



Integrating Service Delivery with Cash Transfers to Improve Nutrition in Ethiopia:

An Impact Evaluation of the IN-SCT Pilot Project in Oromia and Southern Nations, Nationalities, and Peoples' Region

POLICY BRIEF



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Development Studies



Integrating Service Delivery with Cash Transfers to Improve Nutrition in Ethiopia:

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Since its launch in 2005, the Productive Safety Net Program (PSNP) has been a cornerstone of Ethiopia's strategy to address poverty and food insecurity. The PSNP provides cash and food transfers targeted to the poorest of the poor through public works and direct support for clients lacking labour capacity in their household. Enrolment reached 8 million clients in the programme's first decade. In conjunction with the 2015 launch of Phase 4 of the programme (PSNP4), the Ministry of Labour and Social Affairs (MoLSA), with support from UNICEF and funding from Irish Aid, introduced the Improved Nutrition through Integrated Basic Services and Social Cash Transfer (IN-SCT) pilot project in the Oromia Region and Southern Nations, Nationalities, and Peoples Region (SNNPR).

The IN-SCT pilot aims to enhance the PNSP4 by providing an integrated package of multisectoral nutrition services; building MoLSA's capacity to support recipients of permanent direct support; assisting the transition of pregnant and lactating women and caretakers of malnourished children from public works to temporary direct support, which provides payments without work requirements; establishing and testing the programme's management information system; and promoting client compliance with a list of co-responsibilities, including antenatal care visits for pregnant women, immunizations and growth monitoring visits for young children and regular school attendance for children age 6-18. Implementation also focuses on the following areas: supporting Temporary Direct Support; Management Information System (MIS) development; the integrated case management system; the SWW development; client co-responsibilities; behaviour change communication; gender and social development mainstreaming and multi-sectoral collaboration.

The IN-SCT also supports community organization of nutrition social behaviour change communication (SBCC) sessions for public works clients and strengthens linkages among health extension workers, agriculture extensionists, social workers, schools, child protection services, and service providers from other sectors. An additional key feature of the IN-SCT is the employment of social workers operating at the kebele (municipality) level to support these objectives.

The pilot is currently underway in two SNNPR woredas (districts)—Halabja Special Woreda and Shashago Woreda. In Oromia region, the programme piloted the MIS, began the integrated case management system and introduced SWs in the Dodota and Adami Tulu Woredas, but did not implement the nutrition-sensitive component of the IN-SCT.

UNICEF Ethiopia Country Office commissioned the International Food Policy Research Institute (IFPRI), the Institute of Development Studies (IDS), and Cornell University to conduct an impact evaluation of the IN-SCT pilot. The mixed methods evaluation assessed IN-SCT's performance, used quantitative statistical methods to measure the project's causal impacts, and drew on qualitative fieldwork to understand clients' experiences and plausible pathways for the project's effects (Box 1). This brief summarizes the evaluation's main findings and recommendations.

Box 1: Evaluation study design

This study, conducted between March 2016 and September 2018, used mixed-method techniques, including both quantitative and qualitative evaluation components, making it possible to measure causal impacts and understand in greater detail the factors contributing to or limiting programme benefits.

The qualitative assessment, which addressed impacts in both Oromia and SNNPR, included a series of semi-structured group discussions, key informant interviews, and participatory activities at baseline, midline, and endline. The quantitative impact evaluation was restricted to SNNPR only, where the nutrition sensitive component was piloted, and included baseline and endline household surveys with a complex sample design to enable comparison of outcomes and characteristics among

- beneficiaries of the combined IN-SCT and PSNP4 programmes;
- households not participating in either the IN-SCT or PSNP4; and
- beneficiaries of PSNP4 alone.

Sample households in the IN-SCT treatment group and nonparticipating comparison group were drawn from the same IN-SCT woredas. Sample households in the PSNP4-only comparison group were drawn from PSNP4 woredas without the IN-SCT. The samples of IN-SCT or PSNP4-only beneficiaries included public works, permanent direct support, and temporary direct support clients; the latter were further disaggregated between pregnant women and those with children under 2. In addition, the SNNPR sample had two parts:

- 1,920 households in a repeated cross section with pregnant or lactating women or children aged 6–23 months for measuring impacts on child nutrition, child feeding practices, and maternal nutrition knowledge.
- 1,200 households with children under 5 in a panel survey on which estimates were made of impacts on household food security, consumption, poverty, and health.

Using matching techniques, the evaluation estimated the absolute impact in both SNNPR samples of the IN-SCT programme compared with no programme and the impact of the IN-SCT programme relative to the PSNP4 alone. Some limitations of the evaluation include that TDS clients were not always aware of when they were transitioned from PW to TDS, leading to underestimates of TDS clients' duration of exposure to the IN-SCT. This means that impacts of the IN-SCT programme had to be estimated based on participation in programme components (known as intent to treat) rather than based on actual participation (known as treatment on the treated), which leads to lower, more conservative estimated impacts. Another limitation is relatively small samples for assessing impact on some subgroups (such as PDS households) given the need to have two samples and that there are three programme components.

The survey training, field visits and interview process included numerous ethical safeguards for participants. The training of enumerators took place over 10 days and covered essential components of ethical safeguards for the interview process, including respect for the dignity and diversity of the respondents, their families and communities; the respondents' right to self-determination (of their views); fair representation (of their responses); compliance with codes for vulnerable groups; confidentiality; and avoidance of harm. Approval to conduct the interviews was received by local leaders. IFPRI IRB provided ethical clearance for the evaluation protocols.

Successes and Limitations in Programme Delivery

The evaluation revealed both successes and shortcomings in the delivery of the IN-SCT.

What improved:

- For TDS clients, the probability of attending any antenatal care sessions improved as did participation in postnatal care sessions.
- Vaccination of children, treatment of malnourished children, and child school attendance all improved.
- The IN-SCT improved multisectoral collaboration among social workers and local development agents, health extension workers, and school officials, which improved client fulfilment of co-responsibilities in health and schooling, as did keener client awareness of the importance of using services.
- PSNP-linked BCC sessions held at public works sites improved, which also appeared to be implemented better in IN-SCT woredas than in PSNP-only woredas and were viewed positively by participants. Participants noted positive changes in behaviour related to hygiene and sanitation, such as washing hands with soap, latrine use, and keeping their compounds clean.

What needs improvement:

- Social workers were too few in number, overburdened with reporting requirements, and suffered from high turnover rates; they lacked funding for travel to meet with clients and conduct BCC trainings, and had limited interaction with Community Care Coalitions tasked with supporting programme delivery at the community level; and they lacked needed

capacity to identify and respond to cases of child protection violations.

- Due to PSNP4 procedures, health extension workers were understaffed and had to assume new responsibilities and roles required by the PSNP4, which sometimes affected social workers' community visits and may in turn have affected general BCC sessions.
- Although the IN-SCT developed an extensive BCC manual that is being used throughout the PSNP4, development assistants and health extension workers in some areas reported lack of access to the manual, limiting their ability to improve programme delivery.
- The introduction of MoLSA's new management information system was a positive development but it faced some challenges, including slow progress in developing in-house technical expertise which led to the need for external consultants for software updates and general troubleshooting. This caused some delays in reporting.
- Establishment of BCC sessions was relatively successful. However, these sessions were often provided immediately after public works activities, which made it difficult for clients to attend. Low attendance at BCC sessions was mentioned as a challenge by several sources. Some clients also complained that BCC sessions included too many messages.
- The transition from public works to temporary direct support for caregivers of malnourished children often failed due to lack of clarity on the transition criteria and because malnutrition screenings were not always held regularly.



IN-SCT'S Impact on Household and Child Welfare In SNNPR

Impact of IN-SCT relative to PSNP4 alone

The evaluation found substantial evidence that the IN-SCT programme improved diets, food security and, in some cases, mother's nutrition knowledge. The IN-SCT's nutrition-sensitive approach to the PSNP4, relative to the PSNP4 alone, led to statistically significant and meaningful improvements in household dietary diversity, food security, and asset holdings, while impacts on child health and nutrition outcomes were mixed though some were positive.

Dietary diversity, food security and nutrition knowledge. Compared with the PSNP4 alone, IN-SCT increased the overall household dietary diversity score (HDDS) in the sample by 1 food group (out of 12), and this effect was larger, at 1.5 food groups, for IN-SCT permanent direct support households; improved the share of women in permanent direct support households reaching minimum dietary diversity; and reduced the food gap (length of the lean season) for permanent direct support clients by roughly one month. Women in the programme

with older children also learned important nutrition information, but nutrition knowledge did not improve on average for mothers of children under 2 years. Despite this, some nutrition practices, such as breastfeeding improved. More specifically, IN-SCT children were 9.3 percentage points more likely to have received breastfeeding immediately after birth and 28.1 percentage points more likely to have received colostrum than children in the PSNP4 alone.

Asset holdings. IN-SCT improved holdings of livestock and productive assets in households with children under age 5, but had a negative impact on consumer durable assets (Figure 1), leading to a positive impact overall on all assets combined. The IN-SCT contributed substantially to economic mobility: for the poorest 25 percent of baseline households, IN-SCT reduced the probability of their remaining in the poorest quartile of asset holdings at endline by 15.3 percent. However, the programme had either no effect or a negative effect on estimates of monthly household consumption per adult equivalent when compared with the PSNP4 alone.

Child welfare outcomes. Households with children aged 7 to 14 in IN-SCT communities reported that in the previous week their children's school was open on average nearly half a day more than schools in

PSNP-only communities. The activities of IN-SCT service providers appear to have induced schools to remain open more days. This had a weakly significant effect on 7-to-14-year-olds' school attendance, which increased by a quarter day on average in the preceding week (Figure 2). IN-SCT also reduced child labour by 1.6 hours of work per week on average among children aged 5 to 14.

IN-SCT increased the probability of pregnant women receiving antenatal care by 10.6 percent relative to pregnant women in the PSNP4 alone and increased the practice of breastfeeding immediately after birth. Measures of infant and young child feeding practices and of child anthropometry were the same in matched sample of IN-SCT and PSNP-only households, indicating no impact on these outcomes. There was an unexplained, statistically significant negative impact on height-for-age z-scores (HAZ) for children in TDS households, which may be due to remaining bias in the estimates for this outcome. More encouraging was that there was a weakly significant reduction in child underweight prevalence in IN-SCT TDS households.

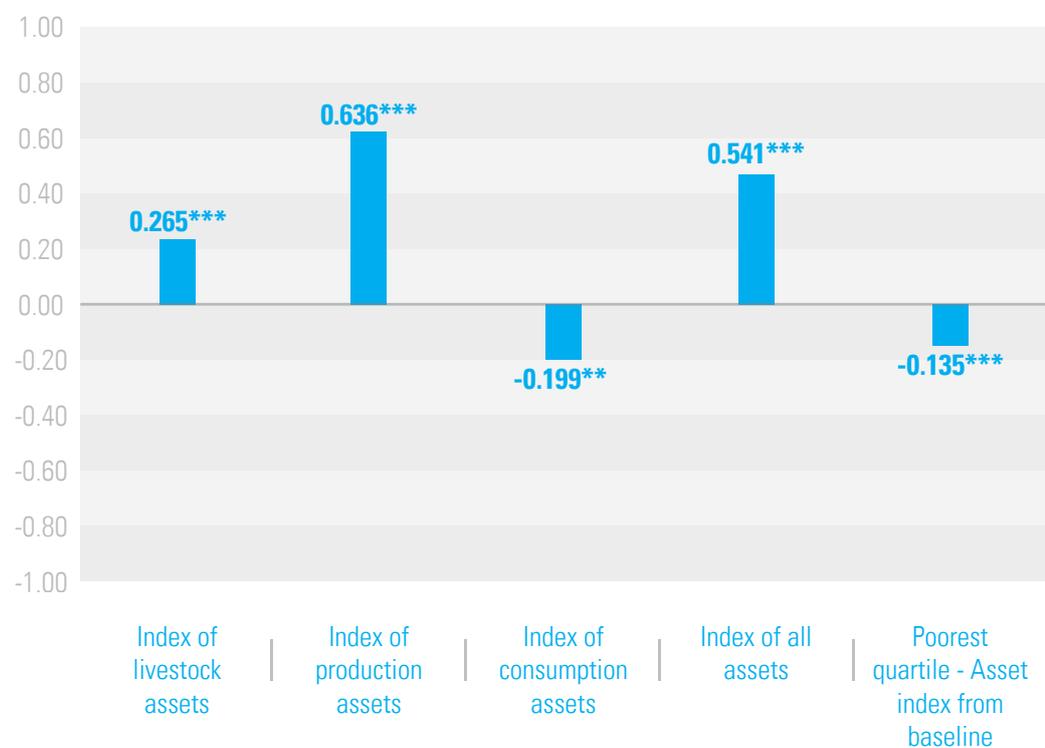
“Before PSNP4 there was a lack of implementing guidelines for nutrition. But this programme is nutrition-sensitive. Now public works are more focused on nutrition. For example, we see that many clients have started backyard gardening. That helps for nutrition. I visited the pilot woredas a few times, and I can see that the benefits are greater in those pilot woredas.”

Key Informant in SNNPR

Integrating Service Delivery with Cash Transfers to Improve Nutrition in Ethiopia:

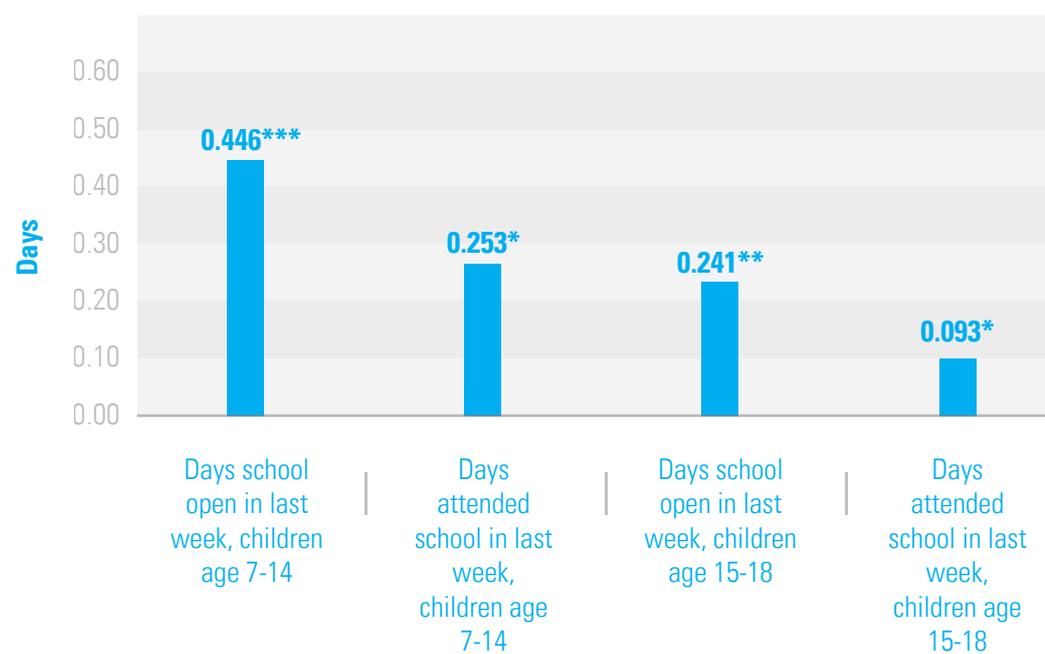
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Figure 1: Impact of IN-SCT vs. PSNP alone on asset holdings



Source: Author calculations using evaluation survey data.

Figure 2: Impact of IN-SCT vs. PSNP alone on child school attendance



Source: Author calculations using evaluation survey data.



Impact of IN-SCT relative to no PSNP4

Estimated impacts on households in the IN-SCT are much weaker when outcomes are compared with those of households in the same communities that are not PSNP4 clients. In this comparison, there is no clear impact on household dietary diversity, food security, consumption, assets, child schooling, child protection, or nutritional status, potentially because nonbeneficiary households were better off in unobservable traits.

This finding suggests that IN-SCT impacts were not broad in scope. It is plausible, however, that benefits from the programme spread to neighbouring households, leading to spillover effects that erode our estimates of impact, although there is little other evidence of this. The results of this comparison are therefore indeterminate, and we must conclude that there were no impacts relative to non-client households, with the caveat that possible spillover effects may weaken the results.

Conclusions

Taking all the evidence together, the impact evaluation found substantial positive impacts of the IN-SCT programme, but also that progress in some areas has been uneven. The IN-SCT increased dietary diversity and reduced the food gap, an important measure of household food security. It also improved participation in antenatal care sessions, increased maternal knowledge of breastfeeding and infant and young child feeding practices, and improved child vaccinations and school attendance. A positive nutrition result includes a reduction in child underweight prevalence, though this effect was weakly significant. Areas in need of improvement included gaps in delivery derived from budgetary and supervisory problems that kept social workers from routinely traveling to communities to do their jobs. These challenges in delivering new nutrition programming coincided with familiar PSNP issues, including small transfers and sometimes burdensome work requirements, as well as delays in making payments. Ultimately, these challenges meant that the IN-SCT programme had almost no measurable impact on child nutrition outcomes, apart from creating a weakly significant reduction

in child underweight prevalence. The programme did increase dietary diversity, food security, and maternal knowledge of breastfeeding and infant and young child feeding practices to make improvements along the impact pathway, but either the intervention period is too short to see impacts or the interventions were not sufficiently intensive to be able to reduce child malnutrition. Indeed, global evidence shows that cash transfers plus nutrition BCC programming requires large sustained transfers and an intensive BCC program to have impacts on nutrition, so further strengthening of the program will be needed to change nutritional status. An important question now for the Government of Ethiopia, UNICEF, and their partners, is whether necessary changes can be made to improve the impact of the IN-SCT.

Recommendations

1. Strengthen IN-SCT components that improve children's diets and nutrition:

IN-SCT had no impact on infant and young child feeding practices or on diet quality for children under 2. Also, service providers and clients indicated a need for more frequent nutrition screenings. IN-SCT should therefore focus more heavily on infant and young child feeding practices during BCC sessions and increase the frequency of nutrition screenings. BCC sessions were often conducted after public works sessions, limiting attendance and contained too many messages. Sessions should be reformed to assure greater attendance and higher satisfaction by participants. Other studies have found that larger cash transfers to mothers combined with high-quality BCC can improve child diets. UNICEF and its partners should consider providing a top-up transfer to lactating women receiving temporary direct assistance. Together, these changes could greatly increase IN-SCT's ability to improve child nutritional status.

2. Expand IN-SCT components that improve diets of pregnant and lactating women:

IN-SCT's combination of transfers plus BCC sessions improved household food security and minimum dietary diversity for women overall, suggesting the potential for an even greater emphasis on improving the diets and food security of pregnant and lactating women. The pilot's success in reducing the food gap suggests that the approach is effective and efforts should be expanded.

3. Emphasize maternal nutrition knowledge:

Despite having positive impacts on diets and food security, there is mixed evidence that IN-SCT improved women's nutrition knowledge in TDS relative to women in TDS in the PSNP4 alone or outside the programme. This gap in the impact pathway suggests a potential limitation in IN-SCT's effectiveness that could be bridged by giving increased attention to nutrition knowledge during BCC sessions.

4. Reform the recruitment and training model for social workers and fund their travel:

Findings show a substantial need for reforms to the staffing of social workers. A promising approach would be to introduce para-social workers hired within each community who could be more readily available to provide services following more modest training. These para-social workers would have lower qualifications but would be more accessible, reducing the need for travel. Retention of SWs would also likely improve. Social workers based at the woreda level currently are very well qualified but have too few resources and a burdensome scope of work, causing many to leave these jobs for other employment. Hiring junior social workers from within communities may be a feasible alternative.

5. Improve and streamline the management information system:

The management information system is recognized as a useful approach to tracking programme delivery, but it took a long time to get the system operational, and SWs were overburdened with MIS reporting requirements. The system should be streamlined to reduce social workers' time spent on reporting. Additional technical support should be provided where needed to complete the transition from the paper-based system to the electronic system, to eliminate the need to continue to keep paper records. In-house capacity to troubleshoot the system should be increased in general to improve response times to technical issues.

6. Increase the size of the PSNP4 transfers:

In response to increased need and budget shortfalls, PSNP removed pulses from the food transfer and similarly allowed the value of the cash transfer to erode. However, there is ample evidence that the impact of transfer programs responds meaningfully to larger transfers, creating larger improvements in food security, assets and consumption, and greater potential for impacts on nutrition when intensive, high quality BCC programs are also included. This level of impact is the goal of the PSNP and many of the components are now in place to achieve it. What is needed is a commitment to provide modestly larger transfers and to further strengthen BCC sessions. This could substantially change the impact profile of the PSNP for years to come.

7. Implement recommendations from clients and service providers:

Service providers focused on the need to increase the number of social workers and build the capacity of all service providers—in terms of numbers, programme knowledge, and resources. To improve impact, clients highlighted the need for larger transfers, an end to payment delays, more frequent nutrition screenings, and more frequent BCC sessions.

8. Strengthen coordination and supervision mechanisms:

Implementation challenges reveal a lack of awareness of job requirements among service providers and weak commitment to implementation at woreda and kebele level. IN-SCT could be improved by stronger social worker training that emphasized their coordination role and an improvement in supervision mechanisms that hold service providers to account.

Lessons Learned

This mixed methods evaluation of IN-SCT provides several lessons. Adding trained social workers to support the nutrition-sensitive components of the PSNP can help to strengthen the impacts of the program along the pathway to improving child nutritional status, as shown by the positive impacts of IN-SCT on dietary diversity, food security and maternal nutrition knowledge. These results show that the role of social workers is having an effect, suggesting that a social-worker-based model could be effective, with other changes in place. However, overburdened social workers were not as effective as desired, leading many of them to resign. Social workers should be encouraged to spend more time in the communities, meeting with families and linking their work with that of HEWs and other service providers.

In IN-SCT, the development of the MIS is underway, and the pilot provided an opportunity to practice using an MIS to inform its scale-up at the national level. Still, there are many dimensions of the MIS that need strengthening. The time cost of getting the MIS operational has been challenging for the social workers. It may be necessary to pause implementation of the MIS while the social workers, or new para-socials workers, gain more experience in the other aspects of their responsibilities before the MIS is reintroduced. Then a more streamlined version of the MIS could be rolled out again on a pilot basis to provide lessons for future scaling up. Ultimately, the objective of the MIS, to have a central database to track services received by households in the program, is a useful one, but this will take more time to be achieved.

Another lesson from IN-SCT is that the program appeared to work best when social workers were able to spend more time in the communities. This suggests alternative ways to recruit and assign social workers, focusing more on recruiting local, possibly lower skilled individuals to play this role, and training them to be useful counterparts to the Health Extension Workers in their communities. This approach might also allow more time for social workers to emphasize improvements in diets for pregnant and lactating women and to further improve learning on nutrition knowledge, which continues to be an area that needs improvement.

The impacts of IN-SCT on schooling are promising and suggest that having social workers prompt school officials to make sure that schools are open and then promoting good school attendance with families can have a large effect on school participation. This approach could be cost effective if it were included with other messaging on nutrition.

The PSNP requirement that pregnant and lactating women transition from public works to temporary direct support appears to help reduce the time burden from participation in PW projects, but more could be done to reduce gender inequalities in the provision of childcare. This could include an expanded set of trainings on nutrition and caring practices that also include men. These trainings could discuss traditional gender roles and the potential to shift them, while also highlighting the potential role of men in childcare activities.

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