Learning from the integration of social protection and nutrition in Eastern and Southern Africa

Enhancing maternal and child nutrition

through the Productive Safety Net Programme (PSNP) in Ethiopia
Acknowledgements

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Executive summary

This is one of a series of case studies that aim to provide internal learning for UNICEF on the linkages between social protection and maternal and child nutrition programming. The Ethiopia case study illustrates how a case management approach can be used to deliver an integrated package of multi-sectoral services to vulnerable households including cash and food transfers and nutrition and health services to support child growth, development, and wellbeing.

Ethiopia's poverty and nutrition situation

Multi-dimensional poverty is high in Ethiopia at 68.7% and the country remains very low on the Human Development Index at 173 out of 189 countries. Conflict in the North of the country and drought in the South have led to large numbers of people in need of urgent humanitarian assistance. Rates of stunting, wasting and underweight remain high at 37%, 7% and 21% respectively, levels of which are expected to rise in crisis-affected regions. Key drivers of child undernutrition in Ethiopia are poor infant and young child feeding practices, maternal undernutrition, low maternal education and gender inequalities, and poverty.

Evolution of integrated social protection and nutrition programming in Ethiopia

Efforts to link social protection and nutrition in Ethiopia are mainly focused on the Rural Productive Safety Net Programme (PSNP). Currently in phase V (2021-2026), the PSNP targets 8 million extremely poor rural households vulnerable to shocks and food insecurity. Around 6.6 million households receive cash or food transfers in exchange for public works and 1.2 million households with members unable to work receive unconditional transfers (“direct support”).

Nutrition-sensitive design provisions of PSNP phase IV included pregnant women and caregivers of children under 12 months being excused from public works, introduction of health and nutrition ‘co-responsibilities’ for the same households (e.g., uptake of health services), delivery of behaviour change communication (BCC) sessions at public works sites and scale up of transfers in response to shocks. An endline review of the PSNP IV found limited or no change in a range of nutrition outcomes and underlying determinants of nutrition.

Between 2016 and 2018 the Ministry of Labour and Social Affairs (MoLSA) with technical support from UNICEF, implemented the Integrated Basic Social Services with Social Cash Transfer (IN-SCT) – a two-year pilot programme in four woredas. A case management approach was used to link PSNP IV clients with an integrated package of services, including behaviour change communication and nutrition and livelihoods support. Evaluation revealed that clients were successfully linked to additional services by social workers, but there was little impact on child nutrition outcomes.

Building on lessons learned, a five-year Integrated Safety Net Pilot (ISNP) was launched in 2019 in four woredas by MoLSA with UNICEF technical support. The programme tests a similar case management approach to the IN-SCT pilot with additional elements to strengthen linkages with health, nutrition, education, and protection services. A new cadre of social work staff (Community Service Workers) has been recruited to provide more consistent individual case management, supported by a new digital information management system, and improved enrolment and referral systems.

Additional nutrition design elements have also been added to the current PSNP V. These include the selection of nutrition-sensitive assets for public works projects, embedded case management and referrals to health and nutrition services, enhanced BCC for clients, improved transfer of pregnant women to direct support, mobilization of female ‘nutrition champions’, and provision of childcare at public works sites. The PSNP V also has an improved shock responsive component to allow the scale up of transfers both horizontally and vertically in response to crises.
Challenges and opportunities

The rollout of PSNP IV nutrition provisions was hampered by underestimation of costs, budget limitations, uneven implementation, and late and irregular cash payments. Evaluation of the IN-SCT pilot highlighted coordination issues, an over-ambitions time frame to achieve change, and lack of social worker capacity. Improved design elements and increased funding for the ISNP and PSNP V provide an opportunity to test the efficacy of improved models of linked social protection and nutrition. Robust monitoring and evaluation will provide quality evidence to inform scale up.

Lessons learned

Large scale social protection programmes provide an opportunity to alleviate poverty amongst the most vulnerable sections of society. The amount of support delivered versus the number of people reached must be balanced in the context of fiscal constraints.

In the context of rising needs and costs, linking social protection clients with livelihood, skills and employment opportunities and use of graduation pathways can ensure the sustainability of social protection, and ongoing access to food to prevent undernutrition.

An enabling policy context is needed to ensure that income transfers can be leveraged to support positive health and nutrition outcomes. Social protection must be embedded within national nutrition strategies and polices, and nutrition objectives included in social protection strategies.

A multi-sectoral, systems approach must be used in the design and implementation of social protection programmes to address the multi-dimensional nature of poverty and undernutrition. Coordination and communication between sectors are essential to enable multi-level linkages.

Use of an individual case management approach embedded within the social welfare system can coordinate the delivery of a multi-sectoral package of services to social protection clients to address the multiple causes of undernutrition and vulnerability.

Successful implementation of nutrition provisions requires adequate budget and staff capacity. Frontline health staff may already be overburdened and unable to take on case management, in which case existing or new social welfare staff can be engaged.

Cash transfers must be delivered regularly and consistently and with adequate value that is reviewed and adjusted as needed to enable household food security and support improved health and nutrition outcomes. When delivered late or inconsistently, vulnerable households are at high risk of malnutrition.

A system to transition pregnant women and caregivers of young children and malnourished children from public works to unconditional transfers has potential to improve nutrition and care practices by protecting women's time and energy expenditure.

The selection of nutrition-sensitive public works assets such as land and water conservation projects within the local community have the potential to improve access to a diverse diet within extremely poor communities.

The expansion of public works to support women as nutrition champions at community level, and childcare providers at public works sites, has the potential to augment local health, nutrition and education service capacities and build the local skills base.

Digital information management systems can provide a useful tool to support case management, referrals, coordination between frontline sector staff and compliance with co-responsibilities.

Social protection systems must be shock responsive to allow horizontal and vertical expansion in times of crisis to prevent food insecurity and malnutrition. This should be made available to all populations experiencing shocks, with provisions made for internally displaced people.

Robust monitoring and evaluation systems of social protection schemes are needed to provide quality evidence to support iterative learning and improved design of each new phase, and to advocate for investments and scale up.
**Introduction**

This is one of a series of case studies that aim to provide internal learning for UNICEF on the linkages between social protection and maternal and child nutrition programming. The Ethiopia case study illustrates how a case management approach can be used to deliver an integrated package of multi-sectoral services to vulnerable households including cash and food transfers and nutrition and health services to support child growth, development, and wellbeing.

**1 Ethiopia situation**

**Development situation**

Until 2020, Ethiopia was one of the fastest growing non-oil producing economies in Africa, with an average growth rate of 10% per year since 2004 (UNDP, 2021). This has translated into reduced economic poverty, with the proportion of the population living below the national poverty line falling from 55.5% in 1999 to 23.5% in 2020 (UNDP, 2021). Despite this, multi-dimensional poverty has remained high at 68.7%\(^1\) and the country remains very low on the Human Development Index at 173 out of 189 countries.\(^2\) Inflation has been a major macroeconomic challenge in Ethiopia during the last few years, with headline inflation averaging 20% during the fiscal year 2019/2020. Slower economic growth due to effects of the COVID-19 pandemic and conflict in the North of the country have exacerbated this situation, leading to massive increases in prices in 2022.

The conflict in the North of the country, driven by longstanding divisions, has led to mass loss of lives and property and over 29.4 million people in urgent need of humanitarian assistance.\(^3\) Parts of the country are also highly vulnerable to climatic shocks. In several Southern regions, three consecutive poor rainy seasons have affected an estimated 6.8 million people, leading to very high levels of food insecurity (USAID, 2022).

**Nutrition situation**

Child undernutrition has decreased in Ethiopia over the last decade. However, rates of stunting, wasting and underweight remain high at 37%, 7% and 21% respectively (EPhI & ICF, 2019) and levels are expected to rise in regions affected by conflict and drought (IPC, 2021).

Poor infant and young child feeding is a key underlying cause of child undernutrition in Ethiopia. Although almost all children (96%) were breastfed at some point, only 59% of infants under six months of age were exclusively breastfed, only 11% of children aged 6-23 months were fed a minimum acceptable diet and only 14% had an adequately diverse diet (EPhI & ICF, 2019). Maternal undernutrition is another key driver, given that 22% of women of reproductive age are underweight (CSA & ICF, 2016) – a key risk factor for low birth weight and infant and young child wasting and stunting.

**Relationship between poverty, gender and undernutrition**

Poverty is an important enabling determinant of child undernutrition in Ethiopia; 42% of children in the lowest wealth quintile are stunted compared to almost 25% in the highest. Children in rural areas are also much more likely to be stunted (41%) than those in urban areas (16%) (EPhI & ICF, 2019).

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1 A person is defined as living in multidimensional poverty if he/she suffers deprivation in three or more key dimensions of poverty: nutrition, health, protection, education, information, sanitation, water and housing.


3 [https://www.unicef.org/appeals/ethiopia](https://www.unicef.org/appeals/ethiopia)
ICF, 2019). Undernutrition is associated with low maternal education, demonstrated by a 42% rate of stunting among children of mothers with no education, compared to 17% among children of mothers with more than secondary education (EPhI & ICF, 2019). Ethiopia ranks low on the Gender-related Inequality Index at 0.517 (125 out of 162 countries), which is significant given that women's empowerment is positively associated with improved nutrition outcomes. Integrated strategies that address multiple household vulnerabilities including poverty and gender inequality are needed to improve child outcomes.

2 Policy, governance and financing for nutrition and social protection

In July 2015, the Government of Ethiopia made a high-level commitment to end hunger by 2030. The National Nutrition Programme (2016-2020, NNP-II) and National Food and Nutrition Policy (NFNP) (2018) aim to fulfill this ambition through the implementation of a comprehensive set of multi-sectoral nutrition-specific and nutrition-sensitive interventions to address the multiple causes of undernutrition, guided by the 2021 National Food and Nutrition Strategy (NFNS). Included within the NFNS are actions to address poverty to support increased access to a diverse diet. Nutrition actions are coordinated by the multi-sectoral National Nutrition Coordination Body (NNCB), hosted by the Ministry of Health (MoH), with technical support from the National Nutrition Technical Committee (NNTC).

The National Social Protection Policy (NSPP) (2014) and the National Social Protection Strategy (2016) guide Ethiopia’s approach to social protection. Both documents detail nutrition-related objectives and provisions to be included in social protection programmes. The Ministry of Women and Social Affairs (MOWSA) has the mandate for social protection in Ethiopia, although the institutional home of the largest rural social protection programme, the rural productive safety net programme (PSNP) is within the Ministry of Agriculture (MoA).

Social protection has expanded in recent years to cover a larger proportion of the population. Levels of donor support for related programmes are falling as domestic contributions rise in line with economic growth. By 2016, social protection spending was 2.8% of Gross Domestic Product (GDP) (OECD, 2019). In a joint Government of Ethiopia, International Labour Organization (ILO) and UNICEF programme on strengthening public finance linkages with social protection, one of the intended outcomes is the development of a financing strategy to create a higher level of financial sustainability for social protection.

3 Social protection system

The National Social Protection Policy (NSPP) comprises five focus areas: promotion of productive safety nets; promotion of employment opportunities and livelihoods; promotion of social insurance; increased access to health, education and other social services; and prevention of violence, abuse and exploitation (Figure 1).

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5 Previously known as Ministry of Labour and Social Affairs (MoLSA), until the changes in government in November 2021.
**Figure 1: Major social protection schemes in Ethiopia**

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<th>Promotion of Productive Safety Nets</th>
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<td>• Rural Productive Safety Net Program (PSNP)</td>
<td>• Urban Productive Safety Net Program (UPSNP)</td>
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<th>Promotion of employment opportunities &amp; livelihoods</th>
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<td>• Livelihood Component of PSNP</td>
<td>• Livelihood Component of UPSNP</td>
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<th>Promotion of social insurance</th>
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<td>3</td>
<td>• Public Servant Social Security Scheme</td>
<td>• Private Organization’s Employees Social Security Scheme</td>
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<th>Enhancement of equitable access to and use of basic services</th>
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<td>4</td>
<td>• Community Based Social Health Insurance</td>
<td>• School Feeding</td>
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<th>Provision of legal protection and support services</th>
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<tr>
<td>5</td>
<td>• Provision of legal protection and support services for those vulnerable to violence and abuse</td>
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**Productive safety nets**

The **Rural Productive Safety Net Programme (PSNP) V** (2021-2026) is the largest social assistance programme in Ethiopia, currently targeting 8 million extremely poor rural households vulnerable to shocks and related food insecurity. Around 6.6 million households that meet poverty criteria are targeted with cash or food transfers in exchange for a stipulated number of days of public works (decided within each region). Around 1.2 million households with no members able to work receive unconditional transfers (permanent direct support). In addition, pregnant women, caregivers of children under 12 months and caregivers of wasted children can be temporarily excused from public works until the child’s first birthday or wasting is resolved (temporary direct support). Transfers can be either food (3kg of cereals for each day worked) or where market systems are functioning well, cash equivalent to the value of food transfers.

The **Urban Productive Safety Net Programme (UPSNP)**, launched in 2016, targets 604,000 extremely poor households in urban areas using a similar model to the PSNP. The UPSNP also has an Urban Destitute Support (UDS) sub-programme that aims to address the basic economic and social needs of the most vulnerable urban citizens including street children, homeless people and people with disabilities. The UDS currently has over 32,000 participants.
Employment opportunities and livelihoods

The Federal Micro and Small Enterprise Development Agency (FeMSEDA) and Regional Small and Microenterprise Agencies (RSMEAs) provide training and education to increase the employability of unemployed and vulnerable individuals. Training, employment services and access to credit are also targeted to youths.

Social insurance

Two mandatory contributory pension schemes managed by the Public Servants’ Social Security Agency (PSSSA) and Private Organisations Employees Social Security Agency (POESSA) provide old age and disability benefits. In 2015, a community-based health insurance (CBHI) scheme was launched to provide universal and equitable access to health care services to rural populations and informal urban workers. Community members pay into a pooled fund that covers basic healthcare costs of members as needs arise and a small percentage of members unable to contribute can join free of charge (currently 21% nationally). The CBHI currently reaches 34.9 million individuals (7.5 million households) and is being linked to the PSNP as described in Box 2.

Access to health, education and social services

The government is improving access to services for the most vulnerable households through health fee waivers and health insurance subsidies; services for persons with disabilities and the elderly; school feeding; early childhood care; and social services. The national emergency school feeding programme (ESFP) targets around two million children in areas affected by disaster and extreme poverty according to the national hot-spot priority classification system operated by the National Disaster Risk Management Commission (NDRMC). An updated national school feeding policy and ten-year strategic plan will soon be released that includes a strong Home-Grown School Feeding (HGSF) component.

Addressing violence, abuse and exploitation

Victims of violence, abuse and exploitation receive legal protection and support and multi-sectoral actions are undertaken to enhance the rights of vulnerable groups.

4 Design of integrated social protection and nutrition programmes

Nutrition provisions of the Productive Safety Net Programme (PSNP) IV

Efforts to link social protection and nutrition in Ethiopia are mainly focused on the PSNP and have evolved over several of its iterations (Table 1). Evaluation findings of the PSNP III (2010-2014) revealed that, while the programme helped to improve household food insecurity, it did not reduce child stunting, child wasting nor improve child dietary diversity (IFPRI, 2013). In response, and in the context of a stronger nutrition policy context in Ethiopia, the PSNP IV (2015-2020) included explicit nutrition-related indicators and embedded nutrition provisions within its design to support improved access to a diverse diet, nutrition and care practices, and access to health and nutrition services (described in Box 1).
Child undernutrition has decreased in Ethiopia over the last decade. However, rates of stunting, wasting and underweight remain high.
37% stunting
7% wasting
21% underweight

(EPHI & ICF, 2019)
Table 1: Phases of the PSNP

<table>
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<th>PSNP phase</th>
<th>Dates</th>
<th>Nutrition focus</th>
<th>Embedded pilot schemes</th>
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<tbody>
<tr>
<td>PSNP III</td>
<td>2010-2014</td>
<td>Identified as lacking in PSNP III evaluation.</td>
<td>None</td>
</tr>
<tr>
<td>PSNP IV</td>
<td>2015-2020</td>
<td>Included a nutrition objective and nutrition provisions based on findings of PSNP III evaluation.</td>
<td>Integrated Basic Social Services with Social Cash Transfer (IN-SCT) programme.</td>
</tr>
<tr>
<td>PSNP V</td>
<td>2021-2026</td>
<td>Included a nutrition objective and enhanced nutrition provisions based on findings of PSNP IV evaluation.</td>
<td>Integrated Safety Net Programme (ISNP).</td>
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</table>

Box 1: Nutrition provisions of the PSNP IV

1. Introduction of ‘temporary direct support’ to excuse pregnant women, and caregivers of children under 12 months and children with wasting from public works to support optimal nutrition and care practices.

2. Introduction of ‘co-responsibilities’ for temporary direct support clients including attendance at health facilities and behaviour change communication (BCC) sessions delivered by Health Extension Workers (HEWs).

3. Increased nutritional value of food transfers (4kg of pulses in addition to cereals and oil) and higher cash transfer values to enable purchasing of pulses.

4. Women able to receive distributions as joint household heads to enhance their control over household resources.

5. Introduced the facility to scale up transfers in response to shocks using contingency budgets to increase the shock-responsive of the system.

6. Selection of public works projects that have nutrition benefit for the community (e.g. building of childcare centres at worksites, WASH facilities, and kitchen gardens and the planting of fruit trees).

7. Improvement of work conditions for women (half the workload of men, lighter works, and building of childcare centres next to work sites).

8. Delivery of monthly two-hour behaviour change communication (BCC) sessions for public works clients (with six sessions counting as one public workday).

9. Linkages with support for nutrition-sensitive livelihoods for public works clients, e.g., producing poultry, goat’s milk, fruit, or vegetable production.

10. Involvement of the health sector in PSNP processes and planning.

11. Embedding of nutrition-related indicators and reporting on nutrition-related outcomes.

Results of an endline review of the PSNP IV found limited or no change in a range of nutrition outcomes and underlying determinants of nutrition. Food security improved marginally for the lowlands (with the food gap reducing by 12 days per year) but not in the highlands. Dietary diversity was marginally improved by 0.11 food groups in the highlands but not in the lowlands. Diets for young children (aged 6-23 months) and exposure to health services were no different in PSNP compared to non-PSNP households (IFPRI, 2019).
The Integrated Basic Social Services with Social Cash Transfer (IN-SCT) pilot project (2016-2018)

In 2016, the MoLSA with technical support from UNICEF and funding from Irish Aid, implemented a two-year pilot project embedded within PSNP IV in four woredas in SNNP and Oromia regions. A case management approach was used to provide an integrated package of services to the most vulnerable PSNP clients to improve access to health and nutrition services and promote positive changes in nutrition and care practices along the pathway to improved nutrition.

Social workers (SWs) and Community Care Coalitions (CCCs) used a newly developed digital Management Information System (MIS) to identify households receiving PSNP permanent or temporary direct support and link them to multi-sectoral services based on their needs. Behaviour change communication (BCC) sessions covering health, nutrition, gender and social development topics were also provided to the same households by CCCs and the Women’s Development Army (WDA). In the two SNNP pilot woredas, nutrition-sensitive interventions were implemented by Concern Worldwide alongside the IN-SCT, including nutrition clubs at schools, cooking demonstrations, additional water points, upgraded Farming Training Centres (FTCs) and provision of seeds and/or animals to PSNP clients.

Baseline, midline and endline mixed methods surveys were carried out in 2016, 2017 and 2018 among intervention and PSNP IV only woredas to compare outcomes. Findings showed that SWs and CCCs successfully linked clients to additional services and supported compliance with ‘co-responsibilities’ (see Box 1). However, there was almost no measurable impact on child nutrition outcomes, except for a weakly significant reduction in child underweight. This is perhaps unsurprising given the short project duration. In the two SNNP pilot woredas where additional nutrition-sensitive interventions were implemented there were some improvements in household dietary diversity, minimum acceptable diet for women, food security, asset holdings, child schooling and child protection and breastfeeding practices. The SNNP Regional Government has since expanded this programme to cover six additional Woredas between 2020 and 2021.

The integrated safety net programme (ISNP) (2019 – 2024)

Building on learnings from PSNP IV and the IN-SCT pilot, a five-year Integrated Safety Net Pilot (ISNP) scheme was launched in 2019 in two woredas in Amhara region and two woredas in Addis Ababa by the MoLSA with UNICEF technical support and funding from the Swedish International Development Cooperation Agency (SIDA). The programme tests a similar case management approach to the IN-SCT pilot with additional elements designed to strengthen linkages with health, nutrition, education and protection services, as described in Box 2 and Figure 2, with the overarching aim of informing full scale up within the PSNP.

A critical component of the ISNP is the recruitment of a new cadre of staff – Community Service Workers, currently supported by UNICEF. CSWs are responsible for individual case management, working closely with government Health Extension Workers (HEWs) who deliver health and nutrition services and government Agricultural Extension Workers (AEWs) who support rural livelihoods. This cadre of staff was recruited to fill the gap in government social work capacity at community-level and to avoid the overburdening of HEWs and AEWs with social work responsibilities. The ISNP provides an opportunity to pilot the CSW approach and gather evidence of its cost-benefit to inform scale up discussions with government.
Box 2: Provisions of the ISNP above basic PSNP

<table>
<thead>
<tr>
<th>Access to Community-based Health Insurance (CBHI) for PSNP clients</th>
<th>the CBHI is a government community insurance programme through which regular member contributions are pooled to cover basic healthcare costs. In the ISNP, PSNP participate in local CBHI groups free of charge. HEWs and CSWs promote CBHI registration to PSNP clients.</th>
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<tr>
<td>Strengthened transition into Temporary Direct Support (TDS)</td>
<td>systems have been strengthened to enable pregnant women and caregivers of malnourished children to rapidly transition from public works to temporary direct support with linkages to health and nutrition services.</td>
</tr>
<tr>
<td>Expansion of transfers and co-responsibilities of direct support clients</td>
<td>clients receiving direct support (permanent or temporary) receive cash transfers for 12 months of the year (up from 6 months of the year in the PSNP). As well as attendance at health clinics, an additional co-responsibility has been added to the ISNP for all children in the household to attend school.</td>
</tr>
<tr>
<td>Strengthened Behaviour Change Communication (BCC)</td>
<td>BCC sessions delivered to all PSNP clients have been strengthened using updated BCC materials. Under the ISNP sessions also include cooking and home gardening demonstrations to improve dietary diversity and food handling and storage practices.</td>
</tr>
<tr>
<td>Strengthened case management</td>
<td>a new cadre of staff - Community Social Workers (CSWs) have been recruited and trained to link clients to all services and refer child protection cases into the child protection system to avoid the overburdening of health extension workers (HEWs).</td>
</tr>
<tr>
<td>Scale up of digital Management Information System (MIS)</td>
<td>building on the IN-SCT pilot, the MIS system is being scaled up and strengthened for use by CSWs to facilitate digital tracking of clients.</td>
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</table>

Early results from a midline evaluation indicate that overall, programme delivery of the ISNP is on track. Cross-sectoral collaboration and coordination at regional and woreda level has improved, including between the PSNP and CBHI, resulting in better programme performance. There is also evidence of improved access to services among PSNP clients, with some positive shifts in health and nutrition knowledge, improved diets, food intake, feeding practices and health seeking behaviours and evidence that caregivers of wasted children have been more able to rapidly access treatment services (UNICEF Office of Research – Innocenti, 2021).
Figure 2: ISNP client management protocol

1. First contacts
   - Collection of Household Profile Information
     - Community Service Worker (CSW)
     - Development Agent (DA)
   - Enrollment in CBHI (Premium-free)
   - Attendance of BCC Sessions on Nutrition and CBHI
   - School attendance by school-age children
   - Regular attendance at health establishments and participation in CBN* and CMAM**
   - CCCs identity potential child protection

2. Suggested co-responsibilities
   - CSW, informed by data from health posts and schools
   - DA, informed by data from woreda CBHI Agency

3. Follow-up / case management
   - Additional case folder opened and child protection procedures activated when risk is identified

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Items outlined in red and red arrows denote design elements specific to ISNP - not presenting PSNP 4 or in the IN-SCT pilot.

* CBN is Community Based Nutrition programme
**CMAM is Community based management of acute malnutrition

Design of PSNP V to increase impact on nutrition outcomes

Coordinated by the World Bank, multiple partners including government and UNICEF, used findings of the evaluations PSNP IV and both pilot programmes to feed into the design of the PSNP V (2020-2025).

In the context of budget constraints that limited any significant expansion of the programme or increased transfer values, the following elements have been selected for strengthening:

- **Increased nutrition-sensitivity of public works assets**: rather than selecting infrastructure projects (roads and bridges) projects are selected that support local agriculture and food security and dietary diversity, e.g., land management and conservation, forest management and water conservation projects, community gardening and household level water access. In addition, household water, sanitation and hygiene (WASH) can now be included as public works projects to address diarrhoea and environmental enteric dysfunction (EED) as key drivers of wasting and stunting.
• **Embedded links to social services**: in this iteration, PSNP clients are routinely linked to BCC, case management, education, and referrals for health and nutrition services and are linked to the CBHI. BCC materials are currently being updated.

• **Scale up of TDS for pregnant women**: the transfer of pregnant women enrolled in public works until their child turns one year was embedded within PSNP IV but not well implemented. This is now being scaled up.

• **Identification of local ‘nutrition champions’**: PSNP clients who are mothers of young children are identified as positive examples and trained to support HEWs as their public works contribution. The aim is to relieve the burden of HEWs and support changes in practices through the positive deviance approach.

• **Provision of childcare for public works**: Early Childhood Development (ECD) makeshift centres are now established at public works sites to provide quality childcare and food for children of women participating in public works. These are staffed by mothers as their public works contribution.

PSNP V has a shock responsive component and scales up in response to crises both horizontally (increased clients) and vertically (cash top ups). However, this is limited to populations affected by food insecurity (not conflict) and to individuals residing at home (i.e. not internally displaced persons (IDPs)). To fill this gap, UNICEF provides a Humanitarian Cash Transfer (HCT) in conflict-affected areas and to IDPs. This is augmented by food assistance from WFP.

## 5 Implementation, workforce, and delivery mechanisms to support nutrition-sensitive social protection

Rollout of PSNP IV nutrition provisions (Box 1) was severely hampered by the underestimation of costs and resulting budget limitations (IFPRI, 2019). Some eligible households were successfully transitioned from public works to temporary direct support and 87% of these complied with co-responsibilities. However, implementation was uneven, and an estimated 80,000 of eligible pregnant women were not enrolled. BCC sessions were unevenly implemented, childcare was implemented in only 3.5% of public works sites, and very few nutrition-sensitive public works projects were selected. The delivery of cash and food transfers were also often late and irregular and, while the transfer value was increased initially, budget limitations meant that this could not be sustained. The IFPRI 2019 review concluded that the lack of impact on nutrition outcomes was not because the nutrition provisions were ill-conceived, poorly designed or ineffective, but rather **because many were not implemented as intended**.

The evaluation of the IN-SCT pilot highlighted coordination issues (the programme in SNNP was implemented by an international NGO which resulted in initial limited acceptance and engagement with government counterparts); an over-ambitious time-frame to achieve changes in child stunting; limited impact due to PSNP cash transfers being delayed and too small; delayed and inconsistent rollout of the pilot and PSNP nutrition activities (especially BCC); and lack of capacity of SWs which led to the overburdening of HEWs.

The ISNP has attempted to address shortcomings of the PSNP IV and IN-SCT pilot by recruiting and training a new cadre of social welfare staff (CSWs) and supervisors to increase capacity for implementation. This has required the development of job specifications, protocols, training,
management structures and sensitization among other existing cadres of staff. Stronger linkages and coordination between the MoWSA, MoH and MoA have also been facilitated in this iteration to enable smoother integration of referral and enrolment systems (e.g. enrolment of PSNP clients into CBHI), and stronger collaboration between frontline staff. Several bottlenecks and challenges have been identified so far, including staffing gaps, budget and logistics constraints, gaps in client understanding of ISNP entitlements, and discriminatory social and gender norms that affect women’s access to services. Efforts are being made to address these to achieve high programme performance.

In terms of PSNP V, cash transfer values are small and their purchasing power is reducing due to high inflation rates and spiralling food prices. This is likely to limit programme impact and requires urgent review. In the context of increasing needs and costs, sustainable approaches need to be explored, such as linkages with livelihoods approaches to ensure ongoing access to food. A review of shock responsive mechanisms within the current system is also due to assess how to enhance both vertical and horizontal scale up in the face of shocks, including populations affected by conflict and IDPs.

6 Monitoring, evaluation, and learning of nutrition-sensitive social protection

A thorough evaluation of the nutrition impact of the PSNP IV and IN-SCT provided valuable evidence to inform future programme iterations and to advocate for donor support. Robust monitoring and evaluation systems have been embedded within the ISNP to inform full integration of the case management approach into the social protection system. A comprehensive set of indicators are being monitored along the impact pathway to improved health and nutrition, for example indicators around early marriage which is a key underlying cause of undernutrition in Amhara and other regions.

7 Overall lessons learned

Large scale social protection programmes provide an opportunity to alleviate poverty amongst the most vulnerable sections of society. The amount of support delivered versus the number of people reached must be balanced in the context of fiscal constraints.

In the context of rising needs and costs, linking social protection clients with livelihood, skills and employment opportunities and use of graduation pathways can ensure the sustainability of social protection, and ongoing access to food to prevent undernutrition.

An enabling policy context is needed to ensure that income transfers can be leveraged to support positive health and nutrition outcomes. Social protection must be embedded within national nutrition strategies and polices, and nutrition objectives included in social protection strategies.

A multi-sectoral, systems approach must be used in the design and implementation of social protection programmes to address the multi-dimensional nature of poverty and undernutrition. Coordination and communication between sectors are essential to enable multi-level linkages.

Use of an individual case management approach embedded within the social welfare system can coordinate the delivery of a multi-sectoral package of services to social protection clients to address the multiple causes of undernutrition and vulnerability.
Successful implementation of nutrition provisions requires **adequate budget and staff capacity**. Frontline health staff may already be overburdened and unable to take on case management, in which case existing or new social welfare staff can be engaged. Any new roles require clear job specification, protocols and training, sensitization among other staff cadres and adequate supervisory structures and capacity. Strong evidence of cost-benefit is needed to inform integration into government staff cadres.

**Cash transfers must be delivered regularly and consistently** and with adequate value that is reviewed and adjusted as needed to enable household food security and support improved health and nutrition outcomes. When delivered late or inconsistently, vulnerable households are at high risk of malnutrition.

A system to **transition pregnant women and caregivers of young children and malnourished children from public works to unconditional transfers** has potential to improve nutrition and care practices by protecting women's time and energy expenditure. Timely transition, concurrent BCC and links with free health and nutrition services including health insurance have potential to boost nutrition impact.

The **selection of nutrition-sensitive public works assets** such as land and water conservation projects within the local community have the potential to improve access to a diverse diet within extremely poor communities. The inclusion of household WASH projects can also help to prevent undernutrition in areas with high incidence of diarrhoea and prevalence of stunting.

The expansion of public works to support women as **nutrition champions** at community level, and **childcare providers** at public works sites, has the potential to augment local health, nutrition and education service capacities and build the local skills base.

**Digital information management systems** can provide a useful tool to support case management, referrals, coordination between frontline sector staff and compliance with co-responsibilities.

Social protection systems must be **shock responsive** to allow horizontal and vertical expansion in times of crisis to prevent food insecurity and malnutrition. This should be made available to all populations experiencing shocks, with provisions made for internally displaced people.

**Robust monitoring and evaluation systems** of social protection schemes are needed to provide quality evidence to support iterative learning and improved design of each new phase, and to advocate for investments and scale up.

### 8 Future opportunities

Opportunities that could be explored for future action are:

- Advocacy to strengthen the shock responsive provisions of the current social protection system within Ethiopia to enable horizontal and vertical expansion in response to all populations experiencing shocks of all kinds and including internally displaced people.

- Continued exploration of the feasibility of integrating Community Social Workers (CSWs) into the MoLSA to build Ethiopia’s social protection workforce at community-level to provide individual case management to link extremely poor and vulnerable households to multiple services.

- Exploration of linkages between the PSNP/ISNP and livelihoods interventions to support sustainable livelihoods of clients, and linkages with other initiatives, such as the ‘egg powder initiative’ (Baye et al, 2021), to ensure access to a diverse diet.
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