been considerable challenges, and not all eligible PW clients are transitioning (or doing so in a timely manner), there has reportedly been important progress in this programme component in the past year. Several factors related to the ISNP drive this positive change, including investments in strengthening transition protocols, improving procedures and capacity of responsible staff to identify and transition eligible clients, and strengthening coordination among key personnel to efficiently manage referrals.

Staff appear to have a solid awareness of the rationale and objectives of TDS. It is generally understood as a gender-sensitive feature that aims to alleviate women's reproductive and care burdens during a specific stage in the lifecycle through exemption from PW. Through its link to co-responsibilities, including the BCC, the TDS mechanism is meant to enable clients to improve their personal and childcare practices and their demand for health and nutrition services:

“After delivery, she will be given leave for one year, until the baby is 1 year old, so in total she will be exempted from PW for about two years … a lot of hard work is not recommended when a lactating mother returns back to work, so she will be assigned simple and easy tasks because she is too weakened and is lactating and that makes it difficult for her” (PSNP coordinator, Libo Kemkem).

A SW from Libo Kemkem gave the following account about how ISNP contributed to improved TDS process: “Yes, the process is going well … After the introduction of ISNP, transition for pregnant women will be performed as soon as it is known she is pregnant. […] Yes, there is a significant improvement. That is because since the implementation of integrated developmental programme, we are working in coordination.”

Communities and clients are also more aware of TDS provisions (potentially through BCC and health centre/home visits) and thus more likely to request a transfer. Pregnant women are now also more likely to visit health centres (partly due to compliance with co-responsibilities), where they can be examined by HEWs and referred to DAs for TDS. A SW from Dewa Chefa explained this change:

“Now […] it is strong. Now all people have awareness about the TDS process and started asking [for] transition into TDS. For example, they started to visit for check-ups to know their status … Before, such tradition was not there. Since their awareness level is increased, the transition process is easy now” (SW, Dewa Chefa).

Those clients who had transitioned were happy with the process and outcome; one respondent in Libo Kemkem stated that the process is continually improving: “Yes. Both pregnant and lactating women are being given the exemption properly and the transition process is improving from year to year” (Lactating woman respondent, Libo Kemkem). But, as the next section reveals, several bottlenecks hinder the effective implementation of TDS.
6.2 Core characteristics of the TDS transition process and bottlenecks

In this section, we provide a detailed description of the TDS protocols used to transition both PLWs and caregivers of malnourished children into TDS and discuss the strengths and weaknesses of the process.

6.2.1 Transitioning PLW

Screening process

According to programme guidelines, the process for identifying and referring clients into TDS has several steps and it involves a group of actors. Identification of PLW can occur at different entry points and locations, such as at the PW sites (by DAs), through home visits (by SWs) and/or client visits to health centres (by HEWs). According to the programme guidelines, PLWs are referred to HEWs for confirmation of their pregnancy status and issued ‘certificates’ as proof for DAs to grant permission to transition.

Interviews with both key informants and respondents confirm that transition of pregnant and lactating women into TDS is initiated and implemented through these diverse pathways and entry points. According to respondents, TDS transition for PLW is most often initiated through HEWs at health centres, and DAs who give leave after this confirmation. This indicates that women are generally aware of the TDS process and tend to visit health centres. In Libo Kemkem, one respondent explained that the transition process had become more stringent in Birkutie, with HEW certification now required for transition:

“After applying for permission, it takes up to a week to process it because it needs consultation … they ask [you] to bring a piece of paper from the [HEW] for a testimonial … so we go to the health services to get it … it is impossible to just say that I am pregnant – it doesn’t work anymore” (PW respondent, Libo Kemkem).

While SWs tend to act as liaisons between HEWs and DAs in the transition process, they also sometimes conduct initial screening of PLW during home visits and assist eligible women throughout the process. The WOLSA officer and HEW from Libo Kemkem describe the SW’s role in this process:

“The SW will tell the DA or [PW] foreman … this mother is pregnant, to not involve her in public work activity. Then the DA or foreman write a letter to the HEW to [get a] pregnancy check-up/certificate, then the SW go with the pregnant mother to health post, then the HEW check her pregnancy and writes a letter to request that she transits from public [work] to TDS” (WOLSA officer, Libo Kemkem).

“After we certify her pregnancy … we have to inform the SW. Then the SW will inform the public work [PW] leader [DA] with letter of pregnancy certification, then that mother becomes a TDS client starting from her certification of pregnancy” (HEW, Libo Kemkem).

There are notable gaps and weaknesses, however, in the PLW transition protocol and screening process that hinder women's participation in TDS.

Sociocultural and gender barriers

First, deeply rooted gender barriers and gaps in programme coordination prevent some women from visiting health centres and learning about associated opportunities for TDS referrals. For example, in Dewa Chefa, it has been reported that PLW were screened and exempted directly by DAs in the absence of HEW confirmation of their pregnancy, as women were deterred from visiting health centres. A HEW explained this situation: “Even though we observe some changes, many things remain as they were before … the culture of health-seeking and visiting heath centres for check-ups is still poor. […] More importantly, women do not consider transition as issue in the community. […] Many mothers are not coming to health centre for check-ups. As a result, the transition process is not doing well. We have no chance to refer them to TDS” (HEW, Dewa Chefa).

Second, women's hesitancy to reveal their pregnancies in public space complicates and often delays the screening and transition process. It may also lead to gaps in the transition protocol, given that DAs would most likely only observe obvious, later-stage pregnancies, and then refer to HEWs for confirmation. This results in women transitioning to TDS beyond their fourth month. The Dewa Chefa PSNP coordinator explained that the transition’s effectiveness depends on how transparent women are about their pregnancies and whether they attend health centres for check-ups:
“In this community, women are not open in expressing they are pregnant. In addition, visiting health centres for check-ups is not common. The effectiveness of the transition process depends on how much pregnant women are transparent and how much they attend health centre for check-ups. Sometimes we encounter pregnant women close to delivery [who] are working in the PW.”

Programme-related bottlenecks: Gaps in staff knowledge and communication

Third, gaps in programme implementation and FLW communication with clients cause a general lack of understanding among some clients (and in some cases, staff) about TDS eligibility and how the TDS process works, in terms of timing and duration. For example, there is discrepancy about where PLW can obtain information about TDS transition; many say it is shared by DAs at PW sites, but others receive no information at all. Women who are not able to attend PW are left unaware of TDS or confused as to whether and how they can ‘transition’ to TDS. As an interviewer from Dewa Chefa observed, the PW household labour requirement is most often covered by male heads of household; therefore, women do not consider public work to be an issue. Other clients were so geographically remote and lacking in contact with DAs and other ISNP staff that they simply had no information about the scheme. Therefore, some women never realize that TDS payment during and beyond pregnancy is an option:

“I haven’t asked for leave because I am not participating in PWs. I do not know how to ask for transition into TDS. It has no value for us also; whether I have leave from PW or not, it cannot help us. To work in PW I have no time. I am occupied with domestic activities” (Lactating woman respondent, Dewa Chefa).

A lack of demand for TDS, or hesitancy to request transition, is also determined by misconception that transition may entail the loss of benefits. A HEW relayed that pregnant mothers are afraid of losing PSNP payments if they enrol in TDS:

“When the DA advises the pregnant mothers to bring certification of pregnancy … they assume that they are going to lose the PSNP benefit. Therefore, we advise such mothers by saying the action of the DA is [only to] … save you from heavy work […] our role is to inform them not to get involved on PW. Now a number of mothers may come and ask to be a TDS beneficiary since pregnancy. Then we inform them that being a PW and TDS beneficiary has equal benefit, and you receive the same amount of money” (HEW, Libo Kemkem).

There is also anecdotal evidence of staff imposing informal restrictions on transition to clients, which is not aligned with programme provision and guidelines. In some cases in Libo Kemkem, it was said that before transferring a pregnant PW client to TDS, the DAs, SWs and PW employer first try to find an alternative family member (husband or child) to take her place. If replacement is not available, the PLW can then transition to TDS. This is not in line with programme guidelines, as transition to TDS should be granted to eligible household with a PLW and/or caregiver unconditionally:

“The discussion about the permission is among the DAs, the SWs and the employer. Then they will ask our husbands or our brothers and they will agree to work on our behalf because they don’t want us to get hurt … If there is a child in the house who is not attending school, he will work on behalf of his mother and the father will work his own share. They give the permission to those who have a child attending school and who cannot replace their work and while the husband is still working. Permission is not given to everyone” (Lactating woman respondent, Libo Kemkem).

Women also sometimes replaced their husbands at PW sites when they were unavailable, meaning that they sometimes worked through pregnancy and lactation. This indicates a lapse in DA involvement and TDS monitoring, as such women should not be allowed to participate:

“I do not know the transition process at all. Since I have no children who help me in participating in public works, I always participate … including when I am pregnant and lactating” (Lactating woman respondent, Dewa Chefa).

“I was back to PW when my child was 5 months, leaving my child at home. Since my husband is not available most of the time, I participate even during my pregnancy until my delivery” (Lactating woman respondent, Dewa Chefa).
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Key informants and respondents’ knowledge of the timing of TDS initiation and termination for PLW also varied, underscoring gaps in information. Some FLWs reported the correct timing and duration, while others showed a lack of knowledge: “If a woman knows that she is pregnant, we make sure that she gets maternity leave from the fourth month of pregnancy till the newborn is 1 year old. We are the ones who collect the maternity leave paper and give to agriculture or health sector” (SW, Libo Kemkem).

Respondents (even in the same kebele) also had varying notions of transition timing. In Libo Kemkem, some asserted that leave from work begins as soon as a pregnancy is confirmed (as early as two months), whereas others wait up to six months’ gestation. Knowledge about clients’ return to the PW programme also differed. While some believed that women can maintain their TDS status until baby turns 1 year or ‘becomes strong’, others in the same area believed TDS only ended after the baby turned 2. These findings highlight important gaps in the capacity of staff to deliver accurate information to PLW clients about the TDS process and resultant limitation on clients claiming their entitlements.

Some respondents indicated that they continued working during pregnancy, and others simply stopped working without receiving DS payments:

“I do not know about this. Nobody mentioned the name of transition to me. I just stopped participation in PW because I am tired [she has a three-month-old baby]. I have no information regarding the rights of PLW” (Lactating woman respondent, Dewa Chefa).

Finally, in some instances, SWs also register PLW for TDS, which is not in line with the transition protocol. A review of TDS procedures indicates that staff roles and specific responsibilities overlap in practice, leading to potential gaps and inefficiencies in implementation of the protocols. These various channels for screening and referring women into TDS may improve their opportunities to learn about and apply for transition in ways that are suited to their contexts. Yet, in the absence of effective coordination, transparent administration and information and clear protocols, overlaps may lead to inefficiency in implementation, leading to women missing out on their entitlements.

6.2.2. Transitioning caregivers of malnourished children

Respondents in Libo Kemkem confirmed that SWs and HEWs identify malnourished children during home visits and health visits and provide case follow-up (transitioning caregivers to TDS and providing check-ups and supplementary food). SWs who identified malnourished children then coordinated with HEWs and the kebele administration to arrange transition to TDS, provision of nutrition/feeding information, follow-up health checks and sometimes distribution of supplementary food. It appears that SWs play a crucial role in facilitating this process for caregivers: “[I am in] TDS because my child is malnourished and gets ill and I had to take care of him. The SW facilitated this [for] me” (Caregiver of malnourished child, Libo Kemkem).

HEWs were said to conduct screenings every month to identify children with nutrition problems. This is usually performed during growth-monitoring visits, underscoring the importance of proper implementation of co-responsibilities. HEWs refer these cases to DAs, recommending that the caregivers transition into TDS, while also providing treatment and support to malnourished children. This process was said to be frequently facilitated by SWs. However, FGD respondents with malnourished children in Dewa Chefa reported no transition to TDS. Some reported that they were entirely unaware they were able to transition, and IDIs in the same client group also reported no knowledge of transition: “No, only PLW and PDS clients are entitled to transition” (Caregiver of malnourished child, Dewa Chefa).

Knowledge about the timing and duration of transition for caregivers of malnourished children seems to be more consistent with the programme provisions compared to PLWs. The PSNP coordinator from Libo Kemkem provided a detailed description of the rationale for, and duration of, TDS transition for this client category:

“A baby with a stunting or nutritional problem will need a caregiver … the linkage will be created between the DA and the HEW and the mother or caregiver will be out of work until the baby returns to normal […] we will not force them to return to work unless the HEW or those working at the health centre say that the child is healthy or that he or she is back to normal, after following up on this situation. This needs a professional explanation.”
6.3 Reported outcomes

6.3.1 Reported outcomes for PLW

Many important benefits of PLW transition to TDS were reported by respondents and key informants, including improvements in women’s health, an increase in time available to care for children, and better child survival outcomes. Participants and key informants explained that PLW involvement in TDS allows them to protect infants from the elements and potential dangers of work sites, while also safeguarding their own health while pregnant and lactating. Women reported that transition also protects unborn babies and their mothers from potential strain or injury on work sites, while more consistent presence at home allows mothers to better care for their children and improve food intake; caregivers cited improvements in maternal care and health outcomes as a result:

“It [transition to TDS for PLW] has great change. Previously a mother was insisted to carry stone on her back and front even if she is pregnant and this harms her badly. Now ... the situation is improving [for women]” (Pregnant woman respondent, Libo Kemkem).

“In the former years they were working [when] they are pregnant and faced a problem of bleeding, unnecessary abortion [miscarriage], but now they have been given time to rest and maintain their health” (HEW, Libo Kemkem).

“If we stay at home ... it helps our children to recover from illness and become healthy” (Caregiver of malnourished child, Libo Kemkem).

“This [transition] makes me focus on our home activities and reduces burden and saves my time. ... It is good for my children. They find me always at home. If I am at home, I take care for them, for example preparing foods for them” (Lactating woman respondent, Dewa Chefa).

KIIIs confirmed these benefits, particularly for infants:

“Especially for babies, it has been of a great value because previously mothers have to leave their baby at home or they have to bring it with them which in both cases is not good for the baby. Currently there is no such problem” (DA, Libo Kemkem).

“The change [from transition] is the mother may look after her and child’s health, properly breastfeed the baby up to 6 months, and the mother also get enough rest during pregnancy, then she became healthy and give birth to healthy baby” (WOLSA officer, Libo Kemkem).

Transition to TDS also reduces women’s work burdens, which can be beneficial for mothers’ mental and physical health – critical factors for family well-being. Additionally, more free time allows mothers to comply with co-responsibilities and seek healthcare, which means they benefit more from the ISNP and its integrated support: “Not working on PW will help her go for ANC follow-up ... as well as ... immunizing the child. But if she works, these opportunities might not be accessed” (SW, Libo Kemkem).

6.3.2 Reported outcomes for caregivers of malnourished children

As a result of their transition into TDS, women caring for malnourished children also reported a range of positive outcomes for themselves and their children. First, participation in TDS ensures that children have access to timely treatment and complementary support. For example, HEWs provided fortified food for children through health centres or home visits. All Dewa Chefa FGD participants with malnourished children indicated that they had received monthly supplementary food and oil since their children were diagnosed with malnourishment. Therapeutic food was also supplied for malnourished children identified in Libo Kemkem. These initiatives improved food consumption among both malnourished children and pregnant women. In particular, supplementary fortified food was cited by clients as important in their children’s recovery from both pre- and postnatal malnutrition:

“My malnourished child recovered after she got supplementary food [HEWs] gave us” (Caregiver of malnourished child, Dewa Chefa).
“This [supplemental food provided by HEWs] helps my baby in womb to grow healthy”
(Caregiver of malnourished child, Dewa Chefa).

“I received] Fafa [fortified food] [and] oil to prepare food for child from health post, so that I have been feed[ing] the child properly and recover now” (PDS respondent, Libo Kemkem).

HEWs also provide nutrition-related ANC, including monitoring foetal growth and providing additional food for pregnant women at risk of malnourishment: “They [HEWs] monitor the growth of baby in my womb, its weight, based on that they provide supplementary foods. I took two times in my current pregnancy” (Caregiver of malnourished child, Dewa Chefa).

Mothers of malnourished children in Libo Kemkem emphasized the value of TDS in that it provided them with additional time to care for their children: It was also highlighted as a means of respite for PLW previously engaged in PW in which they could recover from childbirth and produce enough milk to feed their babies (mitigating the chances of future malnutrition):

“It helped my child to get a little bit better in his health condition because I can take care of him full time as I am free from other responsibilities” (Caregiver of malnourished child, Libo Kemkem).

“If her child is malnourished, she be given a break and care for her child, let her child to get sunlight and feed the child as much as she can. Then she will stay at her home to care for her child and her breast will also give enough milk” (Caregiver of malnourished child, Libo Kemkem).

As a result of these intermediate outcomes, women reported positive health outcomes for their children:

“[Transitioning to TDS] has good benefit, I have rest and give good care for my child … now he is good, he is adding some weight and become healthy” (Caregiver of malnourished child, Libo Kemkem).

“Yes, there is a change [since transition to TDS]. For example, my child used to get ill all the time but now thanks to God he is fine. Regarding workload, it benefited me very much because if the workload hadn’t been reduced, my child wouldn’t have been better even for few days” (Caregiver of malnourished child, Libo Kemkem).

Participation in TDS has also had positive spillovers for non-malnourished children in TDS households, who benefit from improved care, including better food intake. Respondents said that PLW taking a break from work and receiving TDS allows them to provide better childcare and is possibly a means of preventing poor diet/malnutrition in the future: “[Due to my TDS transition] I am freely taking care of my children; I am always available to them. When they give me the cash transfer, I am freely preparing food for my children” (Caregiver of malnourished child, Dewa Chefa).
Section 7
Case management

In this section, we evaluate the progress of case management since baseline and describe its key characteristics and outcomes. We report findings collected only from key informants.

7.1 Implementation progress

There has been solid progress in the implementation of case management, primarily due to the novelty of the concept at baseline, when its system and procedures were underdeveloped. Since then, the ISNP has invested in capacity-building efforts, deployed SWs in all kebeles and strengthened their capacity and skills in case management, and installed the MIS as a core tool in the management of client data for needs assessments and referrals. Staff involved in case management received training in the subject, and as a result have demonstrated a good understanding of its purpose and objectives. A HEW from Dewa Chefa was positive about improved staff understanding of case management: “It is good now. Now we understood it. Before, it was problematic to us. Woreda people trained us on the issue last year and now we are doing well” (HEW, Dewa Chefa).

This marks an important improvement since baseline, when most key informants showed no awareness of case management. It is now typically described as a useful mechanism for programme delivery, as it facilitates service integration – from assessing client needs to managing and monitoring service referrals. It thus improves staff performance and programme impact. A WOLSA officer in Libo Kemkem explained the value of case management for the ISNP pilot: “What makes our job integrated is the existence of case management. If [it] … was not existing, we can’t know and identify such beneficiaries, we can’t work with integration, we can’t manage the data easily.”

7.2 Types of case management support

Respondents associated the purpose and goals of case management with three broad and interlinked areas of support. First, the process is used by SWs to resolve administrative bottlenecks faced by PSNP clients (particularly vulnerable PDS households), including payment delays and administrative requirements for CBHI registration:

“For example, if they get a less amount of money than expected, I write down their names and go to woreda together with DA to ask the reason then we make sure they are reimbursed in the next month” (SW, Libo Kemkem).

“For example, I renewed [the] CBHI card of a woman who have monthly visit scheduled [at the] health facility, so we helped her to continue her medical care” (SW, Libo Kemkem).

Second, case management is used to identify client needs, refer them to necessary services (mainly nutrition- and education-related support) and then follow-up and monitor their uptake and satisfaction with complementary support. Case management is regularly used to manage client transition into TDS, BCC attendance, uptake of services and compliance with co-responsibilities. While programme guidelines specify that case management is provided to PDS clients, our research shows that it is also used to manage referrals and compliance with co-responsibilities for TDS clients:

“One TDS female client who is disabled may give birth and the baby may not get enough food. So the SW links the child to HEW to get supplementary food” (SW, Dewa Chefa).

“If there is a mother who is facing difficulty in educating a child due to a food crisis, we find out what the problem is. For example, if it is due to lack of money to buy [school supplies] … we try to support them through that by providing them with pens or books to help them return to education” (SW, Libo Kemkem).
One key informant also explained that there is a demarcation between case management for social protection and for child protection: “For example, if a student drops out of school, we do follow-ups after discussing challenges together with the school director, kebele administration and local police … If her reason is due to planned marriage, that will be halted” (SW, Libo Kemkem). Further research is required to understand the extent to which the existing case management protocols allow for identification of needs and management of referrals to services for issues related to child protection. Finally, case management also links clients to psychosocial support and general counselling provided by SWs. According to a SW from Libo Kemkem, this is valuable for PDS clients, who are often socially excluded and marginalized, and may lack agency to seek assistance beyond cash: “Our primary job is taking care of those PDS users. They are people with disability, there are many living with chronic health conditions. […] We go home to home and give them counselling service. Our community makes fun of those who are disabled but we go to those people and counsel them.”

7.3 The case management process

In this section, we describe the process of initiating and implementing case management and highlight key lessons based on the perspectives of key informants. Client screening and needs assessments are primarily performed by SWs during home visits or by HEWs at the health centre. To streamline and document the assessment process, FLWs use a set of forms to record client needs for support and suggested measures (Section 11). As both SWs and HEWs are involved in identifying clients’ needs, the potential overlap in their roles highlights the importance of effective cross-sectoral collaboration and timely coordination of data management between FLWs, as this quote reveals: “How does the referral system work? We depend on information provided to us by HEW about [client] health and malnourished children [in order] to refer them. If [the case] is needed to send to woreda-level sectoral office, we send it to them. For this purpose, DA is also working with us in identifying the problems of the clients” (SW, Dewa Chefa).

The assessment process is assisted by the MIS data collection and recording system, and currently relies on paper-based forms to collect data and perform screening. It is expected that a full transition to digital management of data will enhance data quality, simplify the cross-sectoral exchange of information and improve case management planning and monitoring processes. Once the assessment is performed, the client receives a referral and is linked to suitable services. These may be provided directly by service providers (depending on their availability) and/or facilitated by CCCs when material assistance is sought. The SW and MIS officer below explain how nutrition- and education-related referrals are managed and monitored in practice in Libo Kemkem – often through the process of co-responsibilities:

“If there is child with stunting problem, we refer him to the HEWs, and if he needs inpatient care, [they] refer him to the health centre … If the child can recover with Plumpy’Nut or other support, the HEWs can provide that support, but every 15 days the baby’s middle-upper arm circumference will be measured and reported, and we take corrective actions if any problems are identified. Therefore, if the child is quickly recovered from the services provided by the HEWs, he will be automatically returned to his health, if not he will get an inpatient treatment” (SW, Libo Kemkem).

“If one PDS client student drop out from school, the SW will go to their home to identify the problem. Then if [it] is related to his/her family economy or it is because of shortage of exercise book, [the] WOLSA office or CCC will support him/her [with] what she needs to continue school. So, related to students we are working [in an] integrated [way] with schools” (MIS officer, Libo Kemkem).

The MIS officer in Dewa Chefa described the distinct stages and actors involved in case management – from assessment to referrals and follow-up – using the example of a TDS client:

“We implement case management in two ways. First, we register the profile of our clients. Second, we register their needs and [any] support [they have received]. We have specific forms for all client categories. We respond to their problems based on this, for example, when we transition pregnant

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12 Plumpy’Nut is the brand name for a peanut-based paste used for treatment of severe acute malnutrition.
women to TDS. Because she cannot work on PW while she is in such condition, at this point she is expected to seek ANC and PNC. When a woman gets pregnant, she takes confirmation from HEW, and shows it to DAs to be exempted from PW. Then, the SW monitors her status, for example how she is handling her home. In addition, SW checks whether she attends BCC sessions or not … [and] how she handles her newly born baby. The forms we use contain [the] kinds of support they require from us” (MIS officer, Dewa Chefa).
Section 8
Access to FLWs

A key feature of the ISNP pilot is its involvement of FLWs in integrated service delivery. Working directly with PSNP communities, SWs and HEWs are supposed to facilitate and improve the relevance, timeliness and quality of health and nutrition services and education (in the case of SWs). They perform a range of tasks and functions related to the ISNP and beyond, and thus are critical agents for programme sustainability.

In this section, we present the findings related to the presence of SWs and HEWs in sample communities and their interactions with PSNP clients, and the perceived benefits of their support to programme clients. We first report findings from IDIs with PSNP clients, followed by observations from key informants about the role of SWs. These findings should be interpreted in conjunction with the findings presented in previous sections (particularly Sections 3–7) for a comprehensive understanding of SW and HEW roles and contributions.

8.1 Access and interaction with FLWs

8.1.1 FLW availability

At baseline, knowledge and exposure of PSNP clients to HEW activities was quite good. Our quantitative data revealed that 61 per cent of PW clients and 45 per cent of PDS clients reported to know the HEW in their community. Clients' familiarity with SWs was more limited. For example, only 11 per cent of PW and 7 per cent of PDS households reported knowing their SW at baseline. Limited client interactions with SWs were particularly notable in Gula kebele in Dewa Chefa, where a SW was newly appointed.

As highlighted in Section 2.5, important efforts have been made in the past year to improve staff and community awareness of SWs and their role in social protection (and in the ISNP in particular). However, important gaps remain in frequency and quality of HEW and SW interactions with clients, with variations across research locations. This is discussed further in the following sections.

8.1.2 Access to FLWs in Dewa Chefa

Many respondents in Dewa Chefa had limited interaction with HEWs and SWs, although this varied both across and within client categories. Most PLW respondents cited HEWs and SWs as their primary source of information about health and nutrition – particularly healthy child-feeding practices for pregnant women, infants and young children. The following quotation illustrates how lactating women from Dewa Chefa explained HEWs contribution:

“The advisory support services [BCC sessions] given to us from health centres are good ... now we learned to go to health centre to treat our children ... [Also], HEWs are advising us to use family planning for the betterment of children and for example better nutrition ... They advise us how to take care of our children after birth” (Lactating woman respondent, Dewa Chefa).

Several caregivers of malnourished children also cited effective, though limited, interactions and support received from HEWs. Support is mainly provided regarding child vaccination and supplementary food to treat malnutrition. However, in the FGDs, all participants with malnourished children explicitly stated that the programme does not assist with child nutrition. The client from Dewa Chefa described the common perception: “The HEW also doesn’t do a follow-up assessment on the nutritional status of my child and I didn’t ask her to. My child had malnutrition, and no one checked if he recovered or still has the problem.”

Although the former HEW was said to have worked closely with clients to provide nutritional information, none had received support from the current HEW in Gula kebele. Insights from key informants revealed that restricted accessibility to HEWs in this kebele is the result of heavy workloads and language barriers, as he does not speak the local language. This confirms the notion that FLW interaction with clients, and the quality of their support,
largely depend upon the capacity and capability of individual workers. In one case, it was implied that lack of interaction with the HEW may be due to either social friction or staff disinterest:

“I have not received any support from HEW yet. The one assigned is not doing well. She does not visit us, she even does not want to talk to us” (Pregnant woman respondent, Dewa Chefa).

**Most PDS clients and PW clients had no interaction with or support from HEWs.** In contrast, several PDS clients reported that SWs provide nutrition and child-feeding information during home visits, encourage them to attend the health centre and monitor clients’ hygiene practices. A SW in Dewa Chefa described the importance of home visits in building rapport and trust with marginalized clients, which is a critical factor in the efficient identification of their needs:

“I will go to their home and ask about their needs. Since they are my clients, I bring them small gifts such as banana and the likes. Then after, we ask them about their problems. They also treat me like their children and tell me about their problems. They do not hide anything from me. I organize the data and discuss with CCC and provide support to solve their problems. For example, if they need toilet, food, or money, we search for the ways in which we provide them support” (SW, Dewa Chefa).

A handful of PDS respondents in Dewa Chefa reported a complete disconnection from all social services:

“Nobody told us. Nobody comes to our home … I heard they are workers here, but I do not know what they are working. They did not come to us. Nobody told or advised us. [There is] no place to get information” (PDS respondent, Dewa Chefa).

This lack of interaction and connection with FLWs is possibly due to the study kebeles' remote location, difficult terrain or logistical issues due to the area’s recent division into these two kebeles. Additionally, at the time of the midline evaluation, there was reportedly no SW in one part of Gula kebele (note: since the baseline study, Gula kebele was split into two administrative areas, namely Gula Ketemo and Gula Tsige) and a new HEW was recently appointed in Gula Tsige. A SW who is operational in Gula kebele reported facing the pressure of high caseloads, compounded by difficult geographical terrain and lack of transportation, such as motorcycles or cars. The SW explained that she has 33 clients but only has the capacity to visit some of them.

**8.1.3 Access to FLWs in Libo Kemkem**

Access to and interaction with FLWs is better in Libo Kemkem (Shemo site). **Most TDS clients in Shemo kebele received health- and nutrition-related information and support primarily from HEWs and SWs.** Both undertake home visits, which are a critical channel through which all stages of case management are carried out. In Libo Kemkem, monthly home visits are reportedly performed by SWs, who play a vital role in identifying and addressing the needs of vulnerable clients through referrals and collaboration with other ISNP staff:

“We have 85 PDS [clients] and about 106 PW [clients] in the kebele. Yes, I go home to home once a month to 85 PDS households. […] We don’t have pregnant mothers, but we have 10 lactating mothers, so I go to 10 lactating mothers’ house and PDS” (SW, Libo Kemkem).

“SW identifies needs, problems and engages CCC to find solutions” (SW, Libo Kemkem).

HEWs were also often mentioned by all client groups as active in the community (in contrast to Dewa Chefa), imparting information on child nutrition and hygiene, providing vaccinations and encouraging health centre attendance. Consider these testimonials from PLWs:

“Health workers visited home to home … They give vaccine for children … They advise us when we become pregnant [that] we should go [to the] health facility for check-up. They also advise not to give birth at home” (Pregnant woman respondent, Libo Kemkem).

“[HEWs] informed me [during home visits] by saying that … mothers should … try to eat diversified food. After giving birth she has to breastfeed, keep personal hygiene, after 6 months of child age, she has to feed complementary food, then the child become strong” (Lactating caregiver respondent, Libo Kemkem).
FGDs with caregivers of malnourished children indicated that they had learned about improved child-feeding practices and nutrition from HEWs, primarily during vaccination visits at the health centre. IDIs with this group showed that these topics are also addressed by SWs, DAs and kebele administrators:

“For example, about immunization, we get the information from the HEWs, the SWs, the agricultural workers and sometimes they tell us at the church … they sometimes teach us about nutrition and to feed our children appropriately … When there is a vaccination campaign, the kebele administrators give us the information” (Caregiver of malnourished child, Libo Kemkem).

PW clients said they interact with HEWs mainly through BCC sessions at the PW site or other (unidentified) locations where HEWs deliver advice on nutrition, health, hygiene, sanitation and co-responsibilities including ANC, PNC and vaccination. Hygiene information was also provided to some PDS clients by HEWs and SWs, including the importance of using soap, handwashing and latrine use during home visits. SWs also inspected the hygiene of clients’ homes, presumably to ensure they are implementing what they have learned:

“They [SWs] tell us to wash our hands and keep our hygiene after using toilet and to store water in jerrycans” (PDS respondent, Libo Kemkem).

This was echoed by several mothers of malnourished children, who said that FLWs not only provide hygiene information, but in at least one case constructed a latrine and smokeless oven in a client’s home.

Sporadic unavailability of HEWs in Libo Kemkem was reported. This is a result of their wide range of duties, which can leave them overstretched. This has critical implications for client health, as HEWs are often not present at health posts (and break appointments), which can lead to unwanted pregnancies and other health complications. This lack of HEW presence can also force clients to travel to other areas and pay out of pocket for medicines.

“If we don’t find them here [health post] on the date of [our] appointment, we go to Ambo Meda and pay … to get contraceptive because it is way better than having unplanned pregnancy … It was 20 birr but now it is 40 birr because this is harvest time. A mother prefers to sell two large cups of cereal and get injected than getting pregnancy” (Caregiver of malnourished child, Libo Kemkem).

8.2 Key informant perceptions of social worker contributions

Deployment of SWs and their permanent integration into the social welfare system in Ethiopia is of key importance to this pilot and any future integrated social protection programming. One of the key objectives of the pilot is to test the added value of SW engagement in the community and their role in facilitating demand for and uptake of social services among PSNP clients, particularly PDS households. This study deemed it important to examine perceptions of key informants about SW contributions to the pilot since their deployment to inform future policy on SWs.

Key informants expressed strong satisfaction with SW contributions to integrated service delivery and the resultant improvement in support for very vulnerable PSNP client groups. According to DAs and HEWs, although SWs operate in resource-constrained environments, their engagement adds value to programme implementation in several important ways. First, SWs effectively assist other FLWs by supporting various tasks and processes such as payment administration, CBHI registration, BCC implementation and TDS transition. This is an important contribution; however, time-intensive administrative issues could also divert SW attention and time required for other critical duties, such as case management and monitoring of co-responsibilities:

“The observed changes … were mainly due to the contributions of these FLWs. If it is not for their contributions, we cannot have any points for discussions here” (PSNP coordinator, Dewa Chefa).

“SWs are the backbone for us” (DA, Libo Kemkem).

Second, SWs facilitate information retrieval and data management. They are responsible for collecting and managing information about PSNP clients: updating their profiles, conducting needs assessments and monitoring access and uptake of services. Their designated role in managing and sharing this evidence is valued by other staff, as it improves access to better quality information and data, facilitates evidence-informed programme planning.
and monitoring, and encourages collaboration through data exchange. This is only expected to improve through scale-up of the digital MIS. The DA from Libo Kemkem explained how DAs add value to data management:

“The main reason that these problems are solved is the employment of SWs. Before their employment, the job [data collection] was performed by agriculturalists [who] see it just as a side activity.”

**The deployment of SWs has reportedly also led to better service provision, despite the notable gaps in coverage discussed in the previous section.** Through home visits, they achieve greater interaction with clients and the community. This contributes to improved understanding of clients’ needs, many of whom are socially excluded, and meeting those needs through case management:

“In the previous years they [PSNP staff] were working wrongly but now there is a SW who knows the culture of the community. One of the criteria to employ the SW is that they have to know the culture, s/he has the information about who is rich and who is indigent, who is orphan” (WOLSA officer, Libo Kemkem).

“She visits the clients’ homes and follows up their situation regularly. It is she who does much of the work […] In following up the PSNP activities, the SW’s role is big. She closely works with the community […] She goes to PDS home and identifies their problems. SW and PSNP is two sides of the same coin” (DA, Dewa Chefa).

“The existence of the woreda social and labour affairs [office] and one SW at kebele level have reduced problems. We are supporting people who may suffer by disease, people who can’t eat, who can’t move […] The beneficiaries are the DS users. These are people with disabilities, elders, those who can’t work and suffer from food shortages and the very poor. SWs are especially supportive of these people” (WOLSA officer, Libo Kemkem).

**SW outreach to PDS clients also helps to ensure their access to programme-related information and benefits, as they would otherwise miss out due to restricted mobility and low programme participation.** This finding has not necessarily been confirmed in interviews with PDS clients, underscoring the need for more in-depth research on the extent and quality of SW provision of case management to PDS clients, and entry points to maximize this link:

“Some users may be disabled and they might not be able to take payments by their own … the SWs make sure that payment reaches the intended beneficiary. Previously, a person [relative, etc.] who got the payment could give the beneficiary 50 per cent of it; or could give it all or could give some of it and hold the rest for himself, but now the SWs will go home to home and confirm whether the [full] payment reaches the intended user or not” (DA, Libo Kemkem).
Section 9
CCCs

CCCs are community-based structures established to provide support to vulnerable and extremely poor households in the community. Within the ISNP, CCCs are tasked with supporting SWs in integrated programme delivery, including assistance with retargeting indigent clients and mobilization of resources to support the poorest members of the community and PSNP clients. In this section, we discuss the perceptions of key informants regarding CCCs’ roles, capacities and provision of support to the ISNP.

9.1 Progress in CCC outreach

At baseline, the CCCs in both communities were reportedly not very functional, lacked fundraising and management skills and consequently had relatively weak outreach. In the past year, the ISNP invested in strengthening CCC capacity and informing communities about their role. This has reportedly led to improved CCC status in the community, as well as expanded outreach in the community. In Libo Kemkem, sensitization trainings facilitated by WOLSA have increased people’s acceptance of and support for CCC work. Their concrete contributions in fundraising and support for the most vulnerable members of the community have been promoted in community gatherings to strengthen people’s understanding of their value and ensure buy-in:

“CCC is not known last year, people … believed that the collected money is going to government or other things; now people are understood that CCC is providing support for indigent members of the community […] now the community asks the committee to collect the money regularly like tax, because the benefit is given for those children who lost both parents [and] suggest us to increase the payment we collect from them” (SW, Libo Kemkem).

In the past year in Dewa Chefa, ISNP staff – through financial and technical support from UNICEF – have worked to strengthen the organizational and operational capacities of CCCs in fundraising:

“The CCCs formerly were followed up by the Women and Children’s office only. But now other sectors comprising the technical committee including the [ISNP] administration are supporting CCCs. The CCCs [were] organized some five or six years back. But now they are stronger because of the commencement of an integrated approach in the [ISNP] programme” (ISNP coordinator, Dewa Chefa).

9.2 Core characteristics of CCCs

CCCs are composed of eight members including a representative from the Women and Children Affairs Office (the committee chair), the kebele administrator, the agricultural office leader, a school director, a HEW, SW and a DA. As the DA from Dewa Chefa explained, the inter-sectoral membership provides an opportunity for collaboration, joint planning and coordination of diverse ISNP activities on the ground:

“We discuss the issues under consideration and come [to an] agreement with one heart; therefore we have smooth relationship. Yes, it simplifies the workloads. Working in collaboration saves time and money. It also enriches the ideas and helps to do effective jobs.”

In both locations, the primary role of CCCs is fundraising and ensuring that material assistance (such as blankets, food and materials to repair inadequate housing) is provided to the most disadvantaged members of the community, who typically include PSNP clients and other indigent individuals. Once these resources are distributed, CCCs also visit beneficiaries to monitor their status and their use of the assistance. The following quotes illustrate the fundraising process and the profile of targeted beneficiaries, who are often marginalized and in acute need of social assistance:
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“So what we do is we try to collect grain … then change the grain into birr. Those people who can’t provide grain should provide birr. After mobilizing money, we try to identify indigent people out of PSNP beneficiaries and CBHI … who do not have any source of income, living with HIV/AIDS, disabled persons, then give support [to] them” (WOLSA officer, Libo Kemkem).

Beyond fundraising, CCCs support ISNP implementation through their assistance with (re)targeting PSNP clients. SWs and DAs rely on this support in the retargeting process. In Dewa Chefa, CCC members also reported assisting in identifying eligible clients for TDS support, while in Libo Kemkem they disseminated information about CBHI and assisted HEWs with membership renewal. CCCs add value to the implementation of these critical ISNP components through their close interaction and outreach in the community:

“We have to tell those people who have resources to be out of PSNP and make the indigent ones beneficiary of PSNP. So we have been evaluating the resource they have, identified real indigent who are approved by the community and then support those” (CCC member, Libo Kemkem).

“CCC go to the household and understand their [PLW] situation and confirm the transition [to TDS]. If she is pregnant, [the] CCC confirms the transition into TDS by checking the report from health centres” (CCC member, Dewa Chefa).

Finally, in both locations, CCCs engage with child protection issues. In collaboration with SWs, CCCs facilitate important linkage between the safety net and child protection aspects of the ISNP by addressing the socio-economic vulnerabilities of children in PSNP households. Support is often focused on children in destitute households who lack the basic means of attending school, while behavioural nudges are used to sensitize parents and children about the importance of education and delayed marriage:

“We the CCC committees divide the kebele into four villages, then the committees divide and take responsibility in each village […] After collecting money from the community … we went in the community house to house, we [identified] children who do not have clothes and evaluated [their need of assistance]” (CCC member, Libo Kemkem).

“As the CCC we are influencing the family members by saying, ‘You are receiving payment through PSNP to send your children to school.’ Thus, we are working on awareness creation so that abuse of child is reduced. Related to feeding practices … we have been teaching by saying, ‘If the child eats only once, she/he will face mental problem so they should eat three times a day.’” (CCC member, Libo Kemkem).

“We are working [with the CCC] on prevention of early marriage for students. For example, this year we have delayed the early marriage of two children” (ISNP coordinator, Libo Kemkem).

9.3 Perceived effects

The improved capacity and outreach of CCCs has contributed to several positive results. First, in both research woredas, CCCs substantially increased their mobilization of funds in the two-year period since the ISNP launch. According to the ISNP coordinator, this result was driven by good cross-sectoral collaboration and enhanced trust of the community in CCCs:

“Before the implementation of the programme the amount of money collected by CCC at Dewa Chefa woreda was 61,547 birr, but after the project [implementation] … the amount becomes 105,416 birr in 2018/2019 […] The same is true at Libo Kemkem woreda – the amount of money collected through CCC before the project was 298,708 birr, but after the programme the amount become 528,000; [it] almost doubled. Collaboration is leading to these results” (ISNP coordinator, Libo Kemkem).

However, the extent to which these budgetary increases translated into meaningful material support for PSNP clients was not clear. In Libo Kemkem, the reported scale of informal social assistance delivered to the community was relatively limited. As the following testimonials suggest, however, a systematic assessment is required to accurately establish the coverage and number of beneficiaries:
“Last year in summer season, we the committee bought plastic and repair the house of those indigent people by buying plastic for roofing [i.e., Shemo two indigent, Woyera two indigent, and Gubala around four indigent people]. […] Now there is no people who beg on the street due to the existence of CCC”

(CCC member, Libo Kemkem).

“From the community and private investors 105,416 birr [was] collected, therefore the large amount of resources may come not only from government but also from the community. By the use of such money different community members provided 3,257 different types services – for example, uniform, stationery … Around 164 elderly people [and] 155 disabled groups got support at Dewa Chefa woreda”

(ISNP coordinator, Dewa Chefa).

Second, the engagement of CCCs in fundraising has contributed to enhanced social capital through community mobilization, and improved transparency of community targeting processes. This led to increased trust and commitment in government social protection programmes. The following quotes illustrate shifts in perspectives and positive attitudes of community towards the engagement of CCCs:

“Then the community members said we were questioned why [CCCs] collect money but now we have seen that you are supporting the poor people, then they clap their hand and said God bless you” (CCC member, Libo Kemkem).

“Targeting has its own committee called ‘execution committee’ […] In the previous time people who are rich, who have land and who have relationship with kebele leader were beneficiary of PSNP but now […] they are evaluated in terms of resources they have so that those people who do not have any resource become beneficiary of the PSNP” (CCC member, Libo Kemkem).

Importantly, CCCs are leveraging sociocultural dynamics, particularly the religious custom of wealth-sharing, to mobilize community support for the poor. The ISNP coordinator in Dewa Chefa explained how the religious practice of zakat facilitates the process of fundraising:

“[The] majority of the community at Dewa Chefa woreda are Muslim and their norm/culture shows if one individual produce 100 kg, she/he has to give 1 kg for [the] indigent. This culture was there before the project implementation, but we never used it. But now we are using as social capital through mobilization. If we create awareness in the community, the community members are willing to provide support for indigent people” (ISNP coordinator, Libo Kemkem).

Finally, some gains in the domain of child protection were also reported:

“The other problem is, there was no free time for children to study. They may go and carry 20 litres water and bring to home, but now we have solved such problem. The CCC conducted monitoring and evaluation and then informed the community by saying why the children carry much without their capacity, they have to eat breakfast and go to school, they should have time to study. Due to the follow-up of CCC such problem is solved. Now the students are going to school and have time to study, have also time to play games. Now the right of children is protected” (CCC member, Libo Kemkem).

Notwithstanding these achievements, there is significant room to improve CCC operational and technical capacity, making them more sustainable and effective in improving quality of life for disadvantaged PSNP clients, as discussed in the following section. Two factors have been identified as key bottlenecks in terms of CCC capacity to support integrated ISNP service delivery. First, CCC members generally reported a lack of regular support and policy direction from woreda-level stakeholders and UNICEF. Respondents also cited a lack of monitoring and evaluation of CCC activities and outcomes, and an absence of specific focal points responsible for platform coordination, as factors limiting overall CCC impact:

“They simply organize the CCC, but no one asks about the progress we have, no monitoring and evaluation. Woreda women and child affairs are there but they didn’t conduct monitoring and evaluation. But if that was the case [proper M&E], CCC may become stronger” (CCC member, Libo Kemkem).

“This CCC has failed to address the intended activities. [They are] unclear about the tasks they need to perform” (DA, Libo Kemkem).
Second, basic gaps in operational capacity (e.g., lack of office space) as well as issues with staffing – including frequent member turnover and an absence of regular training – contribute to the erosion of CCCs’ capacity to meet regularly and function properly:

“This CCC should have legal status, the CCC should have its own stamp … We now just mobilize the money and support poor people, but we don’t build office […] if the CCC has office, it would function more” (CCC member, Libo Kemkem).

“I suggest UNICEF should continue its support up to five years. Now we are providing trainings and awareness raising. The strength of CCCs and programme achievements is due to UNICEF. The CCCs can get organized as local NGOs after getting strengthened … [and] take out the communities from dependency in a sustainable manner whether there are [other] NGOs or not” (ISNP coordinator, Dewa Chefa).
Section 10
MIS

In this section, we report on ISNP progress in establishing a digital MIS and how it is performing at midline, as well as key challenges.

10.1 Implementation progress

At the baseline stage, staff used a very rudimentary, paper-based system to collect and record client data, which limited its efficiency and quality and restricted cross-sectoral data use. It was recommended that an electronic MIS system be rolled out in treatment woredas to incorporate CBHI data in information management, and that SWs and HEWs be trained to feed data into this MIS.

The midline assessment of the MIS shows mixed progress in these indicators since baseline. After considerable delays (e.g., seven months in Libo Kemkem), a digital MIS has finally been installed at the woreda level. At midline, the MIS officers in both sites were still processing and entering data into the system. The key reasons for this installation delay are software-related technical difficulties and delayed budgets. This has reportedly led to reduced performance of data management and programme planning – particularly case management.

At the kebele level, there has been some progress in setting up the (still paper-based) administrative system for data collection. A systematized set of forms have been developed for FLWs to collect and record data on programme beneficiaries; SWs have been deployed and trained to coordinate this process and collect and share data with MIS officers. However, at the kebele level, the MIS is still not digitized, and staff continue to use the paper-based system. A DA in Libo Kemkem explained the process:

“[In order to store and exchange ISNP data,] SWs use their own phone to capture pictures to show the location and house of the clients. But for reporting and other routine activities, SWs and DA have a paper format on which we register the necessary information manually.”

Staff have also shown different levels of understanding and familiarity with the purpose and role of the MIS within the ISNP. As the PSNP coordinator from Libo Kemkem suggested, not everyone is familiar with the electronic MIS:

“I don’t know about the MIS, so I can’t say anything about something I don’t know. People from federal level came to give training to staff at labour and social affairs about MIS and they installed the software for them.”

Lack of awareness of the digital MIS is particularly prominent among FLWs in Dewa Chefa. Both HEWs and DAs were unfamiliar with the computerized system and relied exclusively on paper-based records. This is not entirely surprising given that within the scope of the pilot, UNICEF has set out to provide only MoLSA staff with a digital MIS system (computers and software) from a national to woreda level. On a positive note, those aware of the digitized MIS typically have very positive attitudes towards it. As the following quotes demonstrate, the MIS is perceived as a valuable tool that can improve programme planning and performance by enhancing data quality, access and use, across agencies and programmes, leading to improved programme and staff efficiency:

“It is new but it is very important, the case management data of 24 PSNP kebeles are available on hard copy, we are now feeding the data into computer, once we finished the data entry we can update the data when needed. It is very challenging, so the installation of MIS may make our job easy” (WOLSA officer, Libo Kemkem).

“Previously I can provide only my own data, but if MIS is working well, people at federal level can see what is going on at woreda level, it has big benefit” (ISNP coordinator, Libo Kemkem).
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The system is also perceived to add value by enabling the oversight of multiple programme components and reducing fragmentation, and by facilitating cross-sectoral coordination and case management. Although the digital MIS is yet to become operational and regularly used by programme staff, these positive attitudes are encouraging, given that staff commitment is a key precondition for the efficient uptake of new technology. A PSNP coordinator in Dewa Chefa explained how the MIS improves the work processes:

“We keep all ISNP information on MIS. It supports … or it simplifies the activities … What are the needs of the ISNP clients? Who needs what and who is referred to whom; we can simply find this issue from MIS … Knowing these, we plan our activities in collaboration with all sectors including agriculture, health and women’s affairs. MIS shows us who performed as per the plan and who did not.”

Importantly, it appears that staff at the woreda level – particularly at WOLSA – are more familiar with the digital MIS than at the kebele level, as WOLSA staff have received basic MIS training and practical exposure to the system. FLWs, particularly in Dewa Chefa, also reported lacking the basic computer skills and equipment required to use the digital MIS. A HEW in Dewa Chefa explained: “There are selected kebeles who are given tablet computers to record data; those kebeles now record every data on computer and they have been given training […] we don’t have computer-related skills and we don’t have the material as well.”

10.2 Core characteristics of the MIS

10.2.1 Roles and responsibilities

Data management is a collaborative process that involves several ISNP actors at both woreda and kebele levels. The process is managed and coordinated by the MIS officer, who is assisted by a SW. The SW is responsible for collecting client information at the individual and household levels using official MIS forms and sending these data to the MIS officer to process and code in the database. This systematized reporting is used by other relevant ISNP personnel, including DAs and HEWs, who collect data in their respective areas of work (e.g., payment records, access and uptake of health services, compliance with health-related co-responsibilities, CBHI enrolment rates). Both the MIS officer and ISNP coordinator in Libo Kemkem claimed responsibility for preparing regular reports and disseminating these to policymakers, ISNP staff at the woreda and regional levels and donors, highlighting potential overlaps in reporting duties.

10.2.2 Processing data management

The systematized reporting system (Box 2) was developed by MoLSA and includes a standardized set of forms for each client category (Form A for PDS, Form B for TDS/PLW and Form C for TDS/caregivers). There are seven forms in each set (18 total). Data are regularly collected by relevant staff, and SWs share the completed forms with the MIS officer monthly. While SWs act as the main data repository, the information is shared among FLWs to facilitate timely exchange of information and coordinated planning:

“We keep all information about PSNP clients by categorizing them as PW, PDS and TDS separately […] Both DA and HEW keep information I have about clients. The kebele should also know what exists in relation to what we do. Since we all work in PSNP our activities are interconnected” (SW, Dewa Chefa).

“With regard to information management, we are also trying to make sure that the SWs have the summary of the information we worked on. So any person who came looking for information can get access through SWs” (HEW, Dewa Chefa).

Given the discrepancy between the digitized MIS used at the woreda level and the paper-based system at the kebele level, the process of data coding has been revised from the original plans. Data coding was initially the responsibility of SWs, but given their lack of computers and tablets, this task is now handled by the MIS officer and other WOLSA staff trained in the MIS. As a result, the process is cumbersome and time-consuming, and potentially reduces data accuracy.
Box 2: Standardized MIS forms

**Form 1:** Used to fill in the initial household information (e.g., client names, family size and client category, birth date, marriage status, death, health status).

**Form 2:** Records the client profile and needs depending on the client category. For example, it specifies whether the clients need to attend ANC/PNC, receive supplementary food, receive vaccination or ensure child education, to name a few. It also records the type of co-responsibilities that apply to each case.

**Form 3:** Records client problems and needs in more depth as well as referrals to services; for example, if a child suffers from stunting, this information is recorded and necessary follow-up actions are based on this.

**Form 4:** Records school attendance of children in PDS households and whether PSNP beneficiaries stop attending school and why. WOLSA works with the education office to monitor PDS student beneficiaries based on their monthly reports derived from the 4A form. For example, after registration of these students, the SWs leave a monitoring form in the school to be completed by teachers; these data are reported to WOLSA each month.

**Form 5:** Tracks information about service provision and uptake. In particular, it records which services clients have/have not received and any other services that should be provided as part of their overall case management.

**Form 6:** Records information about specific services/visits, including the date, the service provided and any outstanding problems. The beneficiary then validates the form with their signature.
10.3 Perceived effects

Although a digital MIS has not yet been operationalized at the kebele level, current improvements in data management have already produced certain benefits for staff and programme service delivery. Perceived positive effects can be grouped across two broad areas.

First, the MIS has already contributed to improved efficiency in programme delivery. For example, since the MIS disaggregates data according to client group, specific information for each group has become more easily retrievable by woreda-level staff – including programme participation, specific support needs and access to services. Data are also disaggregated by sex, age and disability status, among other areas. This improves the breadth and quality of information that can inform project planning, whereas a unified database simplifies staff access to information and streamlines project management and monitoring. The MIS officer from Dewa Chefa described the advantages of digital data management:

“It is very good. It simplifies our jobs. It saves time. It eradicates wandering here and there to collect information. It is good if we can get all information we need in one place. […] Recording data on paper takes more time. It is difficult to copy the data of 1,762 PDS clients for example. However, it is easy in the [digital] MIS” (MIS officer, Dewa Chefa).

The MIS officer in Libo Kemkem explained that project monitoring data is continually updated, which supports the process of retargeting clients to reduce exclusion errors:

“We also update the data related to clients who are transitioning to PDS or PW … clients who are premium waiver and … clients who [are left] out from the programme (during retargeting reported by SWs) […] For example, during home visits, SWs may [see] infirm people who are not enrolled into the programme because of exclusion. In this case the SWs would document them and, during retargeting in May, these people will be considered and included in the programme” (MIS officer, Libo Kemkem).

However, data collection and circulation are still far from sufficient. The MIS officer in Dewa Chefa explained that they do not have enough information on the number of clients in each category or on CBHI coverage and suggested that data entry must be performed at the kebele level to close these gaps. The CBHI coordinator in Libo Kemkem could not always determine clients’ ISNP status due to lack of staff capacity and inadequate information sharing, and the WOLSA officer cited what appears to be a disconnect between their office and FLWs such as DAs, which has led to the creation of information silos: “WOLSA works mainly on PDS clients like elderly and disabled. Agriculture office is responsible about PW clients. We have no detailed information about PW clients” (WOLSA officer, Libo Kemkem).

Second, the MIS has facilitated integrated service delivery and case management. The MIS is perceived to add value by enabling oversight of multiple programme components, reducing fragmentation and assisting in monitoring client needs and service provision. In doing so, the MIS shows what follow-up action is needed to boost outcomes for TDS and PDS clients: “The MIS helps to identify which service is not provided to the beneficiary and it helps follow-up. It helps to prevent redundancy” (MIS officer, Libo Kemkem).

The MIS officer in Libo Kemkem provided an example of how MIS data are used to assist referral coordination across various agencies involved in different types of service provision:

“If there [is a] case management problem when we encode the data, we will report the problem we identified to WOLSA team and to SWs. For example, if the problem is related to health, there is a CBHI focal person. If the problem is related to cash transfer, we will discuss with agriculture office. Generally, we send the finding to the concerned organization” (MIS officer, Libo Kemkem).

A MIS officer from Dewa Chefa echoed this sentiment:

“If their children need education, we facilitate how they send children to schools. If they need supplementary foods, we provide them by connecting them with concerned bodies. If they need health support services, we connect them to health centres. If the problem is BCC attendance, we connect them with HEW and Das” (MIS officer, Dewa Chefa).
10.4 Challenges to implementation

Several operational challenges were identified that have adversely impacted the installation of the MIS and its application at the kebele level. First, instalment was delayed, and subsequent performance of the database has been plagued by technical difficulties and software malfunctions. The MIS officer from Libo Kemkem described the challenges encountered in their application of the MIS:

“Sometimes the MIS software stopped working. After the MIS was set up, the database was not working offline … there was [data] duplication … But now it is adjusted” (MIS officer, Libo Kemkem).

“On the MIS software … we can’t identify who is indigent or [able to pay] for CBHI” (MIS officer, Libo Kemkem).

Second, paper-based data collection at the kebele level hinders the quality and accuracy of data management. Staff have also complained of irregular and inadequate supply of materials and equipment to record and store the data safely. In some cases, as described by the SW in Dewa Chefa, the risks of paper-based filing can lead to lost data: “Paper can be lost, or it can be easily damaged. If we lose the data of our clients, it is difficult to accomplish our activities. For example, the notebook I use for data keeping was eaten by rats two times. It is good if they avail computer for MIS purpose [so] this kind of problem does not happen” (SW, Dewa Chefa).

Such issues underscore the urgency of establishing a digital MIS at the kebele level and training staff to use it effectively. Some key informants suggested that tablets or even smartphones would be an improvement for data collection: “I recommend to distribute tablet or smartphone to SW to [record] the data … or upload the MIS application on their own smartphone to send their data easily and we can take the data from the application easily” (MIS officer, Libo Kemkem).

However, in Dewa Chefa, the absence of regular access to electricity limits the prospects of establishing a digital MIS in the near future: “The big problem we have is network problem. If the server here is working we can easily send or share information to regional or national level. But now we use [encrypted] flash discs to share information” (MIS officer, Dewa Chefa).

Finally, it was highlighted by the MIS officer that MIS design must consider local circumstances, including the spoken language and staff constraints, as well as ensuring ease of use: “The other thing is we have forms prepared in English language. If we send this format to SW, they cannot understand English language. When we translate this format, it takes much time. We have reported this to region” (MIS officer, Dewa Chefa).
Section 11
Programme sustainability

In this section, we briefly examine key informants’ perceptions about ISNP sustainability in the long term. In particular, we asked respondents to share their views on the future of the programme and its integrated programming approach, and to identify key factors that will affect its sustainability. We also unpack the perceived long-term effects that the ISNP and its systems-strengthening agenda may have on clients and the broader community.

11.1 Perceived sustainability of the programme

The ISNP pilot aims to test several design and implementation innovations and strengthen the system for integrated service provision. When asked how they see the long-term future of the system being built through the pilot, respondents shared a variety of perspectives. Some consider the ISNP to be successfully building integrated and collaborative ways of working, which will continue beyond the pilot. A DA in Libo Kemkem shared his positive observation:

“Based on our belief and our current observations of the programme progress [it is] … likely to be expanded and sustained. Based on our view, the collaboration created by the ISNP will continue. We the frontline staff would meet only during kebele meeting and even we didn’t know each other before the start of ISNP. But now the ISNP let us to know each other and be close enough in all activities at the kebele. So, this integration will also help to sustain the programme.”

Cross-sectoral collaboration is seen as a critical factor for sustaining integrated programming, but further efforts are needed to strengthen collaboration across key agencies going forward. A PSNP coordinator in Dewa Chefa explained: “My worry is that if we fail to work on collaboration issues to strength it more, the collaboration we are talking now may get collapsed or discontinued.”

Others highlighted the critical need for MoLSA to take stronger ownership of its responsibilities to oversee the welfare of PDS clients. According to the PSNP coordinator in Libo Kemkem, sustainability of the innovative aspects of the PSNP programme rely on the capacity of MoLSA to independently manage its mandate regarding PDS clients. However, although the ministry was said to be invested in running the programme, it is currently not taking full responsibility for the work and instead imposes its tasks on others. The PSNP coordinator shared his concerns on this point:

“The other thing is the labour and social affairs office had a mission to work independently […] but it is still not implemented, and the programme is still dependent. At the start of the programme, labour and social affairs and the district administration had no knowledge of the programme. So we gave them everything by helping them learn how to do the programme consistently. It seems now that they have created some capacity and want to run it on their own […] but I do not believe that, with the way they are currently working, they can do it well […] They should take on the responsibility for the work on PDS management rather than just throwing the load onto others and taking all the benefits to themselves.”

For most respondents, permanent deployment of SWs is the key to programme sustainability; however, the future of SW outreach is strongly dependent on government commitment and financial capacity to fund this cadre of key workers and scale up the pilot. Views differed as to whether there is the political will and fiscal space to continue with the integrated programme and facilitate permanent engagement of SWs:

“We are working to make the project sustainable. The main objective of this project is to promote the activity of the project to the government and influence [it] to take [it] over … But I suggest that the project should convince the government to employ the SW permanently […] The job of the SW is greater than DA and HEWs” (WOLSA officer, Libo Kemkem).
Improving Children’s Health and Nutrition Outcomes in Ethiopia

“The programme will be sustainable at woreda level because they told me that they can make the programme sustainable by allocating their own budget” (ISNP coordinator, Libo Kemkem).

“In my opinion, the project will not be sustainable. When we went to woreda level for training, we were asking … if the project phase out what do they do about the SW. They told us they don’t have a budget” (CCC member, Libo Kemkem).

Respondents also suggested that UNICEF should continue its support to ensure the programme is scaled up to respond to client needs and sustain good practices in future:

“If this programme is out, we mobilize and support the poor people, the CCC committee will not stop their work, but it is very difficult to give support for all indigent people at Shemo kebele with CCC money. […] The economy is decreasing from year to year, CCC may [try to] continue its function, but it is not feasible. If the UNICEF programme is out … other organization … must come to give support … [or] the community will face problems” (CCC member, Libo Kemkem).

11.2 Perceived long-term impacts on the community

Respondents also had mixed perceptions about sustaining the programme’s impacts. For some respondents, the ISNP affected change in client knowledge and understanding of key issues related to their health and nutrition. This is expected to lead to sustainable changes in practices, as well as benefits for clients and communities that will extend beyond the duration of the ISNP. For example, consider this view from the SW in Dewa Chefa:

“I think the community continues to behave properly even if the programme discontinues. For example, we have taught them on nutrition, and since the community has got awareness on it, I do not think the community discontinues the practices. In addition, since the community understood the benefit of the CBHI, I do not think the community will abandon it whether PSNP exist or not.”

Others were less positive. While some shared concerns about the programme phasing out before achieving the necessary coverage and resilience of clients and community, others worried that the safety net creates dependence on government support. To avoid household reliance on external help, FLWs advise people to build their livelihoods and human capital to overcome poverty:

“Many people developed dependency syndrome. They totally depend on PSNP as if it continues for long” (SW, Dewa Chefa).

“I believe giving direct cash for years does not change clients’ economic state but, if the programme give support, for example support on crop production, support on fertilizer [at] the right time, the clients can get adequate product in annual [basis] and change their economic level […] they will be ready to leave the programme and support themselves” (DA, Libo Kemkem).

“In the year to come, we hope the PSNP continues, but we are telling our people that projects cannot sustainably help till the life ends, and we have to be independent” (SW, Dewa Chefa).
Section 12
Summary of key challenges and lessons learned

In this final section, we summarize the key institutional and operational challenges encountered in programme delivery across the ISNP and its various programme components. We highlight various supply- and demand-side bottlenecks that will need to be addressed to improve ISNP performance in the future. In Section 12.2, we synthesize the key findings across the OECD-DAC evaluation criteria (OECD & DAC Network on Development Evaluation, 2019), including how the pilot is meeting the objectives of programme efficiency, effectiveness and sustainability, focusing both on the process of implementation and the intermediary results.

12.1 Key challenges and bottlenecks

We have identified various supply- and demand-side challenges and bottlenecks encountered in programme delivery that diminish its effectiveness, and hinder client demand for and participation in the scheme. Some of these have already been discussed in previous sections, and are synthesized here.

Staffing issues

Staff deployment and work burdens: Budgetary shortages were widely cited as having an impact on programme staffing, namely in providing sufficient FLWs (particularly HEWs and SWs in Dewa Chefa). As a result, these staff face heavy work burdens and competing priorities, as ISNP-related tasks must be shouldered in addition to a wide range of routine work duties. This leaves staff overstretched and often only sporadically available to ISNP clients, who cited resultant adverse impacts on the availability, consistency and quality of programme service provision.

The need to overextend existing staff to fulfil critical aspects of programme operation has been reported as a key factor hindering effective implementation of CBHI promotional and registration activities, execution of adequate case management (particularly in Dewa Chefa) and monitoring of co-responsibilities. Motivation and interest were referenced as important determinants of staff presence and effectiveness; however, excessive work pressure was said to deplete staff commitment, focus and time for ISNP activities, with critical implications for client health and well-being. One key informant explained that because FLWs already have specialist responsibilities outside of the programme, ISNP tasks can be considered a side activity.

These multiple and competing responsibilities are also a cause of frequent staff turnover, particularly when combined with poor working incentives such as low pay, meagre benefits and the irregular or temporary nature of SW contracts. This in turn results in disruption to project delivery, undermined staff investment and erosion of efforts towards sustainable development of human resources – with significant implications for institutional capacity.

Staff capacity deficits: Inadequate staff training opportunities are also associated with budgetary shortages, and lead to low staff capacity, commitment and performance. Although there is a continuous need to strengthen functional and technical capacities of key FLWs (particularly SWs), a lack of resources was cited as a key constraint to meeting their training needs. Some staff showed critical knowledge gaps regarding TDS, CBHI enrolment, co-responsibilities and BCC; as a result, clients were sometimes left unaware of their entitlements and responsibilities.

Staffing structure and clarity: Although staff coverage and coordination have generally improved, issues remain that pose problems for programme delivery. First, some focal point roles are missing from the current programme structure, such as a kebele-level ISNP coordinator, CBHI promoter and specific focal points responsible for CCC platform coordination. Second, although the ISNP staffing structure is reportedly well defined, clear delineation and demarcation of roles and responsibilities of key personnel is sometimes lacking. In some cases, staff mandates and roles overlap (e.g., both HEWs and SWs are involved in assessing clients’ needs for case management, TDS transition and CBHI enrolment). This leads to coordination issues and potential gaps and inefficiencies in implementation of the protocols.
Operational funding

Limited or delayed budgets have impacted allocation and procurement of resources and materials necessary for programme implementation. This extends not only to basic administrative materials (such as printers, paper, computers and tablets), but also infrastructure such as physical offices for SWs – the absence of which has reduced the potential for collaboration and interaction between service providers and jeopardizes the capacity of SWs to effectively store and manage project data, particularly as most kebele-level data remains paper-based.

Operational budgets have also been cited as too low to allow for adequate implementation of CBHI promotion or supervision activities. BCC execution is also insufficient due to low financial capacity for hiring facilities and managing activities; training duration has also been reduced to cut costs. An inability to purchase refreshments or small gifts for trainees may also explain why BCC participants are not incentivized to attend. Finally, PSNP payments do not go far enough in assisting the poorest families to invest in livelihoods and food production but mainly basic food provision. Therefore, the additional costs associated with obtaining healthcare and education (transport and opportunity costs, appropriate clothing/books for school) often leave clients unable to fulfil co-responsibilities.

Cross-cutting issues

Poor staff knowledge and communication: Many clients had significant gaps in their understanding of the ISNP, which largely emerged from administrative failures, lack of clear communication from staff or terminological confusion. The shortcomings in staff understanding of and ability to convey critical programme information may be caused by poor training, low commitment or overwhelming workloads, among other issues. As a result, the CBHI enrolment and reimbursement processes were sometimes viewed as confusing or difficult. With regard to TDS transition for PLW and carers of malnourished children, there was a general lack of understanding among some clients (and in some cases, FLWs) about the process, time period and eligibility, leading to gaps and delays in transition.

Political commitment: Political will and leadership are critical to setting the programme’s direction and incentivizing staff to perform well. Staff turnover and shortages are partly the result of political reshuffles and associated staff transfers, and most respondents viewed the permanent deployment of SWs as strongly dependent on government commitment and financial capacity to take over and scale up the pilot.

Geographical terrain and transport: Difficult terrain and roads are key obstacles to programme delivery and monitoring, particularly in Dewa Chefa, as they impair the ability of HEWs and SWs to make regular home visits. Some clients were so geographically remote and lacking in contact with DAs and other ISNP staff that they simply had no information about the programme.

Attitudes/cultural and gender norms

Various attitudinal barriers stand in the way of programme participation in target populations. Women face deeply rooted gender and sociocultural barriers that often impede their mobility and ability to access healthcare or attend meetings or PW. Women in Libo Kemkem explained that they were largely unable to attend BCC sessions due to the time constraints and significant work burdens associated with their gender roles. However, in Dewa Chefa, women’s lives are often much more restrictive. Religious and cultural beliefs often prohibit their participation in public meetings, PW and – most critically – prevent access to reproductive healthcare in public facilities. Such limitations severely diminish their channels for acquiring critical information (through BCC attendance, health centre visits with HEWs or interaction with DAs) about CBHI, child and maternal health, nutrition and hygiene, transition into TDS and their co-responsibilities.

With regard to CBHI, the majority of clients are aware of its benefits. However, negative attitudes and misconceptions towards the CBHI stem from cultural beliefs related to management of risk, which can reduce willingness to enrol, even among those with the financial capacity to do so. Reluctance to join the health insurance scheme was also partly driven by the supply-side constraints in the health system and acute lack of available drugs in public facilities, forcing clients to purchase medicines at private pharmacies, increasing their out-of-pocket expenditure.
Table 3: Summary of progress at midline and lessons learned

<table>
<thead>
<tr>
<th>Overall progress since baseline</th>
<th>Efficiency</th>
<th>Effectiveness</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Integration and cross-sectoral collaboration</strong></td>
<td><strong>Progress status</strong></td>
<td><strong>Improvements</strong></td>
<td><strong>Observable change</strong></td>
</tr>
<tr>
<td></td>
<td>Good progress in cross-sectoral collaboration and coordination at regional and woreda level</td>
<td>Staff have solid understanding and commitment to ISNP objectives, components and integrated service delivery</td>
<td>Reduced fragmentation across programmes and agencies</td>
</tr>
<tr>
<td></td>
<td><strong>Drivers of change</strong></td>
<td>Collaboration stronger among FLWs and at woreda level</td>
<td>Strengthened FLW collaboration has improved service delivery</td>
</tr>
<tr>
<td></td>
<td>Efforts to address attitudinal barriers to collaboration and raise awareness of different actors’ roles and responsibilities (via training, cross-sectoral coordination platforms and protocols)</td>
<td>Collaboration overlaps, missing coordination focal points, lack of fieldwork budgets and joint trainings</td>
<td>Improved procedures and processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor working conditions and competing work priorities</td>
<td>Harmonized targeting and improved fee-waiver coverage for PDS clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collaboration insufficient at regional level</td>
<td>Strengthened collaboration between SWs and DAs led to timelier/more predictable client payments, enhanced consumption and economic security</td>
</tr>
<tr>
<td>ISNP delivery</td>
<td>Progress status</td>
<td>Improvements</td>
<td>Observable change</td>
</tr>
<tr>
<td>--------------</td>
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<td>------------------</td>
</tr>
<tr>
<td></td>
<td>Mixed progress overall with variations across locations and components</td>
<td>Dewa Chefa generally on track and in some areas surpassed targets</td>
<td>Improved efficiency in fee-waiver targeting led to increased CBHI coverage/enrolment</td>
</tr>
<tr>
<td>Drivers of change</td>
<td>Investment in delivery infrastructure, coordination systems, staffing and regular reviews</td>
<td>Libo Kemkem implementation more irregular and inconsistent due to operational and political issues</td>
<td>Quality, timeliness and fidelity of implementation varies across programme components</td>
</tr>
<tr>
<td>Bottlenecks</td>
<td>Transportation, budget and staff shortages undermine outreach and field visits and erode performance</td>
<td>Substantive delays in MIS instalment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff roles and responsibilities</th>
<th>Progress status</th>
<th>Improvements</th>
<th>Observable change</th>
<th>Efforts required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mixed (or fair) progress in improving staffing policies and efforts to strengthen human resources</td>
<td>Growing awareness of various actors’ roles and responsibilities</td>
<td>Staff coverage and coordination have improved, leading to improved programme delivery</td>
<td>Reduce overlap of some roles and mandates</td>
</tr>
<tr>
<td>Drivers of change</td>
<td>Building capacity and understanding of key staff roles</td>
<td>Improved staffing allocations and strengthened staff capacity</td>
<td></td>
<td>Establish missing staff positions</td>
</tr>
<tr>
<td>Bottlenecks</td>
<td>Promotion of effective cross-sectoral collaboration</td>
<td>Work burdens and competing priorities among FLWs result in limited availability to clients</td>
<td></td>
<td>Improve working conditions (benefits, pay)</td>
</tr>
<tr>
<td></td>
<td>Overlap leads to coordination issues and resultant gaps/inefficiencies in implementation</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
### Implementation of specific programme components

<table>
<thead>
<tr>
<th>CBHI</th>
<th><strong>Progress status</strong></th>
<th><strong>Improvements</strong></th>
<th><strong>Observable change</strong></th>
<th><strong>Efforts required</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good progress in PSNP/CBHI integration</td>
<td>Improved procedures through development of common targeting systems and improved accuracy of data registries and targeting methods</td>
<td>High enrolment among PDS clients</td>
<td>Community commitment and improvement in targeting processes for fee waivers must continue after ISNP</td>
</tr>
<tr>
<td></td>
<td>Drivers of change</td>
<td>Reduced waiting times for IDs and CBHI access due to improved registration and enrolment process</td>
<td>Strong impacts on health-seeking behaviour and timely access to healthcare</td>
<td>Swifter expansion of CBHI coverage (among fee-paying members) to subsidize waivers for most vulnerable and maintain/expand CBHI</td>
</tr>
<tr>
<td></td>
<td>Improved policies and protocols for harmonized targeting campaigns to enhance buy-in for the expansion of fee waivers</td>
<td>Expanded channels and frequency of promotional activities</td>
<td>Increase in demand and frequency of health visits, resulting in better prognosis and health outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good collaboration between HEWs and SWs</td>
<td>Universal free access to CBHI among PDS clients in both woredas; fee-waiver eligibility and access expanded to other clients</td>
<td>Reported improvements in capacity to mitigate catastrophic health expenditure and negative coping strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bottlenecks</td>
<td>Enrolment expansion among PW clients lagging</td>
<td>Savings redirected towards other essential expenditure, boosting impacts of cash</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staffing issues, low budgets for promotion and supervision activities</td>
<td>Indirect effects include positive changes in mental health (reduced stress and anxiety from greater economic security) and shifts in targeting transparency led to greater trust in government</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibitive premium costs, negative perceptions of health insurance, client registration/logistical issues</td>
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</tbody>
</table>
## BCC

### Progress status
- No progress reported

### Drivers of change
- Irregular implementation due to sociocultural/gender barriers in Dewa Chefa; budget issues and instability in Libo Kemkem

### Improvements
- Clients generally well exposed to nutrition- and health-related messages delivered by SWs and HEWs
- TDS clients are most involved in BCC, followed by PW clients

### Bottlenecks
- Delivery weak and inconsistent
- Staff not fully familiar with BCC content, expected timing and frequency
- Gaps in client awareness and attendance (especially in Dewa Chefa)
- Staffing issues such as language barriers and budgetary constraints to deliver regular sessions
- Gender barriers (women lack time and authority to attend public meetings)

### Observable change
- Some evidence that advice improved knowledge of dietary diversity and led to changes in food consumption and child-feeding practices
- Increased skill in food production and gains in income led to better diets and food intake
- Hygiene and sanitation education led to improved knowledge and observable impact on child illness
- Health messaging led to greater fulfillment of co-responsibilities and increased demand for ANC/institutional delivery with implications for maternal and child survival outcomes
- Unintended increase in family planning

### Efforts required
- As a feature of PSNP, BCC must remain in place after pilot is phased out
- Improvements in BCC delivery to maximize potential for sensitization efforts to shift behaviour and practices
- Continued deployment of SWs and strengthened collaboration with FLWs to ensure access to info/advice among marginalized clients
- Changes in health and nutrition practices require sustained, quality, long-term investments in BCC; staff need capacity to deliver modules properly
<table>
<thead>
<tr>
<th>Co-responsibilities</th>
<th>Progress status</th>
<th>Improvements</th>
<th>Observable change</th>
<th>Efforts required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>Fair to good progress in implementation of co-responsibilities</em></td>
<td><em>Clients demonstrated solid compliance with co-responsibilities</em></td>
<td><em>Combination of co-responsibilities and provision of information led to greater demand for healthcare among women</em></td>
<td><em>As a feature of the PSNP, co-responsibilities must remain in place after the pilot is phased out</em></td>
</tr>
<tr>
<td><strong>Drivers of change</strong></td>
<td></td>
<td><em>Information/literacy gaps leave clients unfamiliar with requirements</em></td>
<td><em>Contributed to increased school enrolment and reduced child labour</em></td>
<td><em>Adequate staff capacity and resources to deliver component efficiently</em></td>
</tr>
<tr>
<td></td>
<td><em>Improved staff capacity for delivering co-responsibilities</em></td>
<td><em>Female clients had limited ability to fulfil co-responsibilities and access healthcare due to distance, terrain/transportation challenges and religious/cultural beliefs, etc.</em></td>
<td><em>Contributed to broader attitudinal shifts regarding the value of education</em></td>
<td><em>Increased ability to address demand-side barriers to adherence</em></td>
</tr>
<tr>
<td></td>
<td><em>Deployment of SWs to encourage and monitor compliance</em></td>
<td><em>Indirect costs of using health and education services</em></td>
<td></td>
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</tr>
<tr>
<td>Transition into TDS</td>
<td>Progress status</td>
<td>Improvements</td>
<td>Observable change</td>
<td>Efforts required</td>
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<td>-------------------</td>
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</tbody>
</table>
|                   | *Mixed progress* in implementation of TDS transition | - Protocols have improved staff capacity and coordination for screening and referring eligible clients to TDS  
- Clients more aware of entitlements | - Exemption from physical labour improves maternal and child health  
- Reduced work burden and greater time available for self-care, child nutrition and healthcare, co-responsibilities  
- Benefits for mothers’ mental and physical health  
- Caregivers of malnourished children reported improved access to treatment and better food consumption and childcare | - Improved awareness, capacity and coordination of key FLWs to institutionalize this component  
- Permanent employment of SWs to act as liaisons between TDS service providers and clients |

**Drivers of change**
- Strengthening of transition protocols  
- Improvement in procedures  
- Improvement in staff capacity to identify and transition clients  
- Strengthened staff coordination in managing referrals

**Bottlenecks**
- Protocols remain complex and arbitrarily applied  
- Overlaps in targeting responsibilities result in potential gaps and inefficiencies  
- Sociocultural barriers and women's restricted participation in PW limits uptake of TDS  
- Gaps in clients’ knowledge of TDS  
- Hidden conditions imposed by staff expose women to risk of exploitation
<table>
<thead>
<tr>
<th>Case management</th>
<th>Progress status</th>
<th>Improvements</th>
<th>Observable change</th>
<th>Efforts required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good progress in implementation of case management</td>
<td>Staff have solid understanding of case management purpose, objectives and processes</td>
<td>Better staff coordination and improved service delivery</td>
<td>Increased commitment and demand for case management and institutionalization into PSNP</td>
</tr>
<tr>
<td></td>
<td>Drivers of change</td>
<td>Identification and referral of clients to appropriate services</td>
<td>Better data management/sharing</td>
<td>Strengthened collaboration, institutionalization and uptake of digital MIS</td>
</tr>
<tr>
<td></td>
<td>Investment in staff capacity via training</td>
<td>Resolved administration bottlenecks</td>
<td>Some progress in use of digital MIS at woreda level</td>
<td>Greater SW capacity, resources and permanent involvement in PSNP</td>
</tr>
<tr>
<td></td>
<td>SWs and HEWs deployed</td>
<td>MIS installed for needs assessment and referral management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MIS installed for needs assessment and referral management</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Bottlenecks</td>
<td>HEW/SW overlap in screening/needs assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paper-based data management erodes quality and efficiency of data exchange, planning and monitoring</td>
<td></td>
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<tr>
<td>Access to FLWs</td>
<td>Progress status</td>
<td>Improvements</td>
<td>Observable change</td>
<td>Efforts required</td>
</tr>
<tr>
<td></td>
<td>Mixed progress in availability of and access to HEWs and SWs</td>
<td>In Libo Kemkem nearly all clients received support from HEWs and SWs</td>
<td>FLWs make critical contributions to integrated programming and improve clients’ access to services</td>
<td>Deployment and permanent integration of SWs into system; this depends on government commitment and financial capacity to take over and scale up the ISNP</td>
</tr>
<tr>
<td></td>
<td>Drivers of change</td>
<td>Notable disparities between woredas in presence and availability of FLWs</td>
<td>SW engagement has positive spillover to the performance of other FLWs (via support in various tasks and processes)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SW and HEW outreach through home visits</td>
<td>Improvements to service provision outreach have improved interaction and case management of clients</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Bottlenecks</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>CCCs</td>
<td>Progress status</td>
<td>Improvements</td>
<td>Observable change</td>
<td>Efforts required</td>
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<tr>
<td></td>
<td><em>Good progress</em> in terms of improved status and capacity to mobilize funds and community outreach.</td>
<td>Improvement in CCC capacity to mobilize funds and engage in community outreach.</td>
<td>More transparent and efficient targeting successfully used to identify clients eligible for fee waivers and social assistance.</td>
<td>Ongoing training and capacity-building efforts to improve mandates, structure, technical and functional skills to enhance operations and outreach.</td>
</tr>
<tr>
<td></td>
<td><em>Drivers of change</em></td>
<td>Awareness-raising efforts have strengthened community support and understanding of CCCs.</td>
<td>Transparent mobilization and distribution of funds increased trust in government programmes and enhanced social capital.</td>
<td>Incentives and policy support to reduce staff turnover and build commitment and motivation.</td>
</tr>
<tr>
<td></td>
<td><em>Bottlenecks</em></td>
<td>Lacking support and policy direction from woredas and UNICEF.</td>
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<td></td>
<td>Lacking regular M&amp;E.</td>
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<td></td>
<td>Lacking focal points for coordination of roles and activities at kebele level.</td>
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<tr>
<td></td>
<td>Scale of support and social assistance provided to PSNP clients is limited despite a substantial increase in funds.</td>
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<tr>
<td>MIS</td>
<td>Progress status</td>
<td>Improvements</td>
<td>Observable change</td>
<td>Efforts required</td>
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<tr>
<td></td>
<td>Limited progress in the establishment of a digital MIS</td>
<td>Standardized forms created to collect and coordinate data on different client categories</td>
<td>Improvements in data management, quality, access and use, leading to better planning processes and enhanced programme performance</td>
<td>Confirmation of MIS contribution to programme delivery and performance may strengthen political and staff commitment to its use and sustained integration within the PSNP</td>
</tr>
<tr>
<td>Drivers of change</td>
<td>SWs engaged and trained to collect, manage and share data</td>
<td>Digital MIS installed with substantive delay; data are still processed at kebele level and FLWs rely on paper-based data</td>
<td>Facilitation of project and case management, implementation and monitoring led to improved programme efficiency and budget use</td>
<td>Capacity must be built to optimize use of digital MIS (staff skills, access to equipment and electricity)</td>
</tr>
<tr>
<td></td>
<td>Delayed budgets and software malfunction led to delays in digital MIS implementation and use</td>
<td>Many staff lack basic skills and equipment to use digital MIS</td>
<td>Disaggregated data are more accessible and retrievable, which simplifies, streamlines and improves breadth/quality of info</td>
<td></td>
</tr>
<tr>
<td>Bottlenecks</td>
<td></td>
<td></td>
<td>MIS assists case management and identifies necessary follow-up action to boost outcomes</td>
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<td>Better oversight of multiple programmes and reduced fragmentation</td>
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Section 13
Conclusions and key recommendations

This study aims to assess the performance of the ISNP pilot and its individual components one year after its launch, and to document early observable changes in client well-being. In this final section, we provide a summary of key research findings across the three evaluation criteria – efficiency, effectiveness and sustainability. We also provide a set of recommendations to improve programme delivery and future impacts.

13.1 Conclusions

13.1.1 Programme efficiency

There have been positive strides forward in ISNP implementation, which is generally on track, with some programmatic targets achieved earlier than expected. Since baseline, there has been considerable investment in building a system to ensure smooth implementation and deliver integrated services to clients more efficiently. This has entailed: the strengthening of institutional structures (shifting ownership to MoLSA and deploying SWs); building closer institutional ties between agencies and programmes; improvement of implementation processes and administrative protocols, such as common targeting for CBHI fee waivers and data management; and enhancement of FLW capacity through joint training and resource commitments.

These gains reflect programmatic innovations of the ISNP that were, in part, built on lessons learned from previous pilots within the PSNP such as the Improved Nutrition through Integrated Basic Social Services and Social Cash Transfer Pilot Programme (IN-SCT) conducted in the Oromia and SNNP regions between 2015 and 2018 (Gilligan et al., 2019). An evaluation of the IN-SCT found uneven gains, in part due to gaps in delivery and budgetary and supervisory problems, which kept SWs from being able to travel to communities to carry out their duties. In addition, the evaluation found that small transfers and delays in PSNP payments further inhibited programme impacts, which led to the IN-SCT having very few impacts on child nutrition outcomes. Building on these lessons learned, the ISNP has improved budgetary support and delivery systems, which have resulted in more efficient integration in planning, outreach and monitoring of activities, thereby improving the use of resources and overall programme performance. Strengthened linkage between clients and service providers has also led to positive changes in relevance, timeliness and quality of service delivery.

Several efficiency gains were achieved related to specific programme components. Coordination between the PSNP and CBHI has improved since baseline. The introduction of clear policy guidelines for fee waivers and common targeting criteria has resulted in free universal CBHI enrolment for PDS clients. There has been fair progress in the delivery of TDS in the past year. Efforts have been made to strengthen transition protocols for TDS, improve coordination procedures and staff capacity to identify and refer eligible clients, and improve women’s awareness of TDS provisions to increase demand.

Management of co-responsibilities and client compliance has also been progressing well. This was mainly due to improvements in the TDS transition process for PW clients, engagement of SWs and HEWs to impart the importance of co-responsibilities, and more effective use of case management to monitor compliance.

At the same time, the midline assessment uncovered shortcomings in performance of the pilot. For example, the ISNP has not met the expected level of progress in enrolling PW households into CBHI. Prohibitive premium costs, gaps in understanding and misconceptions about CBHI, and high indirect costs of drugs were identified as key bottlenecks to PW clients’ enrolment and renewal. BCC interventions suffered from irregular and weak delivery, leading to gaps in client awareness and relatively limited participation of TDS clients. Delays in MIS instalment have reportedly reduced the performance of data management and programme planning – particularly case management and monitoring.
With regard to service linkage, clients reported reasonable improvements in access to health and education services. However, several bottlenecks undermined demand and uptake of complementary benefits. On the supply side, **TDS procedures used to identify and refer clients remain complex and somewhat arbitrary.** FLW roles and responsibilities also continue to overlap in practice, leading to potential gaps and inefficiencies in protocol implementation. **Staffing issues and logistical and budgetary constraints hamper regular monitoring of activities, thereby undermining implementation of BCC and co-responsibilities.**

In addition, **some clients continue to be unaware of their programmatic entitlements and responsibilities or have misconceptions of how they work, indicating a problem in FLW communication of programme expectations.** Such gaps lead to delays in TDS transition and limited access to service referrals.

On the demand side, women's awareness of, demand for and access to TDS and BCC tend to be limited by discriminatory social and gender norms, which constrain their mobility and participation, delay or prevent access to TDS, and limit their ability to seek healthcare. Religious and cultural beliefs (as well as male pressure) particularly in Dewa Chefa prevent women from freely accessing BCC and reproductive healthcare in public facilities. Access to services is also restricted due to transport costs, problematic roads and distance to health centres, PW sites and pay points.

### 13.1.2 Programme effectiveness

While it is too early to detect the impact of the ISNP on health and nutrition outcomes, there are positive indications of its effectiveness across several domains. Client participation in CBHI has led to a significant increase in health-seeking behaviour, particularly among PDS households. Free access to insurance has also enabled clients to avoid catastrophic health expenditure and redirect PSNP payments towards other essential consumption, thereby boosting the impact of the cash payments.

The combination of BCC, individual counselling and access to services via co-responsibilities has led to positive changes in knowledge about dietary diversity, personal hygiene and healthy living environments. In some cases, improved knowledge and attitudes have led to changes in carer behaviour and infant care and feeding practices, greater food consumption and better hygiene practices. The combination of co-responsibilities and the provision of health- and nutrition-related information has reportedly led to some improvements in women's demand for ANC, PNC, institutional delivery and child vaccinations. Co-responsibilities have also been associated with increased school enrolment and reduced child labour.

**Many benefits of TDS transition were reported, including improvement in women’s mental and physical well-being and increased time available to comply with co-responsibilities and seek nutrition-related ANC.** These outcomes were particularly significant for caregivers of malnourished children, who reported improved ability to seek timely treatment and complementary support, with subsequently better care and food intake for their children.

**The pilot has also resulted in a range of unintended, positive effects.** Greater economic security and access to services have had important psychological benefits for PSNP clients, particularly PDS households, including reduced stress and anxiety and greater hope for the future. Greater targeting transparency has increased community trust in local administrations and support for government-run social protection programmes. Regular messaging about the value of education and gender equality has facilitated attitudinal shifts towards education – increasing enrolment and retention of students and, in some cases, creating broader shifts in gender norms and attitudes towards women’s work burdens and healthcare.
Several programme pathways have been identified as key facilitators of these intermediary outcomes. First, although SWs and HEWs operate in resource-constrained environments, they are critical intermediaries between the ISNP and its clients. Through community outreach, they gain improved understanding of how best to meet client needs and generate uptake of services. PLW respondents cited HEWs and SWs as their primary sources of information about nutrition and maternal and child health, while SW case management for PDS households has made services accessible to communities’ poorest and most marginalized groups.

Second, the channels used to deliver information and support matter. Linking informational sessions and advisory support to health centre visits (as a co-responsibility) has been a successful means of reaching vulnerable mothers and children and improving their health outcomes. Home visits are also critical opportunities to teach, advise and motivate clients to adopt and sustain positive practices – and to screen clients eligible for TDS.

Finally, there is evidence that cash transfers work in synergy with co-responsibilities and CBHI. Cash helps to alleviate financial burdens that necessitate sending children to work rather than school and enables PW clients to enrol (or renew) CBHI membership. However, delays in PSNP transfers diminish their capacity to pay and/or renew membership fees. Transfers do not go far enough to assist the poorest families with the indirect costs of obtaining healthcare or education. To maximize the effects of cash plus, core transfers must be adequately sized and delivered regularly.

13.1.3 Programme sustainability

Finally, there are mixed findings regarding the pilot’s sustainability – in terms of the full establishment of an innovative system for integrated service provision, as well as the pilot’s long-term impacts. When considering its establishment over time, there is a general view that the government has demonstrated some commitment to taking over the programme once the pilot phases out. The ISNP has been successfully building integrated implementation processes and mechanisms as well as collaborative ways of working, which are likely to continue beyond the pilot.

Greater efforts are required for MoLSA to take stronger ownership of PDS client welfare, and to permanently embed SWs into Ethiopia’s social welfare system; however, views differ as to whether there is the political will and fiscal space to continue the integrated programme or facilitate the permanent engagement of SWs. Moreover, slow expansion of CBHI coverage among PW households and the larger community is a concern, as this may hinder overall CBHI sustainability and the state’s ability to subsidize fee waivers for its poorest members.

Key informants generally felt it was too early to determine whether programme impacts and benefits would be sustained over time, as changes in health and nutrition require long-term investments. So far, the ISNP has effected changes in client knowledge and understanding of key issues related to their health and nutrition, which are expected to lead to sustainable changes in practices over time. Nevertheless, shortcomings in delivery of various programme components, and gaps in client participation, undermine the scale and magnitude of positive changes and restrict the potential for sustaining impacts in future.
13.2 Recommendations

The following specific actions and recommendations are proposed to address various implementation bottlenecks and challenges to improve the future performance and impacts of the ISNP and PSNP.

**Actions to strengthen ISNP implementation:**

- Undertake a thorough review of previous trainings delivered to ISNP personnel to assess learning outcomes and identify future training requirements. Provide refresher trainings targeted at the right personnel to strengthen their technical and functional skills, with particular focus on knowledge of the BCC modules, case management and CBHI registration.

- Establish focal points at *kebele* level, to better coordinate FLWs. Provide resources for technical committees to engage in more active monitoring of ISNP progress and to facilitate joint work across programmes and agencies.

- Provide more technical and financial resources for ISNP coordinators and FLWs to engage in quality outreach.

- Clearly define roles and responsibilities for key actors delivering the PSNP across administrative levels to reduce overlaps/gaps in responsibilities (strengthen Terms of Reference, particularly for TDS protocols and CBHI registration). Engage a *kebele*-level ISNP coordinator and community-level CBHI promoter.

- Increase staff allocations to reduce workloads and provide SWs with permanent contracts and better salary and incentives. Monitor performance regularly.

**Actions to expand enrolment of PW clients into CBHI and expand fee-waiver coverage:**

- Develop communication campaigns, tailored to fee-paying and fee-waiver clients, to correct misconceptions about CBHI, improve their understanding of how the health insurance works and encourage their enrolment into CBHI.

- Strengthen the capacity of FLWs to promote CBHI by: (1) recruiting a community-level CBHI promoter, (2) providing further training to strengthen CBHI knowledge and administrative skills for registration and (3) clarifying roles and responsibilities of key personnel operating at *kebele* and *woreda* levels.

- Undertake a study to assess whether and how recent increases in CBHI premiums have impacted client willingness and capacity to enrol.

- Address frequent disruption in the supply of medicines in government health facilities and simplify procedures for recouping costs of private prescriptions.

**Actions to improve delivery and boost the synergistic effects of co-responsibilities and BCC to promote sustained changes in nutrition and health-related practices:**

- Use the quantitative survey (ISNP evaluation endline wave) to gain a more accurate assessment of BCC attendance across different client groups, as well as exposure of PSNP clients to other health- and nutrition-related information.

- Strengthen protocols to regularly monitor the relevance and quality of information received, and whether it produces expected changes in knowledge and behaviour.

- Ensure that BCC training modules and learning tools are designed in local dialects that are accessible to all FLWs and participants.

- For women in *kebeles* where gender norms and/or practical barriers restrict women’s participation in PW, explore other avenues/gathering points for BCC information dissemination.

- Provide operational budgets to staff for adequate BCC activities. Provide *woreda*-level support for FLWs (logistics, advice and attention to BCC activities and monitoring of co-responsibilities).
Strengthen FLW ability to communicate the programme’s expectations to clients.

Deliver mobilization and awareness-raising campaigns for community members (including men and boys) to highlight the importance of women’s access to PW, BCCs and health and nutrition services, and increase buy-in and commitment to gender equality and women’s empowerment.

**Actions to strengthen the TDS transition process for women and ensure their timely access to entitlements and complementary benefits:**

- Address staff capacity gaps to deliver accurate information to pregnant and lactating women about their eligibility for TDS and overall process.
- Strengthen coordination, and transparent administration, information and protocols, to reduce overlaps in implementation.
- Monitor staff to ensure they do not impose informal restrictions on TDS transition.

**Actions to improve case management, particularly among PDS clients:**

- Review the case management protocols and manuals to clarify which client categories are eligible (beyond PDS households) and develop specific criteria and processes for their identification and selection.
- Develop specific manuals and written guidelines to facilitate the work of staff engaged in case management – from how to assess client needs to managing and monitoring service referrals.
- Facilitate linkage to fee waivers and provide information on CBHI benefits through case management.
- Strengthen training, staffing and financing of the SW cadre generally (beyond ISNP) for increased sustainability of case management and integration efforts with the child protection system.

**Actions to strengthen and expand the digital MIS for integrated programme planning and service delivery:**

- Expand kebele-level digital MIS installation and train staff, SWs particularly, to use it effectively, including basic computer skills where lacking.
- Supply tablets or smartphones (where electricity supply is irregular) to FLWs to facilitate improved data collection and exchange of information.

**Actions to enhance CCC capacity for sustainability, and effective platforms for reaching and supporting marginalized PSNP clients through social assistance:**

- Undertake a systematic assessment to establish coverage and number of beneficiaries supported by CCCs through fundraising.
- Improve CCC operational and technical capacity to increase their sustainability and effectiveness.
- Provide further incentives to CCC members to improve their commitment and dedication, as well as guidance and support from woreda-level staff. Monitor performance regularly.
Bibliography


