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Integrating Social Protection with Health Insurance and Social Services

Results from an impact evaluation of the Integrated Safety Net Programme in the Amhara Region of Ethiopia

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Executive summary

The Government of Ethiopia and development partners have been implementing various social protection programmes aimed at poverty reduction and the economic empowerment of the poor and vulnerable. This is to address the high level of poverty and vulnerability especially among the three-quarters of the population that live in rural areas. Two key social protection interventions are the rural Productive Safety Net Program (PSNP) and the Community-Based Health Insurance (CBHI) scheme. In 2018, UNICEF supported the government to initiate a pilot Integrated Safety Net Program (ISNP) that provides premium waiver for CBHI enrolment to permanent direct support (PDS) clients of PSNP, and providing information to public works (PW) clients of PSNP about the benefits of CBHI to encourage enrolment. The ISNP was also intended to strengthen the social worker workforce to provide information and case management to PSNP households with malnourished children and children out of school, and facilitating the timely transition of pregnant and lactating women in PW households to PSNP temporary direct support (TDS) status.

The implementation of ISNP started in 2019, preceded by a baseline data collection (December 2018 to March 2019) for an impact evaluation. The objective of the impact evaluation was to rigorously assess the impacts of the ISNP on selected household, women, and children's wellbeing indicators. The purpose of the evaluation is to inform UNICEF, government of Ethiopia and other development partners about the synergistic benefits that can be derived from adding complementary (plus) interventions to households receiving cash transfers. The mixed-methods impact evaluation used a quasi-experimental matching design which was the best option available because the treatment assignment done at the *woreda* (district) level was not random to allow for a randomized controlled trial. Endline data were collected four years after the baseline (December 2022 to March 2023) as COVID-19 and the armed conflict prevented data collections during the scheduled times in 2020 and 2021. This report presents the findings of the impact evaluation using both the baseline and endline data.

The report discusses several contextual shocks that occurred between the baseline and endline, including the exposure to an armed conflict, exposure to COVID-19, re-targeting for PSNP and transition to PSNP5, changes in health facility availability and *kebele* (village) characteristics, exposure to high inflation, and changes to the cost of CBHI enrollment. All these macro changes meant that the ISNP was implemented in a different context than anticipated, and the findings will have to be interpreted with this context in mind. The analysis shows that for the most part, comparison and treatment households were equally exposed to these shocks which means that the overall impact design was not contaminated. Differential impacts of these shocks were observed on the effect of the conflict on household assets and injury to members, as well as access to health services in the *kebeles*. The impact estimates presented controlled for these variables.

Regarding the implementation of the ISNP components, the analysis shows a positive impact on the enrollment of PDS and PDS households in the CBHI. The CBHI enrollment for PDS households was 91 per cent, which is very high although not the 100 per cent as expected by the ISNP design. Administrative records from the PSNP coordinators suggest there is full enrollment of all PDS households in CBHI, and the disparity in the self-reporting of enrollment status might be due to information gaps or the exit of some of the sample households from PSNP during the transition to PSNP5. Overall knowledge about the benefits of CBHI has also improved significantly among both PDS and PW households.

ISNP also had a positive impact on the transition of pregnant and lactating women to TDS status although this was also not universal as intended. About a third of women who were pregnant at the endline had transitioned to TDS status. The main challenge with the transitions is the verification of the pregnancy once the woman reports to the social worker or PSNP coordinators. Pregnant women who had transitioned to TDS status were appreciative of the programme that relived them from compulsory work and gave them more time to care for their children. They recognized that it would have a positive impact on themselves and their unborn children. Transition to TDS because of having a malnourished child was not prevalent. Case management of malnourished and out-of-school children was also not fully implemented. Less than 5 per cent of households with a malnourished child being transitioned to TDS status.

BCC sessions were not implemented fully according to the ISNP design. The non-compulsory nature of participation in BCC sessions by TDS clients was identified as a major challenge by some key informants. In addition, there were information gaps on the timing and venues of BCC sessions, and women preferred that sessions were not scheduled in the evenings after a hard day's work on the public work sites. Key informant interviews also suggested that women have little motivation to attend the BCC sessions mainly because they think they are already familiar with the content of the BCC sessions. Overall knowledge of the existence of frontline workers (health extension workers, social workers, and health development army) improved, but contact in the last three months preceding the two survey rounds did not improve.

Analysis of the impacts of ISNP on several intermediate outcomes shows mixed impacts. The programme significantly reduced the share of households with outstanding loans and significantly improved the use of CBHI card to seek health services. It also substantially improved women's perceived social support and women's participation in social groups such as Iddir – a community-based burial and support group). However, there were no impacts on food security, nutrition knowledge, feeding practices, and health seeking behaviour.

Impacts on medium to long term outcomes were also limited. Despite the lack of impact on nutrition knowledge and feeding practices, ISNP had a positive impact on dietary diversity, driven by increased consumption of legumes and vegetables, among others. The average diet diversity score increased from 3.7 to 4.1 among the treatment households. There was a negative impact on household resilience as both the share of negative coping strategies to shocks and distress asset sale for food needs increased significantly. There was moderate positive impact on women's agency, but not on women's life satisfaction and autonomy. Attitude towards child marriage improved with more respondents in treatment areas indicating a higher ideal age for a girl child to marry.

Finally on child outcomes, there were no positive impacts on any of the anthropometric measures (stunting, wasting, and underweight), school attendance, care-seeking for illness, preventive health, vaccination, and birth registration. For both treatment and comparison groups, about 50 per cent of children ages 6-59 months remain stunted with about 20 per cent being severely stunted. About 40 per cent of children 6-17 years were not attending school, and about 25 per cent of households did not seek health care from a facility when a child was sick. Share of children 12-23 months that have received all required vaccinations is about 60 per cent (up from 40 per cent at baseline) and only about a 20 per cent of children 1 to 4 years have their births registered.

Overall, looking at the multiple shocks, the challenges with implementation, and the fact that this evaluation only assessed the impact of the plus components, the results are not surprising. Results

might have been different if the ISNP was implemented in full, and in a more stable socioeconomic context. Nonetheless, it is important to recognize that more intensive interventions may be required to achieve transformative impacts among the poor and vulnerable households. The following recommendations are made to inform the design of future interventions and for further research.

1. There is the need to allow enrolment into CBHI at any point in the year instead of the current practice where enrollment is only possible in the enrollment window of December to February. Households may get money for enrolment at different times outside the enrollment window but saving till the enrollment window can be difficult.

2. Efforts should be made to improve on health service delivery to address the perception or reality of low quality of care for persons who use the CBHI to seek care. Increased staffing and improving access to prescription medication at public health facilities are recommended steps to prioritize.

3. The content of BCC sessions should be thoroughly reviewed to ensure their relevance to the target households. The timing and delivery of the BCC sessions should also be adjusted to better meet the needs of the participants.

4. There is the need to invest in the institutionalization of social workers to ensure adequate training, clear career path, and predictable financing so that social workers can serve households in a timely manner with quality services.

5. Future interventions should improve on the timeliness for verification of pregnancies and child malnourishment to ensure complete and timely transitions to TDS status. Frontline workers should be further trained on the identification and referral of malnourished children, and subsequent transitioning to TDS. It will also be important for rigorous estimates of the expected number of cases in each calendar year so that appropriate budget can be allocated.

6. For future evaluations, it will be complementary to include post-distribution monitoring data to keep an eye on interventions and effects so that there could be timely remedial actions if necessary.

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Disclaimer: The evaluators and authors of this report are independent of the intervention design and implementation, and have no conflict of interest in the study and reporting. The evaluators have undertaken their duty with the highest standard of credibility and impartiality.

List of Acronyms

BCC	Behavioral Change Communication
CBHI	Community Based Health Insurance
DHS	Demographic and Health Survey
DiD	Difference – in- Difference
ESS	Ethiopia Socioeconomic Survey
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HDA	Health Development Army
HEW	Health Extension Workers
IDI	In- depth Interview
IN-SCT	Improved Nutrition through Integrated Basic Services and Social Cash Transfer
IPWRA	Inverse Probability Weighted Regression Analysis
ISNP	Integrated Safety Net Program
KII	Key Informants Interview
MIS	Management Information System
MoLSA	Ministry of Labour and Social Affairs
MoWSA	Ministry of Women and Social Affairs
MOS	Medical Outcomes Study
PDS	Permanent Direct Support
PPP	Purchasing Power Parity
PSNP	Productive Safety Net Program
PW	Public Work
SW	Social Workers
TDS	Temporary Direct Support
TLU	Tropical Livestock Unit
UNICEF	United Nations Children Fund

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I. Introduction

Ethiopia has witnessed an impressive economic growth in the recent past with gross domestic product (GDP) at purchasing power parity (PPP) per capita more than doubling in the past decade – increasing from USD 1,191 in 2012 to USD 2,811 in 2022 (1). Despite this growth, poverty and food insecurity remains high, particularly in rural areas, often exacerbated by weather shocks such as droughts and floods. Since 2019, Ethiopia has also witnessed many negative shocks including the COVID-19 pandemic, internal conflict, and increased inflation due to disruptions in the global supply chains and cost of living crisis. All these overlapping challenges have had a toll on the living conditions of the population, particularly those most exposed to the conflict and inflation.

Against the backdrop, the Government of Ethiopia and its development partners have been implementing various social protection programmes aimed at poverty reduction and the economic empowerment of the poor and vulnerable. The social protection landscape consists of many diverse interventions, including the nationwide flagship rural Productive Safety Net Program (PSNP), which has been in operation since 2005, a formal social security scheme for civil servants and private sector employees, the Community-Based Health Insurance (CBHI) scheme, and health and education fee waiver schemes. In 2016, the government also rolled out an urban PSNP in major urban centres of the country, including Addis Ababa, to address the challenge of rising urban poverty and unemployment.

These programmes have been fragmented in terms of policy, institutional coordination, and budget allocations. The Government has recognized the potential for better coordination and cooperation and is therefore seeking to establish a comprehensive, integrated social protection system. In 2016, the National Social Protection Platform, hosted by the then Ministry of Labour and Social Affairs (MoLSA), now Ministry of Women and Social Affairs (MoWSA), supported the drafting and endorsement of the National Social Protection Policy and Strategy. The platform was created to offer a framework for a National Social Protection Policy. One of the three key principles of the platform is that a social protection system enables actors to work collaboratively and effectively on social protection programmes through shared commitment, sufficient budget funding, strong partnership with ministries and other stakeholders, enhanced coordination and implementation capacities, and systems and tools.

The United Nations Children's Fund (UNICEF), one of the main stakeholders, is working closely with the Government to facilitate the integration of services and reach the most vulnerable. As part of this effort, UNICEF is supporting MoWSA in building an integrated safety net system to effectively address the multidimensional needs of the most vulnerable women and children in rural and urban areas. In line with this, UNICEF has supported two pilot initiatives – the Tigray Social Cash Transfer Pilot Programme (2011–2014) and the Integrated Nutrition and Social Cash Transfer Pilot Programme (2015-2018). Both pilot programmes linked PSNP clients and other services using social workers and community care coalitions (CCCs). In 2018, UNICEF in collaboration with the government, initiated another pilot programme – the Integrated Safety Net Programme (ISNP) in the Amhara Region.

This choice of rural areas in the Amhara region for the intervention was informed be available data which showed that rural areas in the Amhara region have some of the biggest challenges with development in the country. Data from the 2016 Ethiopia socioeconomic survey showed average total consumption for rural Amhara was BIRR 4,731 while the national average consumption for all rural

areas was BIRR 5,720. Data from the Ethiopia DHS of 2016 also showed that 48 per cent of children in rural Amhara were wasted although the national prevalence of wating was 38.4 per cent. This indicates that the targeting of the intervention had a consideration on equity to help the most vulnerable group of people to realize their rights.

As with other UNICEF-supported interventions, a rigorous impact evaluation was considered crucial to determine the impacts of the ISNP on the target population and inform policy and related initiatives accordingly. This report presents the results from an impact evaluation of the ISNP using data from two rounds of data collection – a baseline conducted between December 2018 and March 2019, and an endline conducted between December 2022 and March 2023. The baseline study report is available here, A midline qualitative study was conducted in January – February 2020 to track the status of implementation and preliminary effects, and to inform necessary corrective measures. A report from the qualitative midline study is available here.

The rest of the report is organized as follows. Section 2 provides a detailed description of the ISNP including the components of the intervention, conceptual framework, and roles and responsibilities of partners. Section 3 describes the evaluation purpose, objectives, and scope, as well as the study design, implementation, data, and analytic methods. Section 4 describes the changing context of the ISNP due to multiple shocks that substantially altered the socioeconomic context between the baseline and endline data collections. Section 5 then presents the status of implementation of the ISNP interventions, while Section 6 presents the impacts of ISNP on intermediate outcomes and Section 7 presents findings on the medium to long-term outcomes. Section 8 concludes with a discussion, lessons learnt and recommendations.

II. The ISNP design, conceptual framework, and stakeholders

ISNP design

The ISNP was implemented between 2019 and 2024 and had 4 broad areas of intervention:

a. Facilitating enrolment of CBHI clients into the CBHI scheme

The ISNP exempts PSNP permanent direct support (PDS) clients from paying the CBHI premium while PSNP clients in the public works (PW) component receive information on CBHI enrollment but are still required to pay the CBHI premium. The goal is to improve access to health among the poor and vulnerable and is part of the strategies towards achieving universal health coverage which is one of the sustainable goals (SDG 3.8).

b. Transitioning of PLW and households with malnourished children into TDS

The component aims to improve the transitioning of pregnant and lactating women (PLW) and caretakers of malnourished children in PW households into temporary direct support (TDS) status to enable them receive payment without the public work requirements. This is expected to allow beneficiaries to allocate more time on activities that promote maternal and child health, children's growth as well as mothers' health. This intervention recognizes the challenges faced by PLW and this gender-sensitive intervention was meant to contribute to gender equality outcomes (SDG 5).

c. Improved access to frontline workers and social services

Another component of ISNP was to improve access of PSNP clients to frontline workers, particularly social workers. The social workers were then required to provide information and education, and facilitate the implementation of the TDS component, as well as case management of malnourished and out of school children. BCC sessions were added to help improve caregiver nutrition knowledge, feeding practices, health, early marriage, gender equality, and adolescent sexual and reproductive health.

d. MIS development to support ISNP implementation.

The MIS development was meant to provide electronic database on PSNP clients and allow for tracking of cases that may require case management. The MIS was also meant to facilitate real time updating of household vital events among PSNP clients.

At the time of the endline data collection, the ISNP had been implemented for 3 years and there was one more year of intervention left.

ISNP Conceptual Framework

Figure 1 provides the theory of change (ToC) that informed the ISNP which further shows the various components of the ISNP relative to the PSNP, identifies the relevant individual and household indicators, and hypotheses the pathways of impact. First, all PSNP clients receive cash support either through conditional public works during the lean season (PW households) or unconditional support for households with no able-bodied members (PDS households). The cash grant allows households to smooth consumption and purchase necessities, such as food, but also pay for other household expenditures, such as health care and education. Phase 4 of the PSNP introduced an additional category, the TDS, which covers pregnant and lactating women in PW households who are exempted from work requirements until the child reaches age 12 months. It also covers caregivers of malnourished children. The cash transfers to TDs clients are associated with certain responsibilities (soft conditionalities), including attending antenatal and postnatal check-ups, attendance at BCC sessions, growth monitoring among infants, and regular school attendance of children ages 6–18 years old. Social workers are tasked with verifying compliance with these commitments, but there is no penalty for non-compliance. The TDS clients receive a regular, monthly cash transfer during the entire year.

Second, the major innovation of the ISNP is the integrated service package, including case management, and these extra or plus components are the focus of this evaluation. The plus package is expected to strengthen four types of capitals among households: economic, social, education, and health capital. Economic capital will increase because of the productive impacts of the cash transfers, and, potentially, due to a decline in out-of-pocket health expenditures because of enrollment in the CBHI or a reduction in the distressed sale of assets. Social capital will expand through participation in the BCC sessions, the support of social workers and CCCs, and participation in the CBHI. Education capital will be enhanced in several ways, such as: (a) among caregivers, through attendance at BCC sessions and the support of social workers and CCCs; (b) access to more extensive information about sexual and reproductive health; (c) among children, through increased school attendance; and (d) greater community awareness of issues revolving around gender equality and the harms of early marriage. Health capital may improve because of enrollment in the CBHI and through improved practices on nutrition, health, and sanitation because of the BCC sessions.

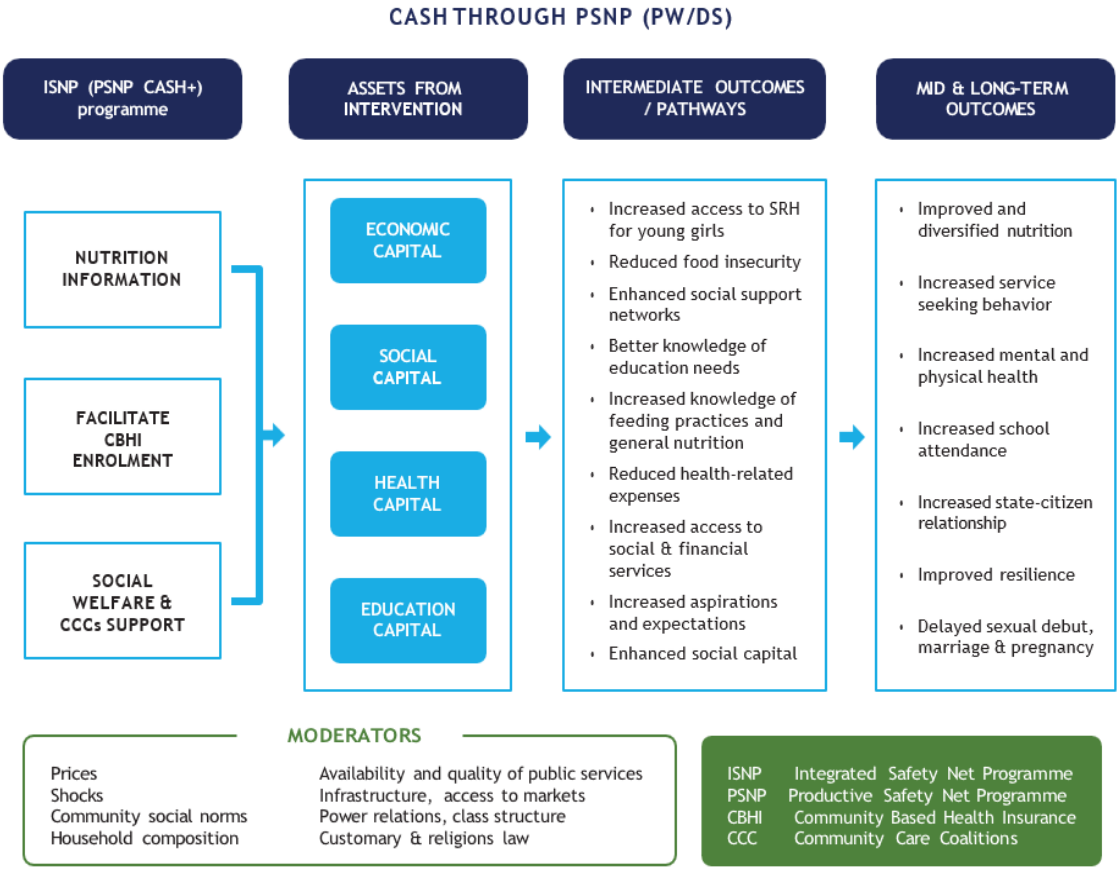
Third, strengthened household assets would improve intermediate outcomes. These include, for example, reduced food insecurity and higher-quality diets resulting from increased economic capital and more knowledge about good feeding practices and nutrition. Positive impacts on intermediate outcomes may also emerge through the greater time availability among caregivers deriving from the drop-off in the time necessary for public works. More time may be freed up for care, rest – essential for pregnant and lactating women – and health seeking. Furthermore, social support networks should expand through the programme. The improved education and social capital assets are expected to boost the access to social and financing services and the awareness of gender and social development. Greater enrollment in the CBHI is anticipated to reduce out-of-pocket health expenditures, thereby fostering more economic security.

Fourth, ISNP also aims to affect mid- and long-term outcomes through these intermediate pathways. For instance, better nutrition can result from reduced food insecurity and better knowledge of feeding practices. CBHI enrollment can lead to more health seeking behaviour through the cut-back in out-of-pocket expenditures on health services. The rise in economic security may allow households to manage shocks and economic stress more effectively, thereby lessening the need for negative coping strategies, such as marrying off young children to manage debt, decreasing household

consumption, or selling off livestock and other productive assets. The social worker sensitization efforts can expand the access of adolescents to sexual and reproductive health services, ultimately leading to delayed sexual debut and pregnancy. While addressing community gender norms on early marriage, these activities may also empower young girls at risk of early marriage by offering them information about where to seek help. Through the extra household responsibilities tied to the programme and monitored by the social welfare workforce, school attendance may increase. The resilience of households could be enhanced by the services provided by the ISNP and the related influence on intermediate outcomes. Greater interaction with the social welfare workforce and social protection programmes may promote better State-citizen relationships.

Fifth, the framework reflects the fact that the ISNP is not being implemented in a vacuum. Contextual factors may shape programme effectiveness. The impact of the ISNP may thus be weaker or stronger depending on conditions in the community, such as household composition, infrastructure and service availability, market access, external shocks, local social and gender norms, power relations, gender equality and women's empowerment, socioeconomic structure, and customary and religious practices. The COVID-19 pandemic, conflict and cost of living crises that occurred during the ISNP pilot period are perfect examples of the anticipated shocks which are taken into consideration in the analysis and interpretation of the findings.

Figure 1: ISNP Conceptual Framework



The ISNP also supports the development of a comprehensive management information system (MIS) for the PSNP implementation and promote inter-sectoral collaboration among the different implementing agencies of PSNP and CBHI. These secondary activities are meant to support institutional strengthening for the management of integrated social protection system in Ethiopia.

Roles and responsibilities of stakeholders

ISNP has three main stakeholders –The Swedish International Development Cooperation Agency (Sida), UNICEF Ethiopia, and government partners. Sida is the donor for both the intervention and the evaluation. UNICEF Ethiopia is responsible for coordination and providing technical support. The ISNP is implemented by government partners including MoWSA, particularly related to the interventions designed for the PDS clients, at the federal level and its structures at the lower level including the regional and woreda Bureaus of Women and Social Affairs. At the woreda level, several government stakeholders also participate in the ISNP implementation including bureau of Agriculture, related to the PW clients, Bureau of Health, and PSNP and CBHI coordination offices. At the Kebele level, the lowest political administrative level, social workers (under the woreda Bureau of Women and Social Affairs), health extension workers (under the woreda Bureau of Health) and development agents (under the woreda Bureau of Agriculture) are key frontline service providers to ensure the effective implementation of the ISNP.

III. Evaluation purpose and methodology

Evaluation purpose, objective and scope

The objective of the evaluation is to assess the impacts of the ISNP on CBHI enrolment, health seeking behaviour, health status, child nutrition outcomes, child protection, and other indicators of wellbeing. The study is expected to advance understanding on the potential impact of an integrated implementation of the PSNP and CBHI on the wellbeing of rural households, including the most vulnerable women and children. Evidence from the study will be used to inform harmonized approach of targeting and implementation of social protection programmes in Ethiopia and elsewhere. The findings will also be of critical importance towards supporting the effort of the Ethiopian Government in reducing multi-dimensional poverty among the most vulnerable sections of the society.

Various Ministries of the government, including MoWSA, Ministry of Health (MoH), and Ministry of Agriculture (MoA) will be the primary users of the evidence to inform decisions about the integration of social protection programmes in the country, harmonize planning, budgeting, and monitoring and evaluation activities of social protection programmes, and institutionalize the implementation of integrated safety net systems. UNICEF and other UN agencies will also utilize the evidence to inform their policies, advocacy efforts, and programming. Evidence based policies and programmes will ensure inclusive development, and the advancement of the sustainable development goals (SDGs). The evidence will also be useful for other stakeholders such as civil society organizations, non-governmental organizations and other multinational development partners.

In terms of geographical scope, the study covers 4 rural woredas – Dawa Chefa, Libo Kemkem, Ebinat and Artuma Fursi – in the Amhara region of Ethiopia. Details on the selection and assignment of woredas to treatment and comparison status are covered under the evaluation methods. Technically, the evaluation employs a prospective quasi-experimental difference in differences design to identify the impacts of the ISNP. The validity of this estimation strategy relies on the parallel trends assumption, according to which the change in a comparison group provides a good approximation of the change that would have occurred in the treatment areas if the ISNP programme had never been implemented there, conditional on controlling for relevant differences between the groups.

Evaluation Questions

Using this conceptual framework, the impact evaluation seeks to answer the following questions:

a. What is the impact of the ISNP on household food security?
b. What is the impact of the ISNP on household assets, debt and shocks?
c. What is the impact of the ISNP on health seeking behaviour among ISNP clients?
d. What is the impact of the ISNP on women's perceived social capital?
e. What is the impact of the ISNP on nutrition knowledge and feeding practices?
f. What is the impact of the ISNP on household consumption?
g. What is the impact of the ISNP on household resilience?
h. Wha tis the impact of the ISNP on women's empowerment and life satisfaction?

i. What is the impact of the ISNP on attitudes towards early marriage?
j. What is the impact of the ISNP on children's welfare?

Evaluation Methods

Quantitative evaluation design

The design of the impact evaluation was constrained by the approach used in the selection of the treatment (ISNP) group. Given that the Woreda [District] serves as the main administrative unit for the PSNP and CBHI, the UNICEF Ethiopia Country Office, in collaboration with district and regional partners, opted for the treatment to be assigned at the woreda level. The selection of the treatment woredas entailed both an inclusive approach and an objective needs and capacity-based assessment. A workshop was first held among the five shortlisted woredas (Borena, Dewa Chefa, Enebsie Sarmider, Libo Kemkem, and Mekdela). UNICEF Ethiopia then performed an in-depth analysis of the woredas using an assessment tool to capture the needs of the woredas in education, nutrition and health. The woredas were also assessed on health insurance (CBHI availability in the woreda); nutrition (the relevant interventions being carried out); the links and coordination between the Woreda Office of Labour and Social Affairs and woreda food security and nutrition–sensitive agriculture; management, technical and administrative capacity; links to other UNICEF interventions; and accessibility and practicability in terms of UNICEF support. The results of the assessment led to the selection of Dewa Chefa and Libo Kemkem as treatment woredas.

Given that the ISNP woredas were purposely selected, a randomized control trial design was not possible although this is the preferred method for estimating causal impacts of an intervention. To find an appropriate comparison group, the team relied on the expertise of technical staff at the UNICEF Ethiopia Country Office who are knowledgeable about the PSNP intervention areas in Amhara to select comparison woredas with similar characteristics relative to the treatment woredas. The criteria included a similarity in socio-demographic profile (being in the same Zone - a higher administrative level next to woreda), health service supply, UNICEF programme organization, culture and ethnicity, agro-ecological characteristics, and level of economic development. The two comparison woredas were selected in the same Zones in which the treatment woredas were located, as follows (see Figure 2):

- For Dewa Chefa, the comparison woreda was Artuma Fursi, both in the Oromo Special Zone; and
- For Libo Kemkem, the comparison woreda was Ebinat, both in Debub/ South Gondar Zone.

To determine the minimum sample size for the evaluation, power calculations was conducted based on estimates of baseline values and the expected impacts on the following indicators:

- Use of health services among those who were sick
- Individuals who consulted a health practitioner or traditional healer or visited a health facility in the four months before the survey
- Enrollment in the CBHI
- Children ages 6–23 months who consume a minimum acceptable diet
- Children ages 12–23 months who have received all basic vaccinations
- Children ages 12–23 months who have received no vaccinations
- Children ages 12–23 months who have received age-appropriate vaccinations
- Women who received antenatal care from a skilled provider during the last pregnancy

For each indicator, the sample size required to detect a desired change of delta (δ) with a minimum power of 80 per cent was calculated based on the assumption of simple random sampling and a zero non-response rate. A one-side statistical test is assumed because the proposed interventions have an expected direction of change. The calculations use the observed values of these indicators for the Amhara Region in the 2016 Ethiopia Demographic and Health Survey (DHS) (CSA and ICF, 2016). For example, in the case of the individuals using health services during the prior month, the desired change is an increase of 10 percentage points from a base of about 56 per cent. In the case of antenatal care from a skilled provider during the last pregnancy, the desired change is an increase of 5 percentage points from a base of 67 per cent.

After estimating the number of households/individuals required for each indicator, the available information on household size and age-sex distribution was used to determine the number of households required in the treatment and comparison arms. The desired number of households was then adjusted for an attrition of 10 per cent between baseline and the follow-up data collection, and 10 per cent margin for lack of support in matching between treatment and comparison households. Based on these calculations, the PSNP client populations in each woreda, and budget considerations, a target sample size of 5,400 households was selected, consisting of 2,700 households in treatment (T) woredas and 2,700 households in comparison (C) woredas. The sample was equally split between PW and PDS households (2)

The quantitative component of the impact evaluation is based on three survey instruments:

- A household questionnaire administered to each household in the sample;
- A community questionnaire administered to kebele leaders in each kebele; and
- A health facility questionnaire administered to focal persons and administrators in all public health facilities in the kebeles in the sample.

The instruments were first developed by the research team at the UNICEF Innocenti Global Office of Research and Foresight (UNICEF Innocenti). They draw on earlier questionnaires implemented by the research team in several countries in sub-Saharan Africa, as well as other household surveys in Ethiopia. Survey items have been pulled from national surveys, such as the Household Consumption and Expenditures Surveys, the Welfare Monitoring Survey, the Ethiopia Socioeconomic Survey (ESS), the Demographic and Health Survey (DHS), Young Lives, the Multiple Indicator Cluster Surveys, and modules previously implemented in Ethiopia and sub-Saharan Africa as part of the Transfer Project, a joint initiative of Food and Agriculture Organization of the United Nations, UNICEF, and the University of North Carolina at Chapel Hill that aims to produce rigorous evidence on cash transfer programmes in sub-Saharan Africa and to facilitate the policy uptake of this evidence.

The instruments have been developed to cover multiple topics. They have evolved from the program's theory of change presented in Figure 1. A brief overview of the instruments are as follows:

Household surveys were administered to one woman in each household both at baseline and endline. Priority was assigned to child caregivers. If no eligible or willing woman was available in the household, then man primary child caregiver was surveyed. The main respondent could be assisted by any household member who was more knowledgeable on a given topic. The key thematic areas covered included economic productivity, health expenditures, health and nutrition status, knowledge of and access to health services, child protection and other services, violence victimization and perpetration, school attendance, women's empowerment, CBHI enrollment and perceptions, shocks, and the distress sale of assets, PSNP participation activities and benefits, and access to social

services. There was also a module on marriage asking about women ages 12-24 years, including those who have lived in the household within the past 5 years, even if no longer currently living in household. The survey instrument also examined topics related to potential moderators of programme impacts, such as perceived social support. Data on the geolocation of households and other services were also collected, and anthropometric measurements were taken of all children ages 6–59 months in the households. The endline household survey also added questions related to COVID-19 and the impacts of conflicts on the households.

Community surveys were administered to a knowledgeable individual or group of individuals in each community – community leaders, teachers, and so on – to probe topics such as access to markets, health facilities, and schools; kebele marriage customs (matrilineal, patrilineal, and so on) and caregiving practices (who would be expected to take in a child if the parent dies); and covariate community shocks.

Health facility surveys were administered to all government dispensaries and primary health care facilities in treatment and comparison areas. Data were collected from official logbooks and through face-to-face interviews with health care workers on child preventive care and sick visits, nutrition-related services, and family planning, and administrators on the availability of personnel, supplies, and services.

The quantitative survey instruments are presented in Appendix C.

Qualitative evaluation design

The qualitative component involved in-depth interviews (IDIs), key informant interviews (KIIs) and focus group discussions (FGDs) to elicit information from various categories of respondents across kebeles [villages] – the lowest administrative level, woredas, and the region. Qualitative data were collected in the two treatment woredas – Dewa Chefa and Libo Kemkem. In each woreda, one kebele was selected for the interviews – Gula (Tsige and Ketemo) in Dewa Chefa and Shemo in Libo Kemkem. However, due to shortage of caregivers of malnourished children for the IDI samples in the kebele, the study interviewed additional IDIs in Birkutie Kebele (a neighbouring kebele to Shamo) in Libo Kemkem woreda as well. In woredas and the region, KIIs were undertaken with PSNP coordinators, UNICEF ISNP coordinators, CBHI coordinators, Management Information System (MIS) experts, and the staff at the Woreda Office of Women and Social Affairs, the regional Bureau of Labour and Social Affairs, and the Bureau of Women and Children's Affairs (BoWCA). In the kebeles, KIIs were conducted with social workers, health extension workers and development agents. The FGDs were also held with kebele CCCs. Customized semi-structured interview guides facilitated the IDIs, KIIs and FGDs.
IDIs were conducted with a subsample drawn from the quantitative household survey sample based on certain household eligibility criteria. The embedded sample was disaggregated to include woman caregivers in three categories, as follows:

- PW and PDS client households with at least one child age under 18 years
- PW households with pregnant or lactating women
- Caregivers in households with malnourished children ages 6–59 months

For each category, a random subsample of three households was selected from the list of eligible households in each of the two kebeles sampled for the qualitative interviews. The IDI interviews focused on the views and experiences of clients of PSNP and the programme's operational and complementary features, such as transfer size, payment delivery, the household responsibilities in

the programme, BCC, case management referral systems, qualities of PSNP implementation and rights and grievance mechanisms. The interview guides also ask questions on health statuses and health seeking behaviour, CBHI enrolment and access to education and nutrition/ feeding practices. IDIs with TDS clients explored experience of pregnancy and the dynamics and implementation of the transition to TDS. The KII and FGD interview guides explore issues related to PSNP implementation, participation in BCC sessions, rights and grievance mechanisms, multi-sectoral collaboration, relevance of plus interventions and impact and sustainability. Th KIIs were also asked about the implementation of TDS and related components including co-responsibilities, case management, and MIS.

The qualitative study tools are presented in Appendix D.

Ethical Considerations

The research team adhered to the Ethical Principles and Guidelines for the Protection of Human Subjects of Research outlined in the Belmont Report (HHS 1979). Enumerators received instruction on ethical data collection and informed consent at data collection training sessions. Informed written consent was obtained from all individuals interviewed ages 18 or more years of age. Ethics approval for both the baseline and endline study were granted by the Amhara Public Health Institute (see Appendix E). All informed consent includes the ethical components on the following: (a) the objectives and content of the study, (b) privacy and data security, (c) voluntary participation, (d) the right to refuse or skip any questions without consequences, and (e) communication of a source to follow up with complaints or to obtain more information on the study. The quantitative interviews lasted approximately one hour per household, and the qualitative interviews lasted approximately 1.5 hours per individual.

Enumerators were also trained on ethical principles and practices for doing surveys with children, including child safeguarding principles. Enumerators had the responsibility to report any suspected cases of abuse of children to their supervisors for further escalation to social workers for appropriate intervention. Taking pictures of children was strongly discouraged, especially when the children were naked. When there was the need for fieldwork pictures with children, enumerators were required to seek consent from parents/caregivers before taking the pictures. Enumerators were also forbidden from inappropriate touch or harassment of children and other members of the households.

Output from the fieldwork

The results presented in this report is based on the quantitative and qualitative data collected from the two study rounds. The baseline quantitative study successfully interviewed 5,389 of the 5,400 households targeted – a response rate of over 99 per cent. Due to efforts in tracking, the endline study also achieved a high response rate of 92 per cent – an attrition rate of 8 per cent which is lower than the 10 per cent attrition rate accounted for in the power calculations. Table 1 gives a breakdown of the sample by woreda and PSNP arm. Community (kebele) level interviews were conducted in all 91 kebeles at baseline and 89 kebeles at the endline. The health facility survey was conducted in 113 facilities at baseline and 125 facilities at the endline.

The qualitative fieldwork was successful in achieving the set targets of IDIs, KIIs and focus group discussions for both the baseline and endline. Only two of the more than 30 planned IDIs were missed, and all the KIIs and focus group discussions were conducted.

Table 1. Baseline and Endline response distribution of household survey

Woreda		PW households				PDS households		
	Treatment Status*	Baseline	Endline	Response rate		Baseline	Endline	Response rate
Libo Kemkem	T	594	562	94.6		666	597	89.6
Ebinat	C	571	533	93.3		698	614	88.0
Dewa Chefa	T	756	739	97.8		685	615	89.8
Artuma Fursi	C	780	737	94.5		639	562	87.9
Total		2701	2571	95.2		2688	2388	88.8

Notes: T = ISNP woreda; C = Comparison woreda

Data and analytic approach

Sampling weights were calculated to account for the unequal inclusion probabilities for the PSNP clients in the quantitative study. The baseline weights were different for PDS and PW households, and baseline inclusion weights were adjusted to account for the differential response rates by PSNP client type and kebele. In view of the quasi-experimental design, there was no expectation that the treatment and comparison groups would be automatically balanced with respect to the many indicators being studied. In the analysis of the baseline data, inverse probability matching was used to find the most suitable comparison households to the treatment households. This matching produced a successful outcome with 92 per cent of treatment households matched and balance checks showing that more than 95 per cent of over 120 indicators were balanced post-matching – including 35 indicators that were not balanced in the absence of the matching (2).

Given the 8 per cent attrition between baseline and endline, overall attrition analysis was used to examine whether the panel households were different from the households that dropped out. Selective attrition analysis was then used to examine whether the panel-T households were different from the panel-C households. Results from the attrition analysis showed that the households lost to follow-up were generally smaller in size, had an older head, were more likely to be headed by a female, and had lower socio-economic status. A check of balance between panel-T and panel-C households showed fewer differences, indicating that the overall attrition has improved the balance between the T and C households in the panel (see Tables C1-C6 in the Annex for the attrition tables). The balance between the panel-T and panel-C households from the baseline matched sample is also preserved.

In keeping with the principle of intent-to-treat for the impact estimates, the main results presented in this report uses the panel of households, uses propensity score matching to identify the best C households in the panel for the T households in the panel, and applies ordinary difference-in-difference (DiD) estimation on the matched panel sample. Several analytic samples and estimation strategies were also used to check for robustness of the results, namely:

- DiD estimation on the panel of baseline matched sample;
- Doubly-robust DiD using IPWRA on the matched panel sample;
- Doubly-robust DiD using IPWRA on the baseline matched panel sample;
- Adjusting for actual treatment status of households in the above estimations; and

Overall, the results from the different alternative estimations are similar and so the preferred results of the intent-to-treat with panel matched sample are presented in this report. Given that the study has not been powered for disaggregation of results by characteristics such as gender or disability status, the findings could not be meaningfully disaggregated by any of these variables.

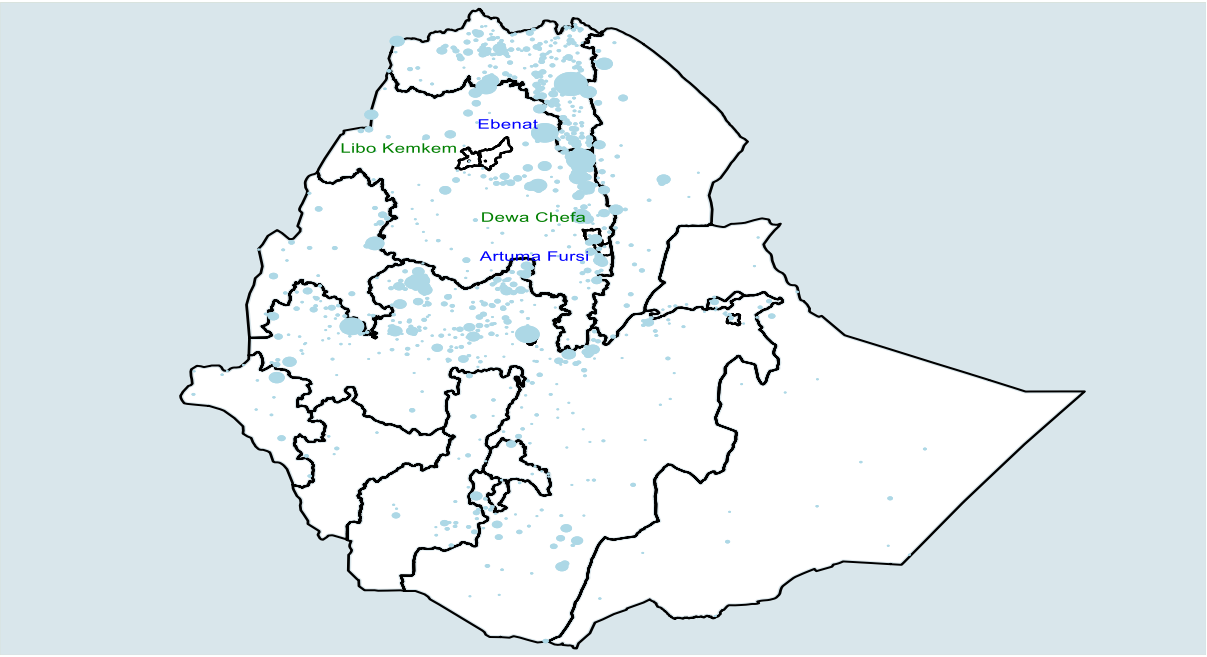
IV. Changing context during ISNP implementation

This section presents an overview of the changing socioeconomic context during the ISNP implementation between the baseline and endline data collections. The section describes the exposure to the conflict, COVID-19, retargeting of PSNP and transition to PSNP5, changes to health facility and kebele characteristics, exposure to inflation, and the changing cost of the CBHI enrollment. The analysis shows that most of these shocks affected the comparison and treatment households to equal extent. The few variables that affected comparison and treatment groups differently – namely loss of property or injury of household member as a result of the conflict and access to health services – are controlled for in the estimations. Nonetheless, it is necessary to interpret the findings with this changing context in mind given that the outcomes could have been different if ISNP was implemented in a more stable context.

Exposure to armed conflict

During the ISNP implementation, an armed conflict erupted between the Ethiopian federal Government and the Tigray People's Liberation Front (TPLF) Forces in November 2020 until November 2022. To assess the exposure of the households to the conflict, the study uses data from the Armed Conflict and Location Event Data (ACLED) (3) for Ethiopia for the stated period. Analysis of conflict events, fatalities, and casualties shows that the South Gondar zone (Libo Kemkem and Ebinat) were not much affected by the conflict, and the Oromo zone (Dewa Chefa and Artuma Fursi) were affected to equal degree (Figure 2).

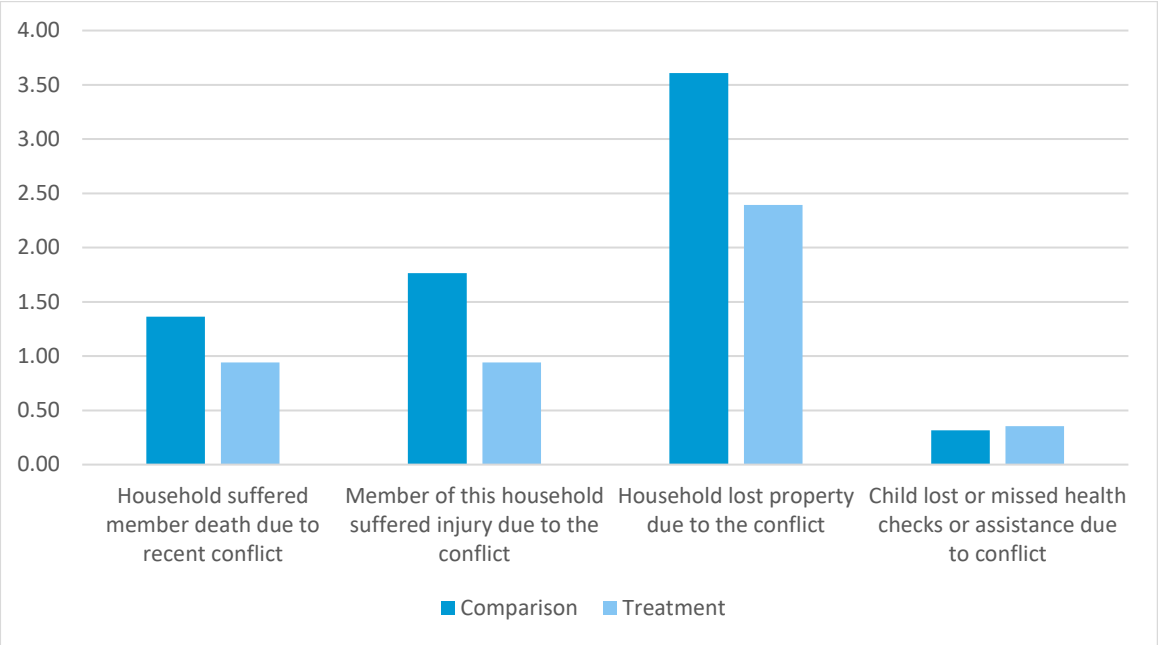
Figure 2: Conflict events in Ethiopia, November 3, 2020 to November 2, 2022



Source: Author's elaboration using ACLED

In the endline household survey, respondents were asked whether the conflict led to death, injury, property loss, and limited access for health checks for children. About 1.4 per cent of comparison households and 0.9 per cent of treatment households reported of the death of a household member due to the conflict. In addition, 1.8 per cent of comparison households and 0.9 per cent of treatment households reported a household member suffered an injury due to the conflict. About 4 per cent of comparison households and 2 per cent of treatment households reported of lost property due to the conflict. Less than 1 per cent of households reported restricted health access for children due to the conflict (Figure 3). Test of equality of the exposure shows that the comparison households were significantly more affected in terms of injury to household members and the loss of property. The overall prevalence of the exposure is low, and the estimation controls for the loss of property or injury of household member as a result of the conflict.

Figure 3: Percentage of households that experienced the events due to the conflict



Exposure to COVID-19

Ethiopia was also affected by the COVID-19 pandemic that hit the world starting in early 2020. Apart from exposure to the health shock, lockdowns and associated measures to contain the spread of the disease also had economic impact on the livelihoods of people. Data shows that Ethiopia was not severely impacted by the COVID pandemic, recording about 500,000 cases and 4,000 deaths (about 61 deaths per million population) by end of 2023. Among the study sample, only 1 per cent of household members reported ever getting a positive test result for COVID-19. This shows that the exposure to COVID-19 was not widespread among the study population, and not likely to have affected the outcome of the intervention.

Re-targeting for PSNP and beginning of PSNP5

PSNP undertakes routine re-targeting of households to determine continued eligibility of households to continue or exit the programme, as well as enroll new households that have become eligible since the last targeting exercise. The fifth phase of the PSNP (PSNP5) started in 2021, and was preceded

with re-targeting and enrollment of new households and exit for other households that were deemed no longer eligible. Data obtained by the study team from administrative records show about 10 per cent of the households in the study were no longer members of the PSNP. The distribution is comparable between comparison and treatment woredas. Self-reported enrollment status in the study indicated a slightly higher proportion of households (16 per cent) are no longer members of the PSNP. There are no significant differences between comparison and treatment woredas with respect to the continual participation of households in PSNP. The results presented are based on the intent-to-treat assumption, but analysis using actual treatment status (treatment on the treated) shows essentially similar results.

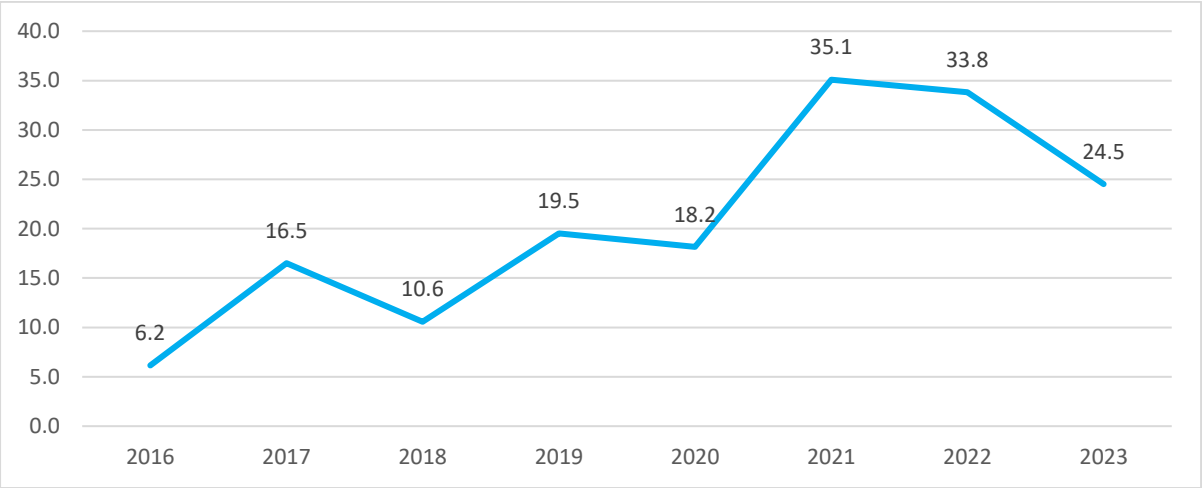
Changes in health facility and kebele characteristics

The ISNP is implemented in the context of kebele and woreda structures, and any differential changes in the context could affect the interpretation of the results. The health facility and kebele level questionnaire were used to collect detailed information about kebele infrastructure, access to services, health facility operations and personnel, and kebele norms (see sample Table B1 in Appendix B). In both comparison and treatment woredas, there were improvements in access to electricity, immunization campaigns, positive attitude towards early marriage, and availability of micronutrient powder at health facilities. Due perhaps to conflict, there were also deterioration in access to asphalt roads, access to pharmacies to purchase medicines, mobile network availability, and share of communities affected by drought. These changes did not follow any systematic patterns with some improvements/ deterioration in some indicators for comparison kebeles only, and same for other indicators in treatment kebeles only. The changes in access to health services is an important factor that can moderate the outcome of the interventions and the estimations control for this variable. It suffices to say that majority of indicators did not see any differential impact between comparison and treatment woredas, and it is fair to assume that net effects on outcomes will be null.

Exposure to inflation

Another macroeconomic shock experienced over the years is high inflation. Figure 4 shows the end of year inflation rate for Ethiopia since 2016. Inflation spiked sharply in 2021 at 35 per cent and remained high at 34 per cent in 2022, up from 18 per cent in 2020. While the inflation eased to 25 per cent in 2023, the high inflation affects the real value of the PSNP transfer over time. It is however worth mentioning that both comparison and treatment households were equally exposed to the inflationary pressure, and the nominal value of the PNSP transfer increased over the period for both groups (PW and PDS clients) to try and offset the impact of the inflation. For example, the daily PSNP wage per person working in PW activities in Dewa Chefa woreda (one of the treatment woredas) increased from 38 Birr (1.31 USD based on the average exchange rate in 2019) in January 2019 to 82 Birr (1.52 USD) in January 2023. Similarly, in Artuma Fursi woreda, the comparison woreda for Dewa Chefa, the daily wage rate for PW clients also increased from 39 Birr in January 2019 to 82 Birr in January 2023. In view of this, it can be argued that the inflation did not have differential impacts on the treatment and comparison households as the change in PSNP wage rates were similar.

Figure 4: Trend in inflation in Ethiopia

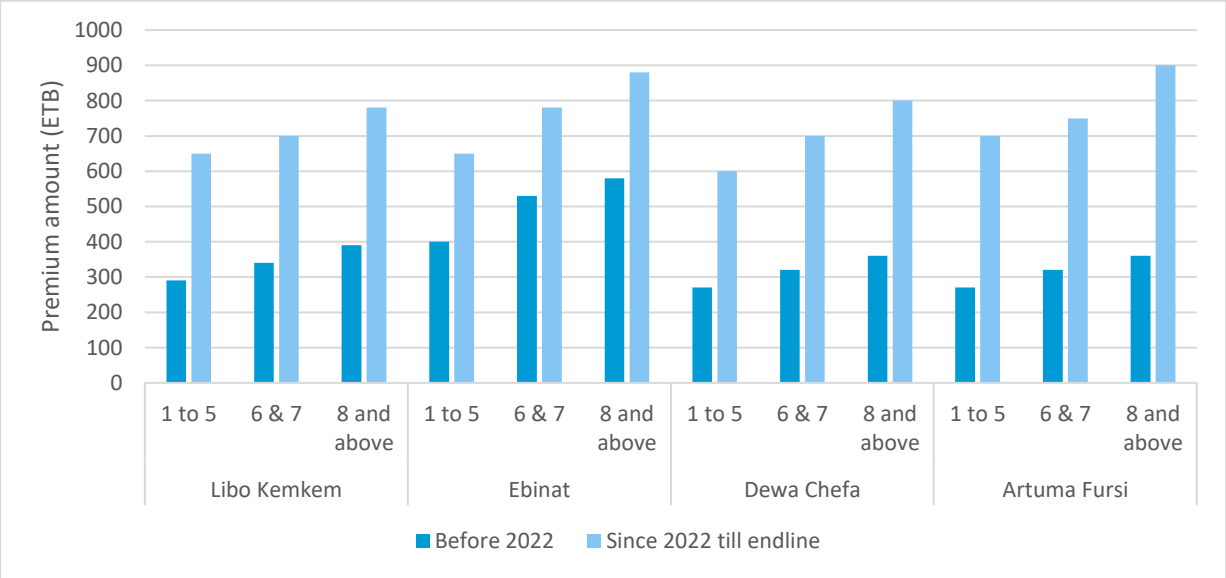


Source: World economic outlook, October 2023 revision

Changes in cost of CBHI enrollment

Another key change in the context of the ISNP implementation is the increases in the cost of premium for enrollment in the CBHI. The cost of CBHI is determined at the household level and has a three-tier fee structure based on household size (1-5, 6 and 7, and 8 and above). The premium also differs by Woreda. Cost also differs between new enrollment (which includes cost of card) and renewals. In 2022, the enrollment fees were revised upwards in all woredas. Figure 5 shows the cost for new enrollments before 2022 and after 2022 – presented by household size and woreda. In Libo Kemkem for example, premium for new enrollment for a household with 1-5 members increased from 290 ETB before 2022 to 650 ETB since 2022. In Artuma Fursi, cost for new enrollment for a household with 1-5 members increased from 270 ETB before 2022 to 700 ETB since 2022. Again, the margin of the changes is similar between comparison and treatment woredas in the two zones, and this does not affect the overall evaluation design. PDS households will still have the waiver from the ISNP, and PW households in both comparison and treatment woredas face these new premiums.

Figure 5: CBHI premiums by woreda and household size, before and after 2022



V. Status of implementation of ISNP plus components

As per the study design, this evaluation assesses the impact of the plus components given that both comparison and treatment groups continued to receive the PSNP treatment either through PW or the PDS. The plus components were free enrollment in CBHI for PDS households and information for PW households to encourage enrollment in CBHI, transition of pregnant and lactating mothers in PW households to TDS facilitated by social workers, intensification of BCC sessions where social workers support participation and compliance, increased access to frontline workers, and case management for malnourished and out of school children. CBHI enrollment improved significantly for both PDS and PW households, and majority of PDS households received the fee waiver per the ISNP design. Transition to TDS status for pregnant women also increase significantly, so did the access to frontline workers. BCC sessions and case management were not fully implemented due to various demand and supply side challenges. Possible reasons based on interviews with clients include the lack of interest by households to participate in BCC sessions due to repetitive contents and inconvenience of BCC delivery time. KII respondents also mentioned shortage of social workers to facilitate BCC participation, provide support for compliance and lack of penalties for non-participation in BCC sessions as possible reasons.

Enrollment and knowledge about CBHI

Table 2 shows the CBHI enrollment status of the households in the study areas. Among the treatment households, the share of PDS households enrolled in CBHI increased from 52 per cent at baseline to 91 per cent at endline. This is not universal as expected by the ISNP design, but very high coverage and a significantly higher share of the PDS households had the fee waiver to enroll in the CBHI. Among PW households, enrollment in CBHI increased from 63 per cent at baseline to 85 per cent at the endline. The impact analysis shows significant positive impacts over the comparison areas. Knowledge of the benefits of CBHI also increased significantly among the treatment group. About 95 per cent of PDS households and 93 per cent of PW households think that CBHI enrollment makes seeking health care services easier. Even a higher share of treatment households (97 per cent among PDS and 96 per cent among PW households) think that CBHI enrollment can also make health seeking more affordable. Treatment households have also higher satisfaction level (on a rage of 1- least satisfied and 10- most satisfied) about CBHI compared comparison households. These results highlight the voluntary nature of CBHI enrollment in the ISNP areas and that fee waiver for PDS clients and information sessions for paying members contributed to increased enrollment.

Table 2: Impact on CBHI enrollment and characteristics

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Currently covered by CBHI	0.116*** (0.02)	0.146*** (0.02)	0.088*** (0.02)	0.88 [0.58]	0.91 [0.52]	0.85 [0.63]
Household has valid CBHI card/ renewed	0.036 (0.001)	0.042 (0.000)	0.032 (0.003)	0.99 [0.98]	0.99 [0.97]	0.98 [0.98]
Received Fee (Premium) Waiver for CBHI	0.120*** (0.02)	0.201*** (0.04)	0.059* (0.03)	0.61 [0.43]	0.77 [0.53]	0.45 [0.36]
Overall knowledge about CBHI (0-100 scale)	-0.684 (0.35)	-0.557 (0.51)	-0.804 (0.48)	67.31 [33.84]	67.42 [33.49]	67.21 [34.17]
Enrolling in CBHI will make seeking health care easier.	0.081*** (0.01)	0.110*** (0.02)	0.054** (0.02)	0.94 [0.81]	0.95 [0.80]	0.93 [0.83]
Being enrolled in the CBHI will make health care more affordable.	0.051*** (0.01)	0.067*** (0.02)	0.035* (0.02)	0.96 [0.84]	0.97 [0.83]	0.96 [0.84]
Overall satisfaction with CBHI	0.636*** (0.12)	0.602*** (0.19)	0.642*** (0.15)	7.79 [6.90]	7.85 [6.90]	7.72 [6.89]
N	5,084	2,072	3,012	6,661	2,995	3,666

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

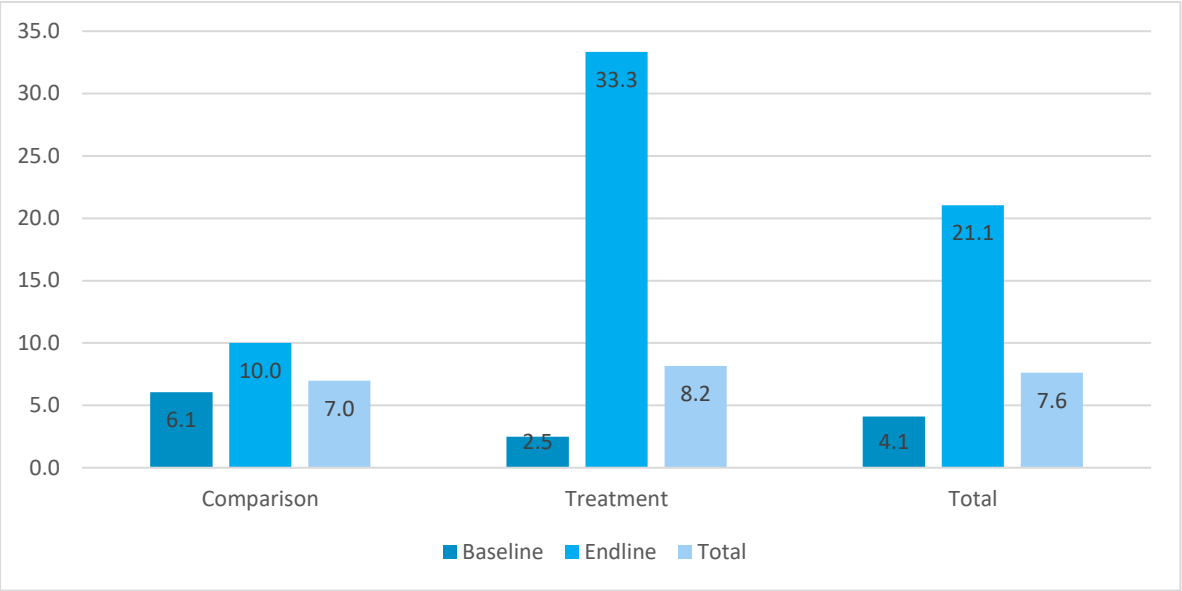
It is worth nothing that administrative records indicate a 100 per cent enrollment of PDS households in CBHI which suggest some households may have indeed been exited from the PSNP but are not fully informed but are rather thinking that their payments may have delayed. Difference between PSNP retargeting and CBHI enrollment times and communication delays about CBHI fee waiver to PDS clients may also lead to this discrepancy. It is also possible that households may not have received their membership cards which is evident in the data as well.

Transition to TDS

Under the ISNP, pregnant and lactating women (PLW) working in PW households were expected to be transitioned to TDS status where they will continue to receive the payment without the work. Unlike the transition to TDS in the comparison woredas, social workers support the identification of PLW and the transitioning process in the treatment woredas. The hours that the women would have worked to earn the PSNP payment should not be substituted by a household member before the payment is made. Similarly, PW households with a malnourished child were also expected to be transitioned to TDS status. The TDS category was introduced in PSNP4 and maintained in PSNP5 as well, and the ISNP was to strengthen the implementation.

Figure 6 shows that at endline, about 10 per cent of pregnant women in PW households in the comparison group transitioned to TDS status compared to 33 per cent of pregnant women in treatment households. At the baseline, the transition to TDS was lower for both treatment arms (6 per cent for comparison and 3 per cent for treatment). The impact estimate shows that the difference in transition to TDS is significantly higher which shows a positive impact of the ISNP.

Figure 6: Transition to TDS among pregnant women



Transition usually occurred between 5-6 months of pregnancy, and more than half of the households reported that they did not replace the public works labour of the woman who transitioned to TDS. A few of the respondents indicated that the husband or other household member had to work in place of the woman who was transitioned. This is contrary to the policy prescription and will require further investigation to ensure consistency.

Time required for verification of pregnancy, lack of standardized reporting by social workers or health extension workers, and shortage of frontline workers such as social workers to identify PLW, link them to social services and close follow-up are the key barriers limiting universal transition of all pregnant women to TDS. On the side of eligible women, there was concern that accepting to stay at home will lead to losing the benefits from PSNP so some women were not willing to accept the offer of the TDS. This calls for intensification of sensitization about the TDS, and for PSNP coordinators to ensure that women who transition to TDS continue to get their benefits in order to promote trust. Women who had been transitioned to TDS status were appreciative and were expecting it will have a positive impact on their lives and that of their children.

> ***"…yes I am transferred to TDS program so that I can get rest and take care of my baby, also to protect me from hard work, sun and other things as well as my baby"*** – LK_IDI_S_L03

Transition to TDS due to having a malnourished child was not common in both comparison and treatment areas. According to key informant interviews, the eligibility criteria is not clear since many children are malnourished, so there is recommendation for transition only in cases of severe acute malnourishment. More work is required in clearly defining the criteria for transition to TDS based on having malnourished child(ren) in the household.

Participation in BCC activities

Participation in BCC activities was limited with only 3 per cent of households reporting that they participated in a community training/awareness raising session in the last 12 months preceding the endline survey. This was like the participation in BCC sessions at the baseline. Key informants also concurred that participation on BCC sessions was a challenge. One key reason appears to be lack of effective communication about the timing of the BCC sessions. The sessions are said to be organized after work on the PW sites at which point many clients may have left for home or are too tired to participate meaningfully. Information from the KIIs suggest that the non-compulsory nature of participation in the BCC sessions made it difficult to enforce attendance.

> *"....it is responsibility but not a must to them. For example, if one takes financial literacy training or if one takes the BCC training, it is only for their advantage, but nothing will happen to them if they absent from this training"* – LK_KII_P01

Additionally, there is no clear understanding if clients are expected to attend these sessions as part of their co-responsibilities and to what extend they are aware of this component.

> *"I think the benefit exists if I have attended the BCC session. However, I don't have any info the type of benefits attached to BCC sessions due to my absence or attending the sessions"* – LK_S_IDI_PW02.

Key informants also identified a budget problem as contributing to the limited organization of BCC sessions. Also, some respondents indicated that PSNP clients have all been exposed to the content of the BCC sessions and there was no need to keep repeating the same information. Lastly, there was a sense that the information provided at the BCC sessions was not actionable due to lack of resources – for example to be able to buy improved seeds for planting, or preventing child marriage which tends to be influenced by religion and culture and is beyond the control of the women who usually participate in the BCC sessions.

The organization of the BCC sessions needs a critical review in terms of timing and content, and how to deliver the information other than through organized meetings. References were made to lack of materials and ingredients for cooking demonstrations for delivering the BCC sessions, and women routinely attended the sessions with their children whose presence causes distractions for effective communication. Also worthy of note that access to radio as source of information is also limited and so might not be a viable option for delivering information to the population under consideration.

Knowledge and access to frontline workers

Three categories of frontline workers operate in the intervention areas – social workers (SW), health extension works (HEW), and health development agents (HDA). Responses from the households indicate that the ISNP had a positive impact on knowledge of all three categories of frontline workers. The share of households that are aware of HEW increased from an average of 57 per cent at baseline to 86 per cent at endline among the treatment households – a difference of about 30 percentage points. An impact of about 12 percentage points implies that the awareness among the comparison households also increased by about 18 percentage points which can be attributed to the

intensification of activities during PSNP5. While the awareness has seen a positive impact, actual contact with the frontline workers during the 3 months preceding the surveys only increased significantly for the HDA. The heavy workload of SW and HEW is likely responsible for this limited contact given that the expectation of having at least one SW per kebele was not realized in several kebeles due to financial challenges, as well as high staff turnover which results in temporary lack of SW or HEW.

Table 3: Impact on access to frontline workers

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Knows the HEW for kebele	11.952***	10.554***	13.222***	85.87	82.96	88.60
	(1.72)	(2.54)	(2.31)	[56.66]	[50.71]	[62.23]
Being in contact with HEW in past 3 months	-3.602	-3.487	-3.473	45.55	43.53	47.32
	(2.85)	(4.42)	(3.72)	[38.24]	[39.12]	[37.57]
Knows the HDA in kebele	30.948***	27.035***	34.581***	55.90	52.09	59.48
	(1.52)	(2.15)	(2.14)	[13.53]	[12.88]	[14.14]
Being in contact with HDA in past 3 months	17.135***	12.143***	21.782***	27.26	22.27	31.95
	(1.19)	(1.62)	(1.72)	[5.07]	[4.97]	[5.16]
Knows the social worker for kebele	35.775***	34.523***	36.943***	65.65	62.82	68.30
	(1.47)	(2.12)	(2.04)	[13.06]	[12.08]	[13.98]
Being in contact with SW in past 3 months	-9.589	-8.140	-10.526	38.13	40.11	36.42
				[45.72]	[46.32]	[45.24]
N	498	202	296	2,390	923	1,071

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

The minimal contact with frontline workers, and apparent dissatisfaction with the quality of work done by the frontline workers was highlighted in the qualitative interviews as evidenced by the following quotations:

> ***"…they did not help us; they simply take statistical data that we do not understand. They do not teach us and they simply write something and go back"*** – LK_IDI_C02

> ***"…they are low grade [lower educational qualification] so to make the job more effective it would be better to give them additional training from time to time. It would be better to hire people who have degree. Now it is hard for them to cope with system or the technology"*** – DC_KII_I01

Case management for malnourished and out of school children

The case management for malnourished children required referrals to the health facility for nutrition treatment and transition to TDS. As indicated above, transition to TDS as a result of malnourished child(ren) was limited due to challenges with definition to clearly identify what constitutes by the term a 'malnourished child'. For out of school children, the social workers were expected to encourage and monitor re-enrollment and attendance. Interviews with the social workers suggests that it is difficult

to observe which school aged children are not attending school – they are usually not in the household when the social workers visit. Even for the cases they find, it is not possible to force the person to go to school because they are often the only caregiver for an elderly person.

Some children enrolled in school also did not regularly attend school due to lack of clothes and school supplies (such as books and pens), problems of concentration, and weakness linked with scarce eating. Some children also feel too old for the class they have to attend which serves as a disincentive as they feel ashamed to be in class with other children much younger than them.

> ***"barriers like buying school exercises books, pens, clothes for students and shoes are very challenging. I am not supporting my children very well. Even, they have no exercise book while attending their class. Some teachers supply them papers to write on it"*** – LK_S_IDI_PW02.

An important step to ensure the increase of children' school attendance is the effort to avoid their involvement in workforce: according to the safety net program rules, minors are not eligible to do public works.

The case management for malnourished and out of school children also needs a critical review in terms of the criteria for malnourished children, and incentives to ensure that out of school children can return to school.

Development of MIS

The goal of a digital integrated MIS is to enable integrated data management across various programme components, facilitate case management including identification, linkages with required services and follow-up, and capture all relevant information about PSNP clients in near real time to facilitate the work of multiple actors. Interviews with key informants shows that ISNP continued to build on the digital MIS that was started as part of the Integrated Nutrition and Social Cash Transfer (IN-SCT) pilot. The MIS has been deployed at the regional and woreda levels, but not in all kebeles due to lack of equipment, trained personnel, and enabling facilities. Lack of access to electricity in some kebeles was cited as an example of the challenges faced as evidenced by the following quote by a woreda coordinator.

> "…some kebeles do not even have electricity or a good structure for office so it is difficult to install or have these computers and other equipment there for use of the MIS." - LK_KII_ME01

Other limitations and problems in the functionality and implementation of the MIS were also raised by MIS focal points and managers at different levels. These include issues about language and limited access to developers to help with troubleshooting challenges.

> ***"…the software was dominantly developed by international companies with a number of language related limitations. It was challenging to easily fix software related problems if it was totally handover by foreigners. Therefore, it is recommended to closely work with domestic software developers. We have several Universities working on Software Development. Thus, empowering in-country software developers is mandatory in the future"*** - LK_KII_ME01

Respondents also indicated that the MIS is not being updated real time because of the challenges with social workers not having computers or tablets to be able to access the information of the PSNP clients and update with new information such as someone passing away, a pregnancy, or presence of malnourished children in the households. The social workers pass for example data on member passed away to the kebele administrators who are expected to undertake their own follow-ups and then in turn pass on the information to the woreda level. Social workers also communicate pregnant mothers and having a malnourished child to health extension workers to start required health checkups and follow-ups. In addition, social workers have to report new case to woreda MIS for registration for MIS-based case management. In this regard, with all the technical and logistical challenges, the MIS facilitates the case management through multi-sectoral collaboration and makes information on linkages with social services and follow-up more efficient.

Despite these challenges, it is re-assuring to note that the MIS has continued to evolve, and having the software in place means that it can be deployed at all levels when the necessary infrastructure and personnel are in place.

VI. Impact on intermediate outcomes

In line with the theory of change presented in Figure 1, the ISNP is hypothesized to have impacts on intermediate outcomes at the household and individual level. These include food security, household assets, health seeking behaviour, women's social support, and feeding knowledge and practices. The analysis shows no impacts of food security and some negative impacts on assets resulting from higher level of self-reported shocks by treatment households. Health seeking behaviour did not improve despite the increased enrollment in CBHI, and this is likely the result of bottlenecks such as distance to facilities, perceived low quality of care for CBHI holders compared to paying service seekers, and general preference for traditional or religious solutions to health problems. Women's perceived social support improved, but nutrition knowledge and feeding practices also did not improve.

Household food security

Food security is the most immediate outcome that any social protection programme is expected to impact. Waiving the fee for enrollment in CBHI for PDS households is expected to protect against a potential catastrophic out of pocket health expenditure and this in turn is likely to improve food security, due more likely to better spending on food. Table 4 presents the impacts of the ISNP on food security indicators and shows that there were no impacts on any of the dimensions – number of meals, food worry, and number of months of food insecurity.

Table 4: Impact on household food security

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means- 2023 [2019] Overall	PDS	PW
Number of meals per day	0.084	0.098	0.070	2.74 [2.75]	2.71 [2.70]	2.77 [2.80]
Never worried about having enough food	0.000	0.032	-0.029	0.17 [0.23]	0.20 [0.23]	0.13 [0.23]
All household members have sufficient food	0.078	0.084	0.072	0.32 [0.34]	0.32 [0.35]	0.32 [0.33]
Child eat nutritious food	0.023 (0.01)	0.015 (0.02)	0.031 (0.02)	0.13 [0.11]	0.09 [0.08]	0.17 [0.15]
Child has enough food	0.037	0.011	0.061	0.15 [0.14]	0.10 [0.10]	0.20 [0.17]
Food insecure at least on month in the year	0.101	0.135	0.069	0.74 [0.74]	0.71 [0.70]	0.76 [0.77]
# of months with food insecurity	0.733	1.028	0.457	3.13 [3.14]	3.07 [2.99]	3.18 [3.27]
N	9,196	4,446	4,750	9,196	4,446	4,750

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

The number of meals per day was already high from baseline (average of 2.75 among treatment households) so there could be ceiling effects in the possibility for further increases. Self-reported perception about children eating adequate or nutritious food is quite low and saw no impacts. Given the context of all the shocks, and the reality that both comparison and treatment households got comparable amounts of PSNP income, this result is not surprising.

Respondents in PW households highlighted the fact that receiving support for only six months of the year is not adequate for a transformative change.

> ***"…we receive the PSNP related services only for six months annually. We would face challenges the rest of six months. We rarely have access to food the whole six months when there is no PSNP"***
>
> **– DC_GK_IDI_P02**

Despite an improvement in the situation regarding consumption and the introduction of new elements in the diet, there is still a lack of water and sanitation in many contexts and no year-round continuity in their food security.

Household assets, debt and shocks

Treatment households reported experiencing more shocks than comparison households. Shocks reported include household idiosyncratic shocks (such as death of a member, or loss of household assets) to covariate shocks (such as floods, conflicts or an epidemic). This suggests that the treatment households were overall more exposed to the multiple shocks outlined in Section III. The risks are external to the households and households only report a shock when they are not able to

avert the impact of the exposure. The shocks have resulted in a significant negative impact on the durable asset holdings of the households (measured by all assets ownership index), but not on housing quality and livestock size (measured by Tropical Livestock Unit – TLU). Interestingly, the share of households with an outstanding debt also reduced significantly, more likely driven by lack of supply of lenders.

Table 5: Impact on household assets, debt and shocks

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
All asset owned index	-0.026*** (0.01)	-0.027** (0.01)	-0.026*** (0.01)	0.28 [0.13]	0.28 [0.12]	0.28 [0.14]
Housing quality index	-0.004 (0.00)	-0.001 (0.00)	-0.007* (0.00)	0.40 [0.40]	0.40 [0.40]	0.39 [0.39]
Total number of animals currently owned, in TLU	0.011	-0.044 (0.04)	0.062	0.53 [0.56]	0.54 [0.54]	0.51 [0.58]
Has an outstanding debt	-0.039** (0.02)	-0.021 (0.02)	-0.055** (0.02)	0.19 [0.17]	0.16 [0.13]	0.21 [0.21]
HH experienced any shock	0.193*** (0.02)	0.211*** (0.03)	0.176*** (0.03)	0.75 [0.42]	0.73 [0.40]	0.77 [0.44]
N	9,196	4,446	4,750	9,196	4,446	4,750

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Health seeking behaviour

Responses on illness and health seeking behaviour shows that the increased enrollment in the CBHI has not translated into positive health seeking from a health facility when a household member is sick (Table 6). Indeed, among PW households, there was a negative impact on health seeking from a health facility when sick. On the positive side, households were more likely to have used their CBHI card to access health care services. Total health expenditure per illness episode has also not reduced significantly which could be due to additional expenses to seek care such as transportation and lodging costs and expenses to alternative cares. This, all things being equal, also explains as to why ISNP did not result into significant impact on food security indicators such as number of meals, food worry, and number of months of food insecurity. Reduced expenditure on health was hypothesized as a key pathway to improved household and child welfare.

Many issues explain the limited impact of the CBHI enrollment on health seeking behavior. First, there is a widespread perception that users of CBHI are not treated with dignity and respect when assessing health care services. There is preference given to those paying with cash, and CBHI holders must wait for more administrative processing. Secondly, most of the drugs needed are often not readily available from the health facilities, and CBHI holders must go and access the medicine in private pharmacies. Third, there is high dependency on self-medication, traditional herbal medicine, and spiritual consultation for health needs. Fourth is the issue of distances to health care facilities. All these issues need to be addressed before enrollment in CBHI can lead to substantial improvements in health seeking behaviour.

Table 6: Impact on health care

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Illness last month	-0.020	-0.005	-0.030	0.14	0.17	0.11
	(0.02)	(0.03)	(0.02)	[0.15]	[0.18]	[0.13]
Sought care for illness last month	-0.118**	-0.068	-0.156**	0.65	0.63	0.67
	(0.04)	(0.06)	(0.06)	[0.50]	[0.48]	[0.53]
Sought care from public health facility	0.031	0.036	0.027	0.83	0.81	0.85
	(0.05)	(0.06)	(0.06)	[0.81]	[0.80]	[0.82]
Accessed health care services using CBHI	0.148**	0.151*	0.139	0.73	0.75	0.71
	(0.06)	(0.07)	(0.08)	[0.58]	[0.55]	[0.60]
Total health expenditures (last month) - curative care	-44.657	-39.374	-33.669	290.42	270.84	309.53
	(81.79)	(115.81)	(96.75)	[225.44]	[213.60]	[235.24]
N	2,885	1,329	1,556	2,885	1,329	1,556

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Women's perceived social capital

We assessed social support using Medical Outcomes Study (MOS) – Social Support score, constructed based on questions such as: whether the individual has someone who would:

1) help them if they were confined to bed
2) take them to the doctor if they need it
3) prepare their meals if they are unable to do it themselves
4) help with daily chores if they are sick

And whether they have someone to:

5) have a good time with
6) turn to for suggestions for dealing with a personal problem
7) understand their problems
8) love them and make them feel wanted.

We obtained the overall social support score by averaging the responses to the items and then standardizing (possible range of 0–100). The analysis shows a positive and significant impact of the ISNP on women's perceived social support (Table 7).

Women's social support is also assessed in terms of participation on communal groups such as Iddir (a local burial association and support group) or Eqqub (an association aimed to mobilize finance and distribute in rotation). The results show significant increase in participation in Iddir but not in Eqqub. While membership into Iddir needs a relatively small financial contribution to encourage participation of all community members, membership into Eqqub requires relatively larger sum of money which might be unaffordable for women. These notwithstanding, women's level of trust in the community declined significantly among women in PW households. It is not clear what might have caused this decline in trust despite increased participation in groups such as Iddir. One plausibility is that women are participating more in the groups because they are being encouraged to do so, but the underlying factors of mistrust have been further highlighted as the women have become more involved in the community activities. It is also conceivable that overall trust in one's community might decrease in a time of war and multiple shocks, especially when pre-crisis expectations of solidarity are not fulfilled during the time of the need. Either way, this observation will warrant further investigation to ensure that interventions perceived as positive do not lead to negative unintended consequences.

Table 7: Impact on women's social support

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
MOS-Social Support score (standardized)	7.357***	7.361***	7.312***	52.12	50.83	53.33
	(1.66)	(1.82)	(2.14)	[43.94]	[42.79]	[45.01]
Woman part of 1+ groups	0.232***	0.231***	0.233***	0.84	0.84	0.84
	(0.06)	(0.06)	(0.07)	[0.53]	[0.54]	[0.52]
Woman belongs to Iddir	0.246***	0.239***	0.252***	0.82	0.82	0.82
	(0.06)	(0.06)	(0.08)	[0.51]	[0.51]	[0.51]
Woman belongs to Eqqub	0.005	0.001	0.008	0.04	0.04	0.04
	(0.01)	(0.02)	(0.02)	[0.03]	[0.03]	[0.03]
Woman feels part of the community	0.094	0.150	0.043	3.18	3.17	3.20
	(0.08)	(0.10)	(0.09)	[3.02]	[3.00]	[3.03]
Woman level of trust in the community (agree)	-0.097***	-0.045	-0.143***	0.02	0.03	0.01
	(0.03)	(0.04)	(0.03)	[0.09]	[0.08]	[0.09]
N	8,389	4,030	4,359	8,389	2,018	2,178

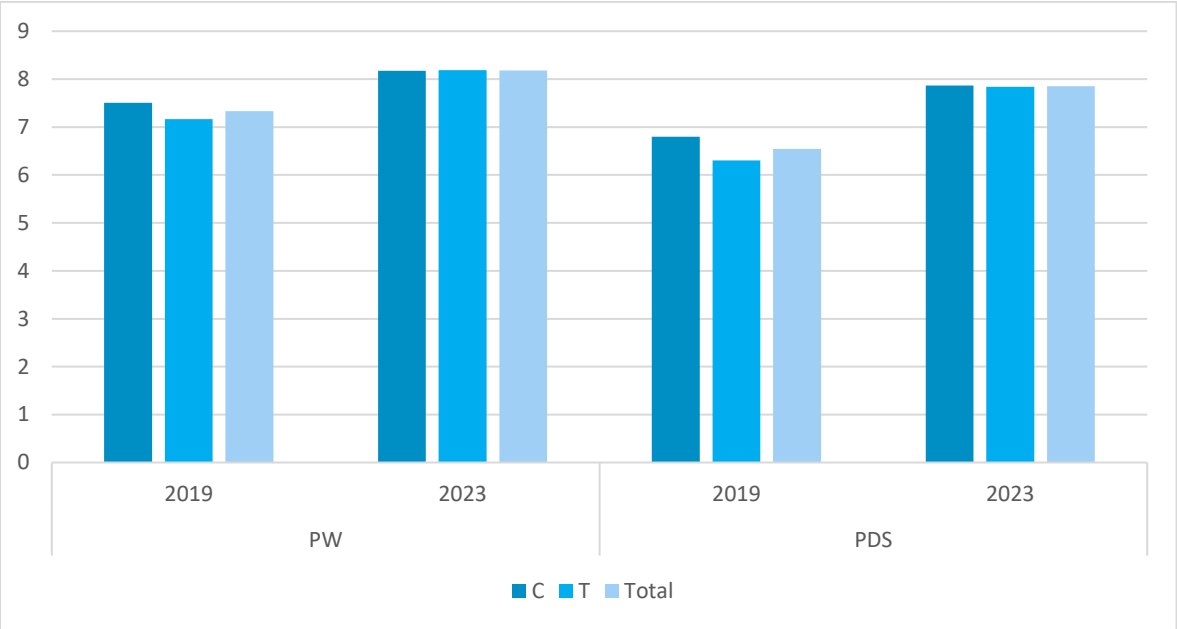
Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Nutrition knowledge and feeding practices

Nutrition knowledge is one of the intermediate outcomes that was theorized to improve based on the BCC sessions and regular interactions with frontline workers, particularly social workers. Nutrition knowledge is assessed with 14 questions including knowledge about foods rich in vitamin A and iron, exclusive breastfeeding, and age-appropriate complementary feeding (see Table B3 of Appendix B). Caregivers who respond correctly to all questions will have a score of 14 while those who respond wrongly to all questions will have a score of 0. For questions on knowledge about foods rich in vitamin A or iron, identifying two or more sources was considered satisfactory.

The distribution of the responses on overall knowledge is given in Figure 7. For both comparison and treatment groups, and for both PW and PDS households, there were general improvements in the overall score between baseline and the endline. However, there are no statistically significant impacts. This is likely the result of the limited participation in the BCC sessions, and the limited visits by the SWs to the households. Analysis of the specific questions shows positive impacts on specific questions (such as knowledge to feed children more when they are sick) and a negative impact in knowledge on some questions (such as identifying foods that are rich in iron). It must be noted that not the same person was interviewed between baseline and endline so some of these impacts could be a result of random chance due to a different person responding. Sub-sample analysis looking at the same respondents over time confirms the lack of impact on the overall knowledge score, but positive and negative impacts on specific questions remains. This can be explained by improved knowledge in one group but not the other.

Figure 7: Impact of overall nutrition knowledge



The analysis on feeding practices also shows no impacts of the ISNP on feeding practices including minimum dietary diversity, minimum meal frequency, and minimum acceptable diet. The share of children that received minimum acceptable diet was less than 5 per cent since the baseline, showing that there is a large room for improvement. The breastfeeding score – comprising of exclusive breastfeeding till child is six months old and continued breastfeeding until child is at least one year old – is also quite low (about 32 per cent).

Qualitative interviews revealed that lack of resources including disposable cash is the main reason why even full knowledge of nutrition will not necessarily translate to better feeding practices. Most respondents reported problems in following the guidance on child nutrition due to scarcity of resources, as the following examples clarify:

> *"…if there was money, it will be good feeding children like eggs, bread and tea, but since I am poor, I will simply feed them shirowote (stew prepared from finely grinded dried peas or chickpeas) or with kikwote (stew prepared from split dried peas or chickpeas) and it is the same for dinner"* – LK_IDI_C03

> *"…I did not get enough food; I simply prepared what is available in the house, but I did not feed her different fruits which have to be bought at the market because I can't afford to buy it"* - LK_S_IDI_L02

Table 8: Impact on infant and young child feeding practice

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Minimum dietary diversity	0.007	-0.007	0.010	0.03	0.04	0.02
	(0.03)	(0.06)	(0.03)	[0.02]	[0.05]	[0.01]
Minimum meal frequency for 6-23 months old children	-0.086	-0.098	-0.076	0.63	0.65	0.63
	(0.07)	(0.16)	(0.08)	[0.60]	[0.62]	[0.60]
Minimum acceptable diet for 6-23 months old children	0.018	0.020	0.014	0.02	0.04	0.01
	(0.02)	(0.06)	(0.03)	[0.01]	[0.03]	[0.01]
Infant and Young Child Feeding Index (6-23 months)	0.195	0.195	0.231	4.08	4.10	4.07
	(0.19)	(0.35)	(0.19)	[3.93]	[3.81]	[3.97]
Infant and Young Child Feeding Index (6-59 months)	0.274*	0.154	0.323	3.23	3.31	3.19
	(0.14)	(0.21)	(0.17)	[2.99]	[3.06]	[2.96]
Breastfeeding score for IYCF	0.094	0.076	0.102	0.32	0.31	0.32
	(0.05)	(0.08)	(0.06)	[0.37]	[0.33]	[0.38]
Diet diversity score for IYCF	0.066	0.011	0.098	0.75	0.77	0.74
	(0.08)	(0.10)	(0.09)	[0.67]	[0.70]	[0.65]
Meal frequency score for IYCF	0.114	0.067	0.123	2.16	2.22	2.13
	(0.09)	(0.17)	(0.12)	[1.96]	[2.03]	[1.93]
N	3,042	970	2,072	3,042	970	2,072

Note: Means adjust for the sampling weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

VII. Impact on medium to long term outcomes

This section presents findings on the outcomes that hypothesized to be impacted by the ISNP in the medium to long term. These include consumption and dietary diversity, household resilience, women's empowerment and life satisfaction, attitudes towards child marriage, and child welfare outcomes. The analysis shows positive impact in household dietary diversity, driven by positive impacts on the consumption of legumes, oils and spices. Household resilience was reduced as evidenced by the increased use of negative coping strategies (such as spending less on health) and sale of valuables (such as land or durable assets) to deal with shocks. This is highly expected given households have faced with multiple shocks simultaneously and the decreasing value of the cash transfers because of spiking inflation. As a result, household may have resorted to negative coping mechanisms which also explains the negative impact on assets reported in the previous session. Women's life satisfaction improved in PDS households, and attitude towards child marriage improved given that the reported ideal age for a girl to marry increased from 16.6 years to 17.4 years among the treatment households. There were no positive impacts on child outcomes such as stunting, school attendance, preventive health care, vaccinations, and birth registration.

Consumption

To analyse the food consumption of caregivers, a dietary diversity score indicator was created that identifies 12 food groups based on a food composition table for use in Africa (HHS and FAO, 1968). For a healthy diet, it is recommended for individuals to regularly consume from at least 4 of the 12 food groups daily. The dietary diversity index sums up the number of different food groups that the household consumes, and this ranges from 1 to 12. Table 9 shows the distribution and impacts of ISNP on the consumption from each of the food groups.

Cereals is the most consumed food group with 99 per cent of households consuming foods in this category. This is followed by the consumption of spices and condiments (about 85 per cent at endline) and then legumes (about 75 per cent at endline). Overall, households consume from an average of 4 of the food groups. The impact estimates show positive impacts on the consumption of legumes, oils, spices, and the overall dietary diversity. Given the lack of impacts on nutrition knowledge and feeding practices for children, the impacts on consumption and dietary diversity is not fully explained, and the qualitative interviews did not explore this in detail. This will warrant further research.

Table 9: Impact on household consumption

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means – 2023 [2019] Overall	PDS	PW
Meat	0.041 (0.02)	0.054* (0.03)	0.030 (0.02)	0.04 [0.01]	0.05 [0.01]	0.03 [0.01]
Fruits	0.000 (0.01)	-0.006 (0.01)	0.007 (0.01)	0.02 [0.02]	0.02 [0.03]	0.02 [0.02]
Vegetables	0.137** (0.05)	0.152** (0.06)	0.124 (0.06)	0.64 [0.58]	0.63 [0.55]	0.64 [0.61]
Dairy	0.013 (0.02)	0.025 (0.02)	0.003 (0.02)	0.04 [0.04]	0.05 [0.04]	0.04 [0.04]
Cereals	-0.009 (0.01)	-0.010 (0.01)	-0.009 (0.01)	0.99 [0.98]	0.99 [0.98]	0.99 [0.98]
Roots	0.018 (0.02)	0.025 (0.03)	0.011 (0.03)	0.16 [0.10]	0.18 [0.11]	0.14 [0.09]
Eggs	0.015* (0.01)	0.028* (0.01)	0.003 (0.01)	0.02 [0.01]	0.03 [0.01]	0.02 [0.01]
Legumes	0.179*** (0.06)	0.186** (0.08)	0.173** (0.07)	0.75 [0.64]	0.74 [0.63]	0.76 [0.64]
Nuts	-0.046 (0.03)	-0.064** (0.03)	-0.030 (0.03)	0.02 [0.05]	0.03 [0.05]	0.02 [0.05]
Oils	0.231*** (0.06)	0.258*** (0.07)	0.205*** (0.07)	0.63 [0.53]	0.64 [0.51]	0.62 [0.55]
Spices and condiments	0.133*** (0.03)	0.146*** (0.04)	0.121*** (0.03)	0.85 [0.75]	0.85 [0.74]	0.86 [0.76]
Household dietary diversity index	0.711*** (0.15)	0.789*** (0.19)	0.638*** (0.17)	4.18 [3.72]	4.20 [3.67]	4.15 [3.77]
N	9,160	4,418	4,742	9,160	4,418	4,742

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Household resilience

Household resilience can be simply defined as the ability of households to cope with shocks without compromising developmental needs. Given the multiple shocks faced by households, it is conceivable that regular sources of livelihood may have been compromised, and households had to adopt various coping strategies to survive. Some of these coping strategies were positive (such as relying on savings or getting unconditional help from family and friends) while others are negative (such as withdrawing children from school or spending less on health). Other coping mechanisms are neither positive nor negative (ambiguous) depending on the initial conditions (such as doing more work). Other coping strategies involve distress asset sale – the sale of productive assets such as agricultural tools or non-farm enterprise equipment – to be able to meet urgent needs.

Resilient households are those that can adopt positive coping strategies to shocks, while avoiding distress asset sales. The result on the coping mechanism shows that households were not resilient as the share of negative coping strategies and distress asset sale for food needs increased significantly. Recalling that treatment households self-reported higher experience of shocks (Table 5), the increased negative coping and distress asset sale corresponds to the increased need, and highlights the vulnerability of households to shocks and stressors.

Table 10: Impact on household resilience

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Share of positive coping to shocks	-7.502	-7.499	-7.421	30.53	34.79	26.72
				[42.05]	[43.91]	[40.49]
Share of negative coping to shocks	11.549***	18.971***	4.991	47.05	44.62	49.22
	(3.57)	(5.24)	(4.84)	[38.60]	[37.06]	[39.90]
Share of ambiguous coping to shocks	-4.047	-11.472**	2.430	22.42	20.59	24.06
	(3.12)	(4.38)	(4.40)	[19.35]	[19.03]	[19.61]
Any distress asset sale (DAS)	0.105***	0.122***	0.090***	0.35	0.33	0.37
	(0.02)	(0.02)	(0.02)	[0.20]	[0.18]	[0.22]
DAS for food needs of household	0.096***	0.117***	0.076***	0.30	0.28	0.32
	(0.02)	(0.02)	(0.02)	[0.17]	[0.15]	[0.19]
DAS for emergency household needs	0.001	0.015	-0.013	0.14	0.13	0.14
	(0.01)	(0.02)	(0.02)	[0.11]	[0.11]	[0.11]
N	9,196	4,446	4,750	9,196	4,446	4,750

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Women's empowerment and life satisfaction

Table 11 presents the impacts of ISNP on women's agency, life satisfaction, outlook, and savings. Women's decision making (agency) was measured using series of questions about how often the woman felt that 1) life is determined by her own actions; 2) she has the power to make decisions that change the course of her own life; 3) she has the power to make important decisions that change the wellbeing of her children; 4) she has the power to make decisions that change the wellbeing of her household; 5) she is capable of protecting her own interests within family; and 6) she is capable of protecting her own interests outside family (see Table B4 in Appendix B).

The agency score is an aggregate of the responses to these questions and the analysis shows that ISNP had a positive impact on the agency score driven mainly by more women in treatment households believing that they can protect their own interests within the family. More women in PDS households indicated being satisfied with their lives. There were however no impacts of ISNP on women's control of their lives, decision making autonomy or savings.

In the qualitative interviews, women highlighted that enrollment in CBHI has given them some level of financial independence from their husbands on health-related issues for themselves and their children, which is the factor that likely increased the increased sense of agency. Nonetheless, domestic chores (house cleaning, cooking, and childcare) are still entirely performed by women.

> *"…before many women depend on their husband financially so it is difficult for them to go to clinic as soon as they get sick they have to wait for their husband approval but now the cycle is broken"* – DC_KII_C01

Table 11: Impact on women's empowerment and life satisfaction

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means- 2023 [2019] Overall	PDS	PW
Agency score	1.035**	1.126**	0.933	16.73	16.34	17.09
	(0.44)	(0.46)	(0.61)	[14.98]	[14.56]	[15.37]
Satisfied with life some/most/all of time	0.078	0.108**	0.049	0.55	0.55	0.56
	(0.04)	(0.04)	(0.05)	[0.42]	[0.40]	[0.43]
Woman level of control over her life	0.329	0.335	0.318	5.96	5.84	6.08
	(0.21)	(0.26)	(0.24)	[5.23]	[5.07]	[5.38]
Woman level of decision-making autonomy	0.221	0.241	0.201	6.29	6.13	6.44
	(0.22)	(0.27)	(0.26)	[5.33]	[5.24]	[5.42]
Woman has savings	0.100*	0.104	0.098	0.16	0.16	0.17
	(0.05)	(0.05)	(0.06)	[0.19]	[0.21]	[0.17]
N	1,229	554	675	1,229	122	136

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Attitude towards early marriage

One of the goals of ISNP is to contribute to the reduction of the high prevalence of early marriage by providing education on the harms of early marriage, and educating the population on the legal provisions regarding early marriage. Table 12 shows that there have been some positive impacts of the ISNP on the attitudes and knowledge about early marriage.

Table 12: Attitudes towards early marriage

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means- 2023 [2019] Overall	PDS	PW
Ideal age a girl should get married	0.614***	0.776***	0.460	17.44	17.28	17.59
	(0.20)	(0.23)	(0.25)	[16.64]	[16.62]	[16.65]
Ideal age a girl should get married: U18	-0.159***	-0.193***	-0.126*	0.34	0.39	0.30
	(0.05)	(0.05)	(0.06)	[0.57]	[0.57]	[0.56]
Ideal age a girl should get married: U15	-0.021	-0.013	-0.030	0.02	0.03	0.01
	(0.02)	(0.03)	(0.03)	[0.08]	[0.09]	[0.08]
Respondent knows legal marital age for girls	0.155**	0.228***	0.097	0.93	0.91	0.95
	(0.05)	(0.07)	(0.07)	[0.76]	[0.74]	[0.78]
N	9,159	4,417	4,742	9,159	4,417	4,742

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

First, respondents' perception about the ideal age a girl should get married has increased from about 16.6 years at the baseline to 17.44 years. While this is still less than the legal minimum age of 18 for a

girl child to marry, the increase is significant by a magnitude of 0.64 which means that comparison households still hold their perceived ideal age for a girl to marry at less than 17 years. Secondly, the share of respondents who think the ideal age a girl should marry is under age 18 has declined from 57 per cent at baseline to 34 per cent at the endline. This drop is also significant which implies more households in the comparison areas still think the ideal age a girl should marry is under 18 years. Third, the share of respondents who are aware of a legal minimum marital age for girls has increased from 76 per cent at baseline to 93 per cent at the endline.

According to key-informants, collaboration with schools has been crucial and in specific cases, the involvement of medical structures and/or the police is needed. Schools are both the places where some campaigns are implemented and the institutions that are supposed to indicate the names of the minors illegally proposed for marriage by their parents/relatives. The police have sometimes been involved to stop early marriages which is helping address the situation.

> *"…this awareness raising process is happened mostly through school. The girls themselves also inform us about any preparations at home for early marriage and ask us to support them in stopping this. So, through the kebele chairperson, administrator and the CCC member, this will be reported to the woreda so that the girl will be examined if her age meets the minimum age for marriage based on the law. If she is under the minimum age set by the law, the marriage will be cancelled"* – FGD_CCC03.

> *"…we encourage people to inform us when they see someone undergoing these harmful practices. As soon as we observe someone practising early marriage, we take the girl to health center for further medical examination and then we work to stop the marriage process. Police also take part in this action"* – DC_KII_SW02.

According to a local coordinator, there are still forced and early marriages in the woredas but not among PSNP families because the work on the promotion of girls' rights has been effective.

Children's welfare

The final domain of the medium to long-term outcomes is about children's welfare. These include children's nutritional status (measured by stunting or severe stunting), school attendance, health care when sick, preventive health, vaccination, and birth registration. Table 13 shows that there were no impacts on any of these child level outcomes. About 50 per cent of children ages 6-59 months remain stunted with about 20 per cent being severely stunted. Impacts on wasting and underweight, as well as the severe forms, are presented in Table B5 of Appendix B. None of them saw any positive impacts which is consistent with the literature on the impact of cash transfers and cash plus programs on child nutrition (5). Past studies show that while programme characteristics including transfer amount, conditionality and health services access play important roles on the effects cash transfer programmes on the nutrition outcomes (6). Tirivayi et al. (5) also argue that chronic malnutrition may not be alleviated using cash transfers alone. Looking at the descriptive results, the study finds that about 40 per cent of children 6-17 years were not attending school, and about 25 per cent of households did not seek health care from a facility when a child was sick. The share of children 12-23 months that have received all required vaccinations is about 60 per cent (up from 40 per cent at baseline) and only about a 20 per cent of children 1 to 4 years have their births registered.

Within a context of multiple shocks and the reality that this evaluation assesses only the impact of the plus components, these results are not very surprising, but indicate that more intensive and differential interventions will be required to bring about positive changes in these indicators. It is also

worth mentioning that households, regardless of membership in CBHI or any cash transfer programmes, can access child health services free of charge at public health facilities which may partly obscure the differential impacts of the ISNP on the utilization of child curative and preventive care services.

Table 13: Impact on child welfare and protection

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Stunted (HAZ <-2 SD)	0.019	0.057	0.003	0.49	0.48	0.51
	(0.05)	(0.09)	(0.07)	[0.50]	[0.47]	[0.51]
N	3,023	960	2,063	3,023	960	2,063
Severely Stunted (HAZ <-3 SD)	-0.058	-0.008	-0.074	0.20	0.19	0.20
	(0.04)	(0.08)	(0.05)	[0.23]	[0.22]	[0.24]
N	3,023	960	2,063	3,023	960	2,063
Currently attending school	-0.009	-0.018	-0.007	0.52	0.58	0.49
	(0.04)	(0.04)	(0.06)	[0.56]	[0.62]	[0.53]
N	14,844	4,884	9,960	14,844	4,884	9,960
Absent from school from more than a week because had to work	0.067	0.073	0.077	0.57	0.45	0.66
	(0.10)	(0.15)	(0.11)	[0.67]	[0.61]	[0.70]
N	662	241	421	662	241	421
Sought care for illness last month	-0.118	0.048	-0.196	0.75	0.78	0.73
	(0.08)	(0.14)	(0.10)	[0.53]	[0.51]	[0.54]
N	1,311	484	827	1,311	484	827
Any preventive care	-0.019	0.075	-0.071	0.31	0.31	0.31
	(0.05)	(0.07)	(0.06)	[0.26]	[0.31]	[0.24]
N	3,363	1,075	2,288	3,363	1,075	2,288
Received all vaccinations	0.049	-0.111	0.106	0.62	0.67	0.60
	(0.12)	(0.14)	(0.16)	[0.43]	[0.46]	[0.42]
N	657	195	462	657	195	462
Birth registered	-0.052	-0.047	-0.051	0.19	0.22	0.17
	(0.05)	(0.07)	(0.06)	[0.24]	[0.23]	[0.25]
N	3,327	1,059	2,268	3,327	1,059	2,268

Note: Means adjust for the sampling weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

VIII. Discussions, conclusions and recommendations

The study presents the findings of the impacts of the ISNP in Amhara region of Ethiopia on intermediate, and medium to long-term outcomes using baseline and endline data. This section discusses the key findings and conclusions and puts forward recommendations to inform future social protection policy and programme designs and further research. It is worth noting that the implementation of the ISNP programme is marked by major unanticipated socioeconomic changes due to Covid-19, conflict, inflation, and upward revision of CBHI premiums that may have influenced the effectiveness of the programme. For example, the emergency of Covid-19 pandemic, which came a year after the baseline data collection, affected the implementation of some of the components of the ISNP such as the delivery of BCC sessions and access to health facilities, particularly for higher risk groups such as PLW and PDS clients. The conflict which erupted in November 2020 and continued till November 2022 is also another major extraneous factor that characterized the context of the ISNP implementation. In addition to death and injury of household members and loss of property, access to social services was hindered during the conflict. What is more, the transitioning of the PSNP phase from PSNP4 to PSNP5 in 2021 and routine retargeting activities also resulted in exclusion of households from the programme. Hyperinflation further eroded purchasing power of clients and put undue pressure on them and may have compromised the programme's effectiveness.

The findings from this study should also be read considering that the cost of CBHI premium across all study woredas more than doubled over the study period. Overall, although all households were equally exposed to the abovementioned changes in most cases and unlikely to have affected the overall evaluation design, the changes negatively impacted the implementation of the ISNP as planned. This resulted in mixed, including insignificant and at times negative, impacts of the ISNP on various outcomes. Thus, it would be highly important to take these changing contexts into consideration when reading and interpreting the findings and implementing the recommendations.

Discussion of Key Findings and Conclusions

Programme Implementation

The ISNP was launched to pilot various plus components on top of cash transfers to PSNP4 clients. These additional components included: 1) facilitation of households' enrolment into the CBHI through exemption of CBHI premium for PDS clients and provision of information for PW (paying) clients about CBHI registration and the benefits; 2) provision of intensified BCC sessions on nutrition, health, child marriage, gender, and adolescent sexual and reproductive health (SRH) supported by dedicated cadre of social workers; 3) case management by social workers to support linkages between PSNP clients and health, nutrition and education services and transitioning of PLW and caregivers of malnourished children in PW households into TDS. Social workers are also tasked to inform clients of their co-responsibilities including attendance of BCC sessions, children's school enrolment and attendance, and health facility visits for antenatal care (ANC) and postnatal care (PNC), monitoring clients' compliance with co-responsibilities and providing follow-up, advice or support in cases of non-compliance. They also provide psychosocial support to PDS clients and support them during CBHI enrollment and renewal. As part of the ISNP's enhanced case management system, treatment woredas also introduced digital MIS to ensure consistent implementation of case management and improved referral systems. The system is also expected to facilitate multi-sectoral collaboration such as between PSNP and CBHI coordination offices. The full implementation of the ISNP thus entails the

proper implementation of these plus components in the treatment woredas on top of the cash transfer to clients through the PSNP. The study findings show that the implementation of the plus components was mixed.

The CBHI enrollment improved significantly for both PDS and PW households following the implementation of the fee waiver for indigent (PDS) households and information provision to paying (PW) clients. For example, the study shows that while 52 per cent of the PDS households were enrolled into CBHI at baseline, this increased to 91 per cent at endline. However, although this is by far a substantial improvement, the fee waiver did not result in a universal insurance coverage among the group as anticipated by the programme. Various factors may explain this discrepancy. First, although social workers are expected to support PDS households during enrollment and membership renewal, households may not be fully aware of whether they are enrolled or their CBHI cards are valid (renewed). In this situation and whenever enumerators are not able to verify by looking at the card, households will be considered as not having a valid CBHI card. This may have been one of the reasons why administrative records still indicate universal enrollment of PDS households. Secondly, households may also think that they are excluded from the programme due to inadequate information of how long they could receive fee waiver. On the other hand, access to better information about CBHI registration process, entitlements (service packages) and the benefits of insurance coverage, resulted in an increase in the enrollment of PW households by 22 percentage points to 85 per cent. Given the change is significantly higher compared to the comparison households while premium is also increased, the evidence shows the effectiveness of the ISNP programme to promote CBHI enrollment among paying members. Enrolment rates at endline among both PDS and PW households are also higher than the national level CBHI enrolment (51 per cent) and Amhara region (69 per cent) as of 2022/23 (7).

Knowledge about the benefits of CBHI among treatment households is also significantly higher compared to households in comparison woredas. Consequently, treatment households are more likely to think that enrollment in CBHI will make seeking health care easier and more affordable compared to households in comparison woredas. The study findings suggest that better awareness about the benefits of CBHI (8,9), enhanced multi-sectoral coordination to facilitate health seeking using CBHI card, and the role of social workers to facilitate linkages to health facilities for PDS households may have also contributed to both higher CBHI enrollment rates and positive perception about the benefits of CBHI in ISNP woredas.

Another plus component is transition of PLW and caregivers of malnourished children in PW households to TDS. The transitioning is expected to be implemented based on multi-sectoral collaboration through frontline workers including development agents, health extension workers, and social workers so that TDS clients are exempted from PW responsibilities to attend BCC sessions and visit health facilities for maternal and child health services, child growth and monitoring, and vaccination. The study shows that 1 in very 3 PLW in treatment PW households transitioned to TDS compared to just 1 in 10 among comparison households. While the transition among treatment households is significantly higher compared to comparison households and shows the important role of ISNP, 2 out of 3 PLW in treatment woredas are still working in PW activities or some members have to make up and do the activities on her behalf. This points to a considerable gap in the implementation of this component and needs to be addressed. The qualitative evidence suggests that the time required for verification of pregnancy and lack of standardized reporting by social workers or health extension workers were barriers limiting universal transition of all pregnant women to TDS. It

was also found that some women think that accepting to stay at home will lead to losing the benefits from PSNP and prefer not to report their pregnancy at all or not willing to accept the offer of the transition. These underscore the knowledge gap about the transition process and the entitlements among households. As reported by Olusola et al. (10) in Somali region, knowledge gap among frontline workers about when the transition to take place and the duration of the TDS can contribute to the lack of the universal transition to TDS among treatment households.

Intensified BCC sessions, supported by dedicated social workers, is also a key feature of the ISNP. Unlike the BCC sessions in the comparison woredas, the ISNP engages social workers to facilitate the delivery of BCC sessions and support TDS clients' participation and compliance to the soft-conditionalities. However, implementation of this plus component was very limited; and not significantly different compared to the comparison households. Qualitative results suggested several possible explanations that could have led to the limited changes (with respect to baseline) and impact. First, as a sofit-conditionality, TDS clients are encouraged and advised to participate in BCC sessions. Participation in BCC session is not a mandatory requirement for cash transfer. Some key informants believe that this condition limited attendance rate. Some TDS clients are also not fully aware that attending BCC sessions is part their co-responsibilities following exemption from PW activities.

Second, due partly to lack of updating BCC training modules, there is a sense among some households that PSNP clients have all been exposed to the BCC content and there was no need to keep attending the same information. The lack of access to resources such as water to engage in backyard vegetable production and finance to buy seeds for planting also reduced motivation among households to attend the sessions on gardening. The qualitative evidence also show that women have also limited capacity to implement the lessons from some of the BCC sessions such as preventing child marriage which is beyond their control.

Third, as a supply side constraint, budget has also been mentioned as a limiting factor to purchase demonstration materials and food ingredients to organize more frequent and tailored cooking demonstrations. Previous studies also report that implementation of BCC sessions in the fourth phase of the PSNP was limited by overlapping commitments of frontline workers, particularly health extension workers (11). A study on IN-SCT also found that low BCC attendance rate was mentioned as a challenge due to too few social workers overburdened with several assignments and lack of resources for travel to reach more households to facilitate participation in BCC sessions (12),

Lastly, the study also shows gaps in the implementation of case management. The qualitative evidence points out some key insights that have likely contributed to the limited implementation of this component. First, although the quantitative data showed high prevalence of child malnourishment in the study areas, lack of clear definition about a malnourished child was one of the challenges preventing social workers to initiate referrals to the health facility and transition the caregivers to TDS. Shortage of social workers is also a critical factor to effectively identify cases, link them with service providers, and for close follow-up until the required services are provided and the cases are closed. Second, related to out of school children, monitoring of re-enrollment of these children and attendance was hindered by lack of cooperation by parents as children are often the only caregiver for an elderly person. Lack of cloths and school supplies and food also reduced regular attendance of school children. Third, although MIS was expected to enable integrated data management across various programme components, facilitate case management including

identification, referrals, linkages with required services and follow-up, the MIS is not available at the kebele level due to lack of equipment, trained personnel, and enabling facilities such as electricity. This means that social workers must collect case management related data on papers from their respective kebeles and share with woreda level MIS focal person for data entry into the system which may delay the referral process, linkages with the required services, and follow-up of the cases.

Impacts on Intermediate outcomes

Household Food Security

Per the ISNP theory of change, improved CBHI coverage was expected to reduce out of pocket health expenditure and free up more money for households. This was then expected to lead to increased food security. Despite the increase in CBHI coverage, the study finds no impact on food security. The insignificant impacts are not unexpected given the changing context including hyperinflation that diminishes the purchasing power of households, Covid-19, and the Northern conflict coupled with inadequate PSNP cash transfer amounts, as reported in the qualitative evidence. The significant reduction in ownership of durable asset index (including farm assets, land, and household durables), due perhaps to higher incidents of shocks among treatment households compared to their comparison counterparts could explain the lack of significant impacts on food security indicators. It is worth noting, however, that in response to Covid, the government used the PSNP system to scale up the assistance to all PSNP households through advance payments (13) and waived PW clients from work requirements (14). This may have moderated the disproportionate impact of the shock on most vulnerable households. The insignificant impacts in this study, however, are consistent with another study in Ethiopia (15). On the other hand, given multiple and wide-scale shocks, sample households could have experienced higher food insecurity. For example, Abay et al. (16) find that although participation in the PSNP largely offsets the adverse effects of Covid-19 on food security, the likelihood of becoming food insecure among PSNP households also increased by 2.4 percentage points after Covid-19.

Household assets, debt and shocks

The study shows that treatment households tend to experience more shocks including idiosyncratic (household and individual specific incidents) and covariate (community wide events) than comparison households. Furthermore, the estimates also suggest that durable asset ownership index among treatment households significantly declined, possibly due to their disproportionate exposure to shocks. Significant reduction in the percentage of treatment households with outstanding loans may also mean that households may have turned to distress asset sales to alleviate cash constraints instead of getting loans. On the contrary, local lenders may also be unwilling to lend cash to households during multiple covariate shocks, due to as households may have limited repayment capacity. The results jointly suggest that the treatment households could be overall more exposed to the multiple shocks occurred during the ISNP programme implementation. On the other hand, no significant impacts found on housing quality and size of livestock owned. Past studies also provide evidence that the realization of positive impacts of social protection programmes among vulnerable groups in fragile contexts is substantially influenced by the programme design choices including

targeting and choice of transfer modality (17), suggesting that cash transfer alone in times of multiple shocks may not be sufficient to prevent asset depletion.

Health seeking behaviour:

The quantitative findings show that the increased enrollment in the CBHI has not translated into positive health seeking behavior from a health facility when a household member is sick. However, the impact is significant but negative among PW households, suggesting that PW households in treatment woredas are less likely to seek care for illness compared to comparison PW households. On the positive side, households, particularly PDS clients but in a marginal extent, were more likely to have accessed health care services using their CBHI card. While this is a desirable trend towards improved health seeking behavior due to the programme, the results also showed that total health expenditure per illness episode has not reduced significantly. This means that households may still be constrained by cash and will be unable to purchase more and diversified food, thus more likely to engage in negative coping strategies in times of distress. These partly explain the lack of significant impact on food security outcomes and reduced asset ownership as discussed earlier. Sustained health expenditure can also prevent households from meeting the material needs of children, including clothing and school materials.

Insignificant health seeking behavior for illness although a higher level of CBHI enrollment can be due to various factors. First, there is a widespread perception that users of CBHI are not treated with dignity and respect when assessing health care services. There is preference given to those paying with cash, and CBHI holders must wait for more administrative processing. This may have discouraged CBHI households from seeking care using CBHI card. Secondly, most of the drugs needed are often not readily available from the contracted public health facilities, and CBHI holders must go and buy medicines from private pharmacies and laboratory services from private health facilities. These involve additional expenses which may lead to lower service utilization. Third, there is high dependency on self-medication, using traditional herbal medicines, and spiritual consultation for health needs. Fourth is the issue of distances to health care facilities, particularly for those residing in remote villages. All these issues need to be addressed before enrollment in CBHI can lead to substantial improvements in health seeking behaviour. Literature also shows that higher opportunity costs associated with visiting health care in the urban areas traveling long distance and foregoing farming activities may also be one of the factors leading to lower facility visits among insured PW households (18).

Women's perceived social support:

The estimates on the impact of ISNP on the Medical Outcomes Study (MOS), a social support score constructed based on responses to eight questions, shows that the programme has positive and significant impact on women's perceived social support. Women's participation in communal groups shows that the ISNP increased the likelihood of their participation in at least one local group and their participation in Iddir (a burial and support association), but not in Eqqub (Iqub) (an association aimed to mobilize finance and distribute in rotation). Limited participation of women in Eqqub may also suggest that ISNP did not change some traditional gender structures. Participation in Eqqub could have provided women the opportunity to access finance to engage in non-farm activities and resolve their immediate financial constraints. This also highlights the challenges in changing some culturally embedded gender norms and arrangements despite PSNP's progressive gender equity goals (19) and

comprehensive gender provisions (20). In relation to this, a recent study in Ethiopia also finds that households economic security and emotional wellbeing can be improved through access to information and links to social networks (21), with positive implications on social support, gender relations, and joint decision making (22). As unintended impact of the programme, however the study finds that level of trust in the community declined significantly among women in PW households. This might occur when: 1) they are passive participants in the community affairs and local groups and unable to get the expected support and 2) the conflict and multiple shocks weaken their social networks, support system, and excluded them which may lead to overall mistrust in one's community. This can also happen especially when pre-crisis expectations of solidarity are not fulfilled during the time of the need.

Nutrition knowledge and feeding practices:

Finally, evaluation estimates also show that the ISNP did not result in significant changes on infant and young child feeding practices. A number of factors can explain this, including limited participation in the BCC sessions, limited visits and support by the SWs to the households, and increased food price that diminished their ability to acquire food items. However, further analysis on the specific questions shows positive impacts on some aspects such as knowledge to feed children more when they are sick and a negative impact in identifying foods that are rich in iron. It should be noted here that changing the respondent from baseline to endline may have also contributed to some of these impacts. In relation to children's feeding practices, the results on the minimum acceptable dietary diversity (3 per cent), minimum acceptable diet for all children (2 per cent), and breastfeeding score (32 per cent), suggest that large gaps remain, and improvements are still possible in these dimensions. The qualitative data show that lack of resources is the main reason why even full knowledge of nutrition will not necessarily translate to better feeding practices. The lack of significant impact on the percent of children receiving a minimum acceptable diet or on the minimum dietary diversity is consistent with the findings on the IN-SCT impact evaluation study (23). Lack of meaningful impacts can be also explained by the fact that food accessibility and utilization dimensions, in addition to improvements in health and nutritional behaviours of mothers, need to be met to ensure improved child feeding practices (24).

Impacts on medium- and long-term outcomes

Consumption and household dietary diversity:

The ISNP significantly increased household dietary diversity, driven by the positive impacts on the consumption of legumes, oils and spices. While households consume from an average of 4 of the food groups, the most widely consumed food groups included cereals, spices and condiments and legumes. Given the lack of impacts on nutrition knowledge and feeding practices for infant and young children, the impacts on consumption and dietary diversity is not fully explained, and the qualitative interviews did not explore this in detail either. The strong impact on household dietary diversity but lack of impacts on nutrition knowledge and feeding practices for children also points to an important aspect of intra-household food distribution which underscores the need for further study. Looking at the results in respect to impacts on food security indicators, the findings also suggest that the

positive impacts on dietary diversity index has not been matched by increased number of meals per day, reduced number of food insecure months in the 12 months, increased availability of sufficient food, and the perceived quality and quantity of food consumed by children ages 6-59 months.

Household resilience:

Resilience of treatment households was significantly reduced as evidenced by increased share of negative coping strategies to cope up with shocks, increased probability of distress asset sale and sale of assets to meet food needs. Given the multiple shocks faced by households, it is conceivable that regular sources of livelihood may have been compromised and source of non-farm income unavailable, forcing households to adopt various coping strategies. Considering higher incidence of self-reported shocks among treatment households, the adoption of negative coping and distress asset sale thus expected. This also highlights the vulnerability of treatment households to shocks and stressors. The evidence suggests that small size transfer for shorter duration to meet short term needs (consumption) may not be sufficient to bring positive and substantial changes in the long-term outcomes such as resilience (25). This calls for a rise in transfer ("big push") to balance short-term objectives and long-term outcomes over multiple years and combining safety nets with asset building initiatives may be required. Insufficient cash transfers from PSNP during pandemic and during the conflict may have been unable to protect households from the impacts of multiple shocks. As a result, the unmet needs may have forced households to engage in negative coping strategies such as sale of productive assets (26).

Women's empowerment and life satisfaction and attitudes towards child marriage:

The study examined impacts of the ISNP on a range of indicators related to women empowerment and life satisfaction due mainly to more women in treatment households believing that they can protect their own interests within the family. The findings also show that the ISNP had a positive impact on the agency score and satisfaction with life, driven by women in PDS households. The programme also marginally increased savings among pooled (PW and PDS clients together) treatment households. Although the progamme had no impact among women in PW households, the qualitative results show that enrollment in CBHI has given women some level of financial independence from their husbands on health-related issues for themselves and their children. This may have likely increased the agency score for pooled sample. No significant impacts were found related to woman's level of control over her life and level of decision-making autonomy. The evidence in the literature is mixed in this regard. For example, Ranganathan et al. (21) find that participation in PW activities combined with complementary programmes increased women's decision-making without reducing husband's controlling behaviours, suggesting that traditional gender roles may persist.

The programme also led to some positive impacts on the attitudes and knowledge about early marriage. It increased the ideal age a girl should get married (although it is still under the of 18) and reduced the share of respondents who think that under 18 is the ideal age for a girl to get married. More treatment households than comparison households tend to know the legal marital age for girls. Qualitative findings suggest that the desired impacts could be due to better collaboration with schools and in specific cases, the involvement of medical structures and/or the police. However, forced and early marriages still practiced in the woredas but not among PSNP families because the

work on the promotion of girls' rights has been effective. The ISNP, through the cash transfer and intensified BCC sessions supported by social workers, is expected to reduce girls' early marriage. Improved awareness about the consequences of early marriage among parents, better income due to cash transfer, and improved access to girl's education opportunities are jointly expected to contribute for the desired outcome. Social workers are also expected to facilitate girls' education and provide support for parents for compliance. Perhaps limited BCC implementation and overstretched role of social workers may have contributed to the lack of significant impacts on some aspects early marriage including attitudes whether under-15 years of age should be an ideal age for girls to get married.

Child welfare outcomes:

The results show that the programme had no significant impacts on any of the child level outcomes including children's nutritional status, school attendance, health care when sick, preventive health, vaccination, and birth registration. For example, while about half the children ages 6-59 months remain stunted and 1 in every 5 of such children is being severely stunted, none of these outcomes has been significantly impacted by the programme. However, this is consistent with the literature on the impact of cash transfers and cash plus programs on child nutrition (5,24). The evidence in the literature suggests that impacts of cash transfers on child nutrition outcomes could be influenced by poor health infrastructure (27) and programme features including transfer size and duration, and supply-side investment (6,28).

No significant impact also observed on school attendance among of children 6-17 years, seeking heath care from a facility when a child was sick, and vaccinations. Within a context of multiple shocks, households can access child health services free of charge at public health facilities, and the reality that this evaluation assesses only the impact of the plus components. These results are not very surprising but indicate that more intensive and differential interventions will be required to bring about positive changes in these indicators.

Recommendations

The findings provide several insights to inform policy and programme actions and to guide future studies to better understand and inform integration of fragmented social protection programmes under changing contexts. The findings overall show that the pilot ISNP intervention, implemented against a background of several covariate shocks, did not achieve most of the intended intermediate and medium- to long-term outcomes. With some adjustments based on the recommendations suggested below, it will be good to pilot the intervention again in another setting, hopefully with less socioeconomic shocks, or better preparedness for some of these shocks. Furthermore, it should also be noted that impacts may have been different had the comparison households were non-PSNP households.

Policy and Programmatic Recommendations

1. Address barriers to ensure universal CBHI Enrollment and renewal of membership among indigent (PDS) clients.
    a) Use tailored communication approaches: Indigent households are often elderly, people with disabilities, orphaned children and people with chronic illnesses. They tend to have difficulties

traveling to service providers and have weaker social networks. As a result, social workers are expected to support their enrollment in CBHI and membership renewal. However, despite the CBHI fee waiver, universal insurance coverage was not achieved in ISNP woredas, possibly due to information gap. CBHI coordination office should collaborate with social workers to aware households' CBHI fee waiver eligibility and membership statuses through home visits.

b) **Improve multisectoral coordination:** The ISNP plans to automatically waive CBHI fee for PDS households, necessitating effective collaboration between CBHI coordination office, Bureau of Women and Social Affairs, and MIS. To make sure that PDS clients (particularly newly targeted ones) are also automatically enrolled in CBHI, stakeholders need to use MIS platform to share information and update the household recording. Social workers should pass the information to newly targeted households, inform them about the CBHI benefit packages, and track the use of CBHI card to seek care.

2. Address CBHI enrollment and renewal barriers for paying (PW) clients and ensure utilization of CBHI card to seek health care
   a) **Revise CBHI enrollment and renewal periods**: The current arrangement requires households to pay annual premiums at once within three months (December to February), just after PSNP PW started and when they start receiving PSNP cash transfers. These months were selected for administrative purposes to align CBHI enrollment and renewal with the collection of taxes so that tax collectors don't need to travel to the kebeles twice. However, it is noted that PSNP household don't pay taxes. Re-entry to CBHI after dropped out for some years also requires payment of premiums for all the unpaid times in the past. Given substantially increased CBHI enrollment and renewal fees, this might put pressure on PW households and discourage membership and renewal. Redesigning enrollment and renewal periods to align with PSNP cash transfer period (6 months) may reduce the dropout rate due to cash constraints and rigid enrollment period.
   b) **Invest in the quality of care at public health facilities:** It is important to recognize that enrollment in CBHI is not a panacea for health seeking behavior. Challenges about the lack of medicines and lab services at contracted public health facilities require households to get the services from private pharmacies and health facilities, resulting in more expensive purchases compared to the prices at public health facilities. This may discourage CBHI members from seeking health care using CBHI card and resort to alternative care services including traditional practitioners or religious sources. CBHI coordination offices should coordinate with contracted service providers to ensure the necessary services and supplies are always available at the health facilities. This requires investment in facility infrastructures and supplies. CBHI insured households may not also use public health facilities due to the perceived quality of care and attitudes of health professionals towards CBHI insured households. This can be resolved through continuous information sessions on the overall socioeconomic and development role of CBHI with staffs and dedicate certain service windows for service seekers using CBHI.

3. Expand access to health services and service providers for CBHI holders
   a) **Expand health service providers through public private partnership**: Currently, CBHI insured households can seek healthcare services from contracted public healthcare providers only. This may have resulted in pressure on the facilities leading to shortage of medical supplies and lab services. In addition, service seekers have to also travel long-distances to reach the nearby contracted healthcare provider and referral hospitals also often require travel to

another city that involves transport, lodging and food costs, on top of care related advance payments. One way to address this challenge could be through contractual arrangements with private health service providers, addressing the issues of advance payments and continued availability of supplies to avoid out of pocket expenses.

b) Introduce mobile health services: Mobile health services can help to reach the most remote and vulnerable groups including people with disability, elderly and people with chronic illness.

4. Invest in the institutionalization of social workers, staffing, and provide adequate resources to ensure more households are reached on a timely manner and quality services are provided.
   a) Increase staffing of social workers: Social workers are directly and indirectly critical in the implementation of all Plus components. However, they are currently employed on a temporary basis with lower salaries compared to other civil servants. As a result, the study shows that there is high turnover and the active social workers are overstretched in several assignments, covering multiple kebeles. High-level advocacy is required due to budgetary implications for the government to institutionalize their employment to permanent positions and increase staffing.
   b) Provide incentives and improve working conditions: To reduce turnover of social workers, incentive mechanisms such as top ups and provision of transport systems (e.g. motorbikes) might be needed. Improved transport facility improves their working conditions and helps them access remote areas where households tend to dropout from insurance and less likely to access healthcare services. Additional incentives can be also attached to the number of households visited per month, transitioned to TDS, number of PDS households enrolled in CBHI and whose CBHI cards renewed.
   c) Provide continuous capacity building and training: Continued capacity building and training should be given to social workers on key areas such as standard psychosocial support approaches, case management, ethically responsive case referral systems, gender provisions in the PSNP, data management and data sharing protocols.

5. Address the barriers to realize universal transitioning of PLW and caregivers of malnourished children to TDS and compliance with co-responsibilities
   a) Continuous communications about the TDS provisions with frontline workers: Frontline workers should be continuously updated regarding the timing of transition to TDS, duration, and the need for full exemption of TDS clients from public works, and standardized reporting system by social workers and health extension workers.
   b) Continuous awareness creation about TDS transition for PW households: Lack of knowledge about the entitlement was mentioned as one of the key barriers limiting universal transition of all pregnant women to TDS. Through BCC sessions, public gatherings and other channels, PW households should be continually made aware of the entitlements in PLW and caregivers of malnourished child including transition to TDS and associated co-responsibilities.
   c) Adopt a clear and standardized definition of a 'malnourished child': The case management for malnourished children also needs a critical review in terms of the criteria for the identification of malnourished children and transition of the caregiver to TDS. This definition and criteria need to be communicated with all frontline workers so that frontline workers including development agents, social workers and health extension workers have the same understanding. Frontline workers should also receive capacity building on the effective identification of malnourished children based on definition, transitioning of caregivers to TDS, linkages with health and nutrition services and appeal systems by clients in cases of

complaints.

6. Improve the content and delivery of BCC sessions to improve attendance and influence practice
   a) Redesign BCC training contents and delivery modalities:
   To deal with the concerns of households regarding repetitive contents, it is advised that the contents of BCC sessions be revised/ updated based on the emerging issues, needs, and knowledge gaps. This will require pre-assessment of knowledge gaps to make the information more useful/ focused and consistent. It is also important to tailor contents for example, nutrition sessions based on the age of children, and timing to the needs of the intended beneficiaries to make the training sessions efficient and effective to deliver. It is recommended that in addition to gap assessments, updating of the contents should be participatory, through engaging community members. Community-based consultations should also be used to determine delivery modalities and the time to fit into women's time availability. Delivery methods should also be supported by innovative approaches such as using videos to inspire participants, visual materials (accessible to illiterate members), experience sharing sessions through 'model-mothers', and text messages to nudge actions and behavioral change. Th evidence also show that BCC sessions seem to be more effective if the messages are reinforced through home visits and follow-ups. Improving radio access and use can also be another strategic policy to lay a strong foundation for mass media broadcasts.
   b) Classify mandatory and optional BCC sessions: The findings highlighted limited attendance (due to demand and supply side barriers) and higher non-compliance due to soft-conditionality of the BCC sessions. To ensure follow-up and enforce compliance, it will be important to classify sessions as mandatory and optional. Accordingly, mandatory sessions should be attached with additional incentives on top of basic/ standard transfers, thus nonattendance at mandatory BCC sessions is followed-up through monitoring and case management. This approach ensures the basic/ standard transfers and incentivizes participants for every additional mandatory session attended.
   c) Improve the quality of BCC delivery centers: References were made to lack of materials and ingredients for cooking demonstrations for delivering the BCC sessions, and women routinely attended the sessions with their children whose presence causes distractions for effective communication. This will entail allocation of adequate budget to support the proper delivery of BCC sessions, purchase of materials to facilitate the delivery, and equip the centers with water, childcare points, and hygiene facilities. To ensure adequate budgeting and attention, delivery of BCC session should also be considered part of basic social services, part of the health education and messaging.
   d) Engage men in group-based delivery of BCC sessions: This can help address detrimental cultural practices around nutrition, decision making, and resource utilization. Past studies show that group-based delivery of cash plus interventions (using Village Economic and Social Associations as platforms) to couples in Amhara and Oromia regions of Ethiopia improved individual agency, collective power and social networks, which in turn strengthened social support, gender relations and joint decision-making (22). Similar approach may increase participation in BCC sessions, facilitates implementation of BCC sessions, and bring gender transformative changes.

7. Link Plus components and cash transfers with complementary asset building activities to increase resilience of households

a) **Balance between short-term and long-term outcomes**: Cash transfers combined with Plus components did not improve household resilience. It is important to meet the short-term needs and achieve long-term outcomes through a balanced approach. Accordingly, combining cash transfers with complementary activities such as engagement in non-farm activities, skill development opportunities, and support through productive assets may help households to be resilient to shocks. Provision of livelihood grant to women may also help to help build their resilience and bring gender equity in access to finance. This can also empower women and reduce IPV.
b) **Encourage savings and livelihood diversification**: Savings can serve as positive coping mechanisms in times of stress. Household savings can be increased though arrangement of incentives such as provision of trainings on financial literacy and business planning to increase engagement in non-farm enterprises through which they can access to innovative financial sources such as group-based revolving funds.
c) **Adjust the size of cash transfers for inflation**: Inadequate cash transfer has been mentioned as one of the challenges limiting households from meeting basic needs including diversified diet, invest in children's human capital and diversify their livelihoods. This becomes even more challenging when households face multiple shocks such as hyperinflation and rise in CBHI premium. In this regard, upward adjustment of the cash transfers size will help households to smooth consumption, invest in productive assets, enroll and continue their membership in CBHI and avoid using negative coping strategies in times of stress. This will also help households build their resilience to shocks. However, this policy measure requires intensive stakeholder discussions so that the change will be sustainable, it has minimal inflationary effects in the local markets, and does not distort the local labor market of unskilled and low skilled labor.
d) **Revise the cash transfer provision for TDS clients**: The current provision of the PSNP allows cash transfer for TDS clients during the PW period only (6 months per year) as they are basically from PW households. However, they are expected to attend BCC sessions such as cooking demonstrations and implement the lessons, attend health facilities for ANC, PNC and delivery, and send children to school. As these sessions can happen anytime of the year, cash constraint can hinder their full compliance. This suggests that TDS clients need to have access to cash transfer throughout the year, keeping the changing food and nonfood prices into consideration.

8. **Invest in the accessibility, efficiency, and functionality of MIS to ensure real-time data entry, management and decision-making**.
   a) **Improve overall functionality of MIS system**: Language and limited access to the MIS developers in case of troubleshooting have been mentioned challenges in the functionality and implementation of the MIS. This requires improving the MIS infrastructure at the woreda level and build capacity of MIS experts through continued training and updates on the changes in the MIS programme.
   b) **Improve accessibility of the MIS at lower levels**: Provide training to social workers at the kebele level on digital literacy, the use of MIS for real time data capture, update the records for any events such as death and migration of beneficiaries, management and reporting or results such as status of case managements. This in turn requires social workers are provide with personal tablets installed with the MIS programme.

9. Conduct interim programme monitoring activities and data sharing to use and unlock outstanding challenges and interventions are being executed as planned.
   The findings showed limited implementation of BCC sessions and transition to TDS and no or limited impacts of the programme on several intermediate, medium and long-term outcomes. Undertaking interim monitoring activities could help to get timely and reliable data to assess whether adequate resources are allocated for the implementation of interventions and planned interventions are being executed before evaluations are undertaken. This also helps to initiate adaptive project management strategies for unexpected changes or shocks and unlock challenges to fully implement the interventions. Establishing mechanisms for regular performance reviews, joint monitoring visits, and multi-stakeholder review meetings will further facilitate the use of evidence to revisit the implementation strategies, resources, and targeting approaches, ultimately enhancing the ISNP's effectiveness and impact.

10. Strengthening case management for out-of-school children:
    The study indicates that the case management for out-of-school children was not fully implemented under the ISNP programme. To address this, it is critical to allocate more resources and provide comprehensive training to social workers to enable them to effectively identify, support, and monitor the re-enrollment and attendance of out of school children. This may include developing standardized protocols for case management, strengthening referral mechanisms, and ensuring regular follow-up and monitoring of the children's well-being and progress. Engaging local elders, religious leaders and parents in the identification and re-enrollment of out-of-school children and social support to elderly may also help to ensure effective case management.

Future Research Areas

1. Future studies may explore the joint effects of large-scale covariate shocks among PSNP households and the extent to which households in treatment and comparison woredas and by client type cope up with exposure to multiple shocks.
2. The link between nutrition knowledge, feeding practices, and actual consumption needs further unpacking. The evaluation finds no impacts on nutrition knowledge nor feeding practices but find positive impacts on food consumption. Understanding the moderating role of availability of foods, access to markets, and affordability will help with designing complementary ecosystem of supportive policies. The further link to children's nutritional status also needs more assessment.
3. A strong positive impact on household dietary diversity but no impacts on food security related indicators and child nutrition outcomes also highlights the need for further study to unpack the dynamics in intra-household food distribution and consumption during stresses.
4. The implementation of development (and humanitarian) projects and programmes may be influenced by the political decisions in respect to equity or vote which may affect active pilot projects due to changing designs. This is likely to underestimate the impacts of pilot interventions in case new projects and programmes tend to channel to comparison woredas. To better understand this, future studies may conduct how the local political economy influences project distributions across woredas.

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Appendix A: Attrition analysis

Table A1: Attrition table: Baseline Full Sample - PDS

Variable	Panel versus Attrited sample			Comparison versus Treatment in Panel Sample		
	Panel sample	Attrited sample	p-value	Comparison	Treatment	p-value
Head is female	0.626	0.774	0.000	0.666	0.603	0.007
Age of head	60.758	66.407	0.000	61.815	60.701	0.226
Head is Muslim by religion	0.482	0.485	0.947	0.463	0.516	0.624
Head is Orthodox by religion	0.513	0.509	0.910	0.534	0.477	0.608
Head is literate	0.106	0.070	0.049	0.088	0.126	0.051
Head is married	0.311	0.142	0.000	0.279	0.314	0.149
Household size	3.239	1.925	0.000	2.916	3.386	0.001
Mean age (years)	43.464	56.055	0.000	46.263	42.580	0.001
Share of females	0.674	0.769	0.000	0.701	0.657	0.001
Percentage of children 0-4 years	0.045	0.012	0.000	0.041	0.041	0.906
Percentage of children 5-17 years	0.240	0.133	0.000	0.214	0.251	0.017
Percentage of adults 18-59 years	0.314	0.234	0.000	0.292	0.328	0.024
Percentage of elder (60+)	0.401	0.620	0.000	0.453	0.380	0.000
# of orphans	0.194	0.088	0.000	0.155	0.228	0.004
# of children (5-17 years) with no shoes	0.359	0.136	0.000	0.296	0.396	0.047
# of children (5-17 years) with no two sets of clothes	0.472	0.195	0.000	0.404	0.502	0.056
# of children (5-17 years) with no pair of shoes and no two sets of clothes	0.278	0.088	0.000	0.234	0.295	0.165
# of rooms per person	0.570	0.794	0.000	0.611	0.569	0.052
Toilet- no facility	0.858	0.858	0.995	0.849	0.873	0.414
Has water, soap, or other cleansing agent	0.001	0.000	0.165	0.001	0.001	0.957
Uses solid fuels for cooking	0.995	0.998	0.276	0.997	0.992	0.069
Roof	0.447	0.327	0.000	0.365	0.550	0.001
Has Electricity	0.112	0.099	0.564	0.101	0.127	0.533
Currently covered by CBHI (among all)	0.520	0.371	0.000	0.501	0.506	0.884
Overall satisfaction with CBHI	6.786	6.300	0.072	6.654	6.894	0.372
The maximum amount willing to pay to buy health insurance.	99.963	66.531	0.000	83.969	116.957	0.007
# meals	2.730	2.668	0.052	2.737	2.701	0.450
never worried about food	0.227	0.246	0.489	0.228	0.232	0.918
All hh members sufficient food	0.361	0.353	0.774	0.369	0.344	0.438
food insecure at least on month in the year	0.720	0.673	0.104	0.726	0.696	0.310
N# of months food insecurity	3.211	3.146	0.753	3.297	3.045	0.278
Number of animals currently owned on the farm, in TLU	0.518	0.240	0.000	0.484	0.490	0.919
Total number of animals currently owned, in TLU	0.541	0.249	0.000	0.501	0.520	0.765
Total number of animals owned exactly one year ago, in TLU	0.529	0.252	0.000	0.507	0.483	0.699
Household does not have a non-farm enterprise	0.891	0.951	0.000	0.902	0.891	0.433
Has an outstanding debt	0.130	0.060	0.000	0.120	0.126	0.745
HH experienced any shock	0.393	0.415	0.583	0.390	0.406	0.667
Any distress asset sale (DAS)	0.202	0.233	0.283	0.216	0.188	0.365
Own savings account	0.432	0.417	0.711	0.437	0.418	0.775
Number of assets owned	4.567	3.345	0.000	4.336	4.585	0.376
N	2,388	300		1,176	1,212	

Table A2: Attrition table: Baseline Full Sample - PW

Variable	Panel versus Attrited sample			Comparison versus Treatment in Panel Sample		
	Panel sample	Attrited sample	p-value	Comparison	Treatment	p-value
Head is female	0.353	0.484	0.001	0.342	0.388	0.117
Age of head	49.742	48.183	0.226	49.803	49.442	0.489
Head is Muslim by religion	0.571	0.504	0.214	0.567	0.568	0.991
Head is Orthodox by religion	0.421	0.487	0.226	0.425	0.425	0.994
Head is literate	0.126	0.109	0.500	0.120	0.134	0.470
Head is married	0.640	0.491	0.001	0.658	0.594	0.043
Household size	5.048	4.152	0.000	5.025	4.965	0.765
Mean age (years)	26.349	27.908	0.189	26.238	26.723	0.430
Share of females	0.532	0.548	0.507	0.529	0.540	0.331
Percentage of children 0-4 years	0.095	0.092	0.819	0.099	0.089	0.134
Percentage of children 5-17 years	0.378	0.371	0.724	0.385	0.367	0.149
Percentage of adults 18-59 years	0.428	0.407	0.312	0.417	0.443	0.040
Percentage of elder (60+)	0.099	0.131	0.173	0.099	0.102	0.805
# of orphans	0.286	0.450	0.092	0.283	0.312	0.425
# of children (5-17 years) with no shoes	0.791	0.646	0.187	0.755	0.827	0.526
# of children (5-17 years) with no two sets of clothes	1.123	0.984	0.246	1.129	1.096	0.791
# of children (5-17 years) with no pair of shoes and no two sets of clothes	0.643	0.573	0.504	0.619	0.669	0.629
# of rooms per person	0.329	0.388	0.011	0.318	0.354	0.040
Toilet- no facility	0.888	0.914	0.277	0.880	0.904	0.332
Has water, soap, or other cleansing agent	0.001	0.000	0.155	0.001	0.000	0.151
Uses solid fuels for cooking	0.997	1.000	0.004	0.999	0.996	0.129
Roof	0.376	0.342	0.438	0.287	0.505	0.000
Has Electricity	0.077	0.086	0.749	0.073	0.085	0.678
Currently covered by CBHI (among all)	0.706	0.605	0.035	0.750	0.628	0.000
Overall satisfaction with CBHI	6.892	6.578	0.229	6.872	6.889	0.924
The maximum amount willing to pay to buy health insurance.	146.062	128.704	0.076	135.623	159.487	0.023
# meals	2.839	2.765	0.025	2.863	2.793	0.122
never worried about food	0.209	0.218	0.848	0.199	0.226	0.456
All hh members sufficient food	0.344	0.300	0.349	0.352	0.328	0.556
food insecure at least on month in the year	0.762	0.742	0.615	0.755	0.769	0.673
N# of months food insecurity	3.214	3.043	0.419	3.178	3.247	0.758
Number of animals currently owned on the farm, in TLU	0.771	0.485	0.000	0.898	0.543	0.000
Total number of animals currently owned, in TLU	0.791	0.501	0.000	0.916	0.565	0.000
Total number of animals owned exactly one year ago, in TLU	0.746	0.507	0.003	0.893	0.493	0.000
Household does not have a non-farm enterprise	0.850	0.859	0.786	0.859	0.837	0.275
Has an outstanding debt	0.197	0.232	0.351	0.190	0.212	0.454
HH experienced any shock	0.400	0.364	0.355	0.375	0.434	0.162
Any distress asset sale (DAS)	0.206	0.259	0.284	0.202	0.218	0.642
Own savings account	0.493	0.480	0.812	0.498	0.483	0.802
Number of assets owned	5.796	5.268	0.280	5.925	5.533	0.118
N	2,571	139		1,270	1,301	

Table A3: Attrition table: Baseline Full Sample - PDS and PW

Variable	Panel versus Attrited sample			Comparison versus Treatment in Panel Sample		
	Panel sample	Attrited sample	p-value	Comparison	Treatment	p-value
Head is female	0.427	0.618	0.000	0.437	0.445	0.732
Age of head	52.703	56.576	0.000	53.315	52.443	0.113
Head is Muslim by religion	0.547	0.495	0.219	0.536	0.554	0.874
Head is Orthodox by religion	0.446	0.497	0.226	0.456	0.439	0.880
Head is literate	0.121	0.091	0.082	0.110	0.132	0.183
Head is married	0.552	0.330	0.000	0.547	0.520	0.310
Household size	4.562	3.126	0.000	4.408	4.544	0.436
Mean age (years)	30.950	40.871	0.000	32.091	30.949	0.132
Share of females	0.570	0.650	0.000	0.579	0.571	0.430
Percentage of children 0-4 years	0.081	0.055	0.002	0.082	0.076	0.290
Percentage of children 5-17 years	0.341	0.261	0.000	0.335	0.336	0.931
Percentage of adults 18-59 years	0.398	0.327	0.000	0.380	0.412	0.001
Percentage of elder (60+)	0.180	0.356	0.000	0.203	0.176	0.015
# of orphans	0.261	0.284	0.694	0.246	0.290	0.125
# of children (5-17 years) with no shoes	0.675	0.411	0.000	0.621	0.712	0.331
# of children (5-17 years) with no two sets of clothes	0.948	0.621	0.000	0.917	0.938	0.839
# of children (5-17 years) with no pair of shoes and no two sets of clothes	0.545	0.350	0.002	0.507	0.569	0.459
# of rooms per person	0.394	0.575	0.000	0.403	0.412	0.648
Toilet- no facility	0.880	0.888	0.678	0.871	0.896	0.307
Has water, soap, or other cleansing agent	0.001	0.000	0.126	0.001	0.000	0.258
Uses solid fuels for cooking	0.997	0.999	0.097	0.998	0.995	0.056
Roof	0.395	0.335	0.045	0.310	0.517	0.000
Has Electricity	0.087	0.092	0.779	0.081	0.097	0.634
Currently covered by CBHI (among all)	0.656	0.497	0.000	0.677	0.595	0.001
Overall satisfaction with CBHI	6.870	6.483	0.066	6.825	6.890	0.728
The maximum amount willing to pay to buy health insurance.	133.678	100.071	0.000	120.532	148.158	0.004
# meals	2.810	2.720	0.000	2.826	2.768	0.188
never worried about food	0.214	0.231	0.583	0.207	0.228	0.555
All hh members sufficient food	0.349	0.325	0.418	0.357	0.332	0.489
food insecure at least on month in the year	0.751	0.710	0.115	0.747	0.750	0.915
N# of months food insecurity	3.214	3.090	0.426	3.213	3.193	0.925
Number of animals currently owned on the farm, in TLU	0.703	0.372	0.000	0.777	0.529	0.000
Total number of animals currently owned, in TLU	0.724	0.385	0.000	0.795	0.553	0.000
Total number of animals owned exactly one year ago, in TLU	0.688	0.390	0.000	0.780	0.490	0.000
Household does not have a non-farm enterprise	0.861	0.901	0.042	0.872	0.852	0.214
Has an outstanding debt	0.179	0.153	0.273	0.170	0.189	0.407
HH experienced any shock	0.398	0.388	0.711	0.379	0.427	0.214
Any distress asset sale (DAS)	0.205	0.247	0.203	0.206	0.210	0.907
Own savings account	0.476	0.451	0.513	0.480	0.465	0.802
Number of assets owned	5.466	4.382	0.000	5.460	5.280	0.404
N	4,959	439		2,446	2,513	

Table A4: Attrition table: Baseline Matched Sample - PDS

Variable	Panel versus Attrited sample			Comparison versus Treatment in Panel Sample		
	Panel sample	Attrited sample	p-value	Comparison	Treatment	p-value
Head is female	0.604	0.624	0.805	0.599	0.618	0.624
Age of head	60.731	62.749	0.541	61.029	60.863	0.879
Head is Muslim by religion	0.476	0.481	0.950	0.444	0.534	0.462
Head is Orthodox by religion	0.517	0.516	0.994	0.549	0.459	0.466
Head is literate	0.102	0.076	0.241	0.089	0.116	0.214
Head is married	0.323	0.143	0.000	0.301	0.302	0.976
Household size	3.371	1.908	0.000	3.128	3.322	0.309
Mean age (years)	41.838	52.842	0.000	43.296	42.856	0.727
Share of females	0.656	0.638	0.797	0.649	0.661	0.663
Percentage of children 0-4 years	0.042	0.013	0.000	0.038	0.040	0.806
Percentage of children 5-17 years	0.261	0.119	0.000	0.242	0.248	0.745
Percentage of adults 18-59 years	0.318	0.355	0.606	0.320	0.326	0.792
Percentage of elder (60+)	0.378	0.514	0.035	0.399	0.386	0.560
# of orphans	0.214	0.111	0.020	0.189	0.225	0.287
# of children (5-17 years) with no shoes	0.410	0.099	0.000	0.374	0.373	0.980
# of children (5-17 years) with no two sets of clothes	0.558	0.182	0.000	0.527	0.490	0.610
# of children (5-17 years) with no pair of shoes and no two sets of clothes	0.335	0.063	0.000	0.315	0.280	0.600
# of rooms per person	0.553	0.791	0.000	0.585	0.573	0.623
Toilet- no facility	0.861	0.881	0.555	0.861	0.867	0.834
Has water, soap, or other cleansing agent	0.001	0.000	0.318	0.001	0.000	0.316
Uses solid fuels for cooking	0.993	0.998	0.184	0.995	0.991	0.429
Roof	0.521	0.479	0.502	0.512	0.525	0.858
Has Electricity	0.133	0.100	0.304	0.126	0.135	0.866
Currently covered by CBHI (among all)	0.535	0.342	0.001	0.512	0.511	0.979
Overall satisfaction with CBHI	6.931	6.385	0.143	6.888	6.891	0.993
The maximum amount willing to pay to buy health insurance.	101.535	73.325	0.004	89.942	112.730	0.119
# meals	2.705	2.655	0.397	2.700	2.697	0.959
never worried about food	0.234	0.232	0.971	0.235	0.231	0.920
All hh members sufficient food	0.326	0.311	0.811	0.317	0.338	0.605
food insecure at least on month in the year	0.693	0.618	0.215	0.670	0.709	0.294
N# of months food insecurity	2.931	2.730	0.456	2.792	3.111	0.235
Number of animals currently owned on the farm, in TLU	0.527	0.190	0.000	0.497	0.468	0.758
Total number of animals currently owned, in TLU	0.545	0.198	0.000	0.511	0.492	0.844
Total number of animals owned exactly one year ago, in TLU	0.514	0.205	0.000	0.488	0.459	0.746
Household does not have a non-farm enterprise	0.893	0.956	0.001	0.904	0.895	0.657
Has an outstanding debt	0.135	0.056	0.000	0.128	0.121	0.711
HH experienced any shock	0.364	0.433	0.287	0.360	0.393	0.395
Any distress asset sale (DAS)	0.177	0.170	0.836	0.172	0.185	0.654
Own savings account	0.445	0.444	0.998	0.471	0.398	0.337
Number of assets owned	4.411	3.115	0.000	4.169	4.416	0.461
N	2,129	264		1,066	1,063	

Table A5: Attrition table: Baseline Matched Sample - PW

Variable	Panel versus Attrited sample			Comparison versus Treatment in Panel Sample		
	Panel sample	Attrited sample	p-value	Comparison	Treatment	p-value
Head is female	0.405	0.402	0.969	0.418	0.386	0.396
Age of head	49.616	49.542	0.967	49.674	49.518	0.815
Head is Muslim by religion	0.543	0.504	0.633	0.529	0.560	0.816
Head is Orthodox by religion	0.449	0.464	0.848	0.462	0.433	0.831
Head is literate	0.146	0.086	0.044	0.146	0.137	0.729
Head is married	0.580	0.534	0.594	0.566	0.596	0.420
Household size	4.933	4.523	0.454	4.890	4.944	0.820
Mean age (years)	26.695	27.939	0.546	26.778	26.730	0.955
Share of females	0.527	0.509	0.537	0.517	0.539	0.172
Percentage of children 0-4 years	0.087	0.093	0.775	0.087	0.088	0.880
Percentage of children 5-17 years	0.369	0.387	0.561	0.370	0.369	0.959
Percentage of adults 18-59 years	0.445	0.380	0.052	0.443	0.440	0.883
Percentage of elder (60+)	0.099	0.139	0.344	0.100	0.102	0.844
# of orphans	0.325	0.400	0.496	0.338	0.317	0.766
# of children (5-17 years) with no shoes	0.767	0.655	0.529	0.724	0.818	0.494
# of children (5-17 years) with no two sets of clothes	1.058	0.975	0.749	1.026	1.095	0.605
# of children (5-17 years) with no pair of shoes and no two sets of clothes	0.625	0.596	0.875	0.597	0.662	0.610
# of rooms per person	0.361	0.384	0.575	0.367	0.354	0.539
Toilet- no facility	0.883	0.942	0.015	0.876	0.901	0.359
Has water, soap, or other cleansing agent	0.001	0.000	0.321	0.001	0.000	0.322
Uses solid fuels for cooking	0.998	1.000	0.013	0.999	0.997	0.313
Roof	0.526	0.432	0.247	0.534	0.502	0.609
Has Electricity	0.097	0.097	0.990	0.103	0.087	0.662
Currently covered by CBHI (among all)	0.664	0.477	0.028	0.667	0.636	0.554
Overall satisfaction with CBHI	6.871	5.893	0.072	6.811	6.871	0.777
The maximum amount willing to pay to buy health insurance.	145.140	124.422	0.111	133.204	160.543	0.026
# meals	2.810	2.697	0.144	2.812	2.793	0.788
never worried about food	0.228	0.163	0.185	0.224	0.225	0.974
All hh members sufficient food	0.360	0.225	0.038	0.370	0.327	0.422
food insecure at least on month in the year	0.759	0.791	0.591	0.750	0.776	0.543
N# of months food insecurity	3.269	3.319	0.898	3.292	3.239	0.851
Number of animals currently owned on the farm, in TLU	0.537	0.236	0.000	0.505	0.546	0.480
Total number of animals currently owned, in TLU	0.555	0.244	0.000	0.522	0.566	0.454
Total number of animals owned exactly one year ago, in TLU	0.514	0.256	0.000	0.503	0.496	0.891
Household does not have a non-farm enterprise	0.819	0.858	0.413	0.809	0.838	0.455
Has an outstanding debt	0.194	0.171	0.564	0.179	0.214	0.248
HH experienced any shock	0.432	0.444	0.886	0.427	0.440	0.834
Any distress asset sale (DAS)	0.180	0.193	0.818	0.155	0.220	0.043
Own savings account	0.517	0.432	0.291	0.533	0.483	0.522
Number of assets owned	5.691	4.829	0.115	5.739	5.505	0.405
N	2,450	130		1,210	1,240	

Table A6: Attrition table: Baseline Matched Sample - PDS and PW

Variable	Panel versus Attrited sample			Comparison versus Treatment in Panel Sample		
	Panel sample	Attrited sample	p-value	Comparison	Treatment	p-value
Head is female	0.456	0.504	0.391	0.468	0.444	0.447
Age of head	52.443	55.574	0.035	52.852	52.358	0.505
Head is Muslim by religion	0.526	0.494	0.630	0.505	0.553	0.696
Head is Orthodox by religion	0.467	0.488	0.740	0.486	0.439	0.708
Head is literate	0.135	0.081	0.012	0.130	0.132	0.934
Head is married	0.515	0.355	0.011	0.492	0.523	0.365
Household size	4.535	3.329	0.002	4.397	4.538	0.487
Mean age (years)	30.547	39.312	0.000	31.401	30.767	0.512
Share of females	0.559	0.568	0.777	0.554	0.570	0.332
Percentage of children 0-4 years	0.076	0.057	0.108	0.073	0.076	0.686
Percentage of children 5-17 years	0.341	0.265	0.006	0.334	0.339	0.742
Percentage of adults 18-59 years	0.413	0.368	0.178	0.408	0.411	0.828
Percentage of elder (60+)	0.170	0.310	0.000	0.184	0.173	0.506
# of orphans	0.297	0.268	0.647	0.296	0.294	0.963
# of children (5-17 years) with no shoes	0.677	0.401	0.017	0.626	0.707	0.472
# of children (5-17 years) with no two sets of clothes	0.930	0.613	0.055	0.886	0.943	0.607
# of children (5-17 years) with no pair of shoes and no two sets of clothes	0.551	0.353	0.084	0.518	0.567	0.640
# of rooms per person	0.409	0.570	0.000	0.428	0.409	0.325
Toilet- no facility	0.877	0.914	0.057	0.872	0.893	0.395
Has water, soap, or other cleansing agent	0.001	0.000	0.201	0.001	0.000	0.201
Uses solid fuels for cooking	0.997	0.999	0.151	0.997	0.996	0.301
Roof	0.525	0.453	0.180	0.528	0.508	0.732
Has Electricity	0.106	0.099	0.774	0.110	0.099	0.781
Currently covered by CBHI (among all)	0.631	0.416	0.000	0.623	0.604	0.674
Overall satisfaction with CBHI	6.884	6.076	0.017	6.828	6.875	0.821
The maximum amount willing to pay to buy health insurance.	134.062	101.086	0.001	121.116	148.575	0.018
# meals	2.783	2.678	0.030	2.781	2.769	0.850
never worried about food	0.229	0.195	0.374	0.227	0.226	0.990
All hh members sufficient food	0.351	0.265	0.052	0.355	0.330	0.590
food insecure at least on month in the year	0.742	0.712	0.508	0.728	0.759	0.377
N# of months food insecurity	3.183	3.050	0.575	3.152	3.207	0.819
Number of animals currently owned on the farm, in TLU	0.534	0.215	0.000	0.503	0.527	0.666
Total number of animals currently owned, in TLU	0.553	0.223	0.000	0.519	0.547	0.605
Total number of animals owned exactly one year ago, in TLU	0.514	0.233	0.000	0.499	0.487	0.807
Household does not have a non-farm enterprise	0.838	0.903	0.040	0.836	0.852	0.571
Has an outstanding debt	0.179	0.118	0.011	0.165	0.191	0.284
HH experienced any shock	0.414	0.439	0.627	0.409	0.428	0.692
Any distress asset sale (DAS)	0.179	0.182	0.941	0.160	0.211	0.051
Own savings account	0.499	0.438	0.344	0.515	0.462	0.451
Number of assets owned	5.365	4.046	0.001	5.300	5.233	0.801
N	4,579	394		2,276	2,303	

Appendix B: Supplemental tables

Table B1: Access to services at the kebele level between baseline and endline

	Baseline			Endline			
Indicators	C	T	T-C	C	T	T-C	DID
Woreda office present in this kebele	4.26	4.55	0.29	4.08	2.13	-1.95	-2.24
	(20.40)	(21.07)	(4.35)	(19.99)	(14.59)	(3.58)	(5.61)
Vehicles pass on the main road in this kebele	57.45	50.00	-7.45	53.06	68.09	15.02	22.47
	(49.98)	(50.58)	(10.54)	(50.42)	(47.12)	(9.97)	(14.50)
Kebele has access to public grid	27.66	38.64	10.98	42.86	51.06	8.21	-2.77
	(45.22)	(49.25)	(9.90)	(50.00)	(50.53)	(10.26)	(14.29)
Has access to piped water	44.68	52.27	7.59	48.98	40.43	-8.55	-16.15
	(50.25)	(50.53)	(10.57)	(50.51)	(49.61)	(10.22)	(14.70)
Nearest town has access to electricity	63.83	81.82	17.99*	87.76	100.00	12.24**	-5.74
	(48.57)	(39.02)	(9.27)	(33.12)	(0.00)	(4.83)	(10.30)
There is a place in the kebele to purchase common medicines	21.28	27.27	6.00	42.86	42.55	-0.30	-6.30
	(41.37)	(45.05)	(9.06)	(50.00)	(49.98)	(10.21)	(13.70)
Observations	47	44	91	49	47	96	187

Note: Significance *** p<0.01, ** p<0.05, * p<0.1.

Table B2: Impact on housing conditions

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
# of rooms per person	0.010	0.041**	-0.018	0.50	0.61	0.39
	(0.01)	(0.02)	(0.01)	[0.45]	[0.54]	[0.35]
Roof is finished	0.110***	0.127***	0.093***	0.71	0.76	0.67
	(0.01)	(0.02)	(0.02)	[0.53]	[0.55]	[0.50]
Uses solid fuels for cooking	0.003	0.003	0.002	1.00	1.00	1.00
	(0.00)	(0.00)	(0.00)	[0.99]	[0.99]	[1.00]
Source of water summer	0.025	0.016	0.033	0.62	0.66	0.57
	(0.01)	(0.02)	(0.02)	[0.55]	[0.60]	[0.51]
Source of water winter	0.015	0.002	0.027	0.62	0.66	0.58
	(0.02)	(0.02)	(0.02)	[0.57]	[0.61]	[0.53]
Does something to make water safe	-0.002	0.014	-0.017	0.04	0.05	0.03
	(0.01)	(0.01)	(0.01)	[0.02]	[0.02]	[0.02]
Toilet- no facility	-0.071	-0.061	-0.079	0.73	0.72	0.74
				[0.89]	[0.88]	[0.91]

Has water, soap, or other cleansing agent	-0.005*	-0.006	-0.005	0.00	0.00	0.00
	(0.00)	(0.00)	(0.00)	[0.00]	[0.00]	[0.00]
N	9,196	4,446	4,750	9,196	4,446	4,750

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Table B3: Impact on feeding knowledge

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Baby should be breastfed immediately after birth	0.060	0.102**	0.022	0.86	0.87	0.85
	(0.03)	(0.04)	(0.04)	[0.95]	[0.92]	[0.97]
Mother should give colostrum to baby soon after birth	-0.009	-0.013	-0.006	0.67	0.65	0.69
	(0.06)	(0.07)	(0.06)	[0.62]	[0.57]	[0.67]
Baby should be exclusively breastfed until 6 months age	0.061	0.067	0.056	0.86	0.83	0.88
	(0.03)	(0.04)	(0.04)	[0.70]	[0.63]	[0.76]
Baby should start receiving liquids (including water) at 6 months age	0.209***	0.267***	0.156**	0.81	0.79	0.83
	(0.06)	(0.08)	(0.06)	[0.53]	[0.48]	[0.58]
Baby should start receiving food (such as porridge) at 6 months age	0.121*	0.152*	0.093	0.57	0.55	0.59
	(0.06)	(0.07)	(0.07)	[0.42]	[0.37]	[0.46]
Baby between 6-8 months that is still breastfeeding should eat 2-3 meals per day	0.025	0.085	-0.031	0.50	0.50	0.51
	(0.07)	(0.08)	(0.08)	[0.45]	[0.43]	[0.46]
Baby between 9-11 months that is still breastfeeding should eat 3-4 meals per da	-0.087	-0.116	-0.060	0.67	0.65	0.68
	(0.06)	(0.07)	(0.07)	[0.56]	[0.54]	[0.58]
Infant between 12-24 months that is still breastfeeding should eat 3-6 meals per	0.044	0.040	0.047*	0.98	0.98	0.98
	(0.03)	(0.04)	(0.02)	[0.85]	[0.83]	[0.87]
Child should be fed more than usual when sick	0.188***	0.238***	0.142*	0.43	0.43	0.44
	(0.05)	(0.05)	(0.07)	[0.36]	[0.33]	[0.39]
Child should be fed more often than usual when sick	0.093	0.115*	0.073	0.51	0.50	0.52
	(0.05)	(0.05)	(0.07)	[0.40]	[0.36]	[0.44]
Salt is often fortified with iodine	-0.108***	-0.121**	-0.097*	0.47	0.46	0.47
	(0.04)	(0.05)	(0.05)	[0.34]	[0.32]	[0.36]
Can identify foods that are rich in iron	-0.094**	-0.032	-0.152***	0.19	0.18	0.19
	(0.03)	(0.04)	(0.04)	[0.16]	[0.14]	[0.18]
Can identify foods that contain vitamin A	-0.103**	-0.084*	-0.120**	0.22	0.19	0.24

	(0.04)	(0.04)	(0.05)	[0.17]	[0.16]	[0.18]
Can identify foods a mother could make to complement breastfeeding	-0.066	-0.065	-0.067	0.28	0.25	0.31
	(0.04)	(0.05)	(0.05)	[0.24]	[0.21]	[0.26]
N	9,160	4,418	4,742	9,160	4,418	4,742

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Table B4: Impact on women's agency

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Believes life determined by own actions	0.090*	0.057	0.119	0.68	0.63	0.72
	(0.05)	(0.05)	(0.07)	[0.51]	[0.48]	[0.54]
Believes have power to make decisions - life course	0.055	0.056	0.053	0.65	0.61	0.69
	(0.04)	(0.04)	(0.06)	[0.51]	[0.48]	[0.55]
Believes have power to make decisions - children's wellbeing	0.048	0.022	0.069	0.62	0.57	0.67
	(0.04)	(0.04)	(0.06)	[0.49]	[0.45]	[0.53]
Believes have power to make decisions - household wellbeing	0.062	0.044	0.076	0.64	0.59	0.68
	(0.04)	(0.05)	(0.05)	[0.50]	[0.46]	[0.53]
Believes capable protecting own interests within family	0.124**	0.097*	0.146*	0.68	0.64	0.72
	(0.04)	(0.05)	(0.06)	[0.51]	[0.47]	[0.54]
Believes capable protecting own interests outside family	-0.018	-0.012	-0.026	0.54	0.52	0.56
	(0.04)	(0.04)	(0.06)	[0.44]	[0.41]	[0.46]
N	8,389	4,030	4,359	8,389	2,018	2,178

Note: Means adjust for the matching weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Table B5: Impact on nutritional status

Dependent Variable	Overall Impact	Impact for PDS	Impact for PW	Treatment Means - 2023 [2019] Overall	PDS	PW
Length/height-for-age Z-score	0.029	-0.177	0.092	-1.78	-1.70	-1.83
	(0.18)	(0.31)	(0.23)	[-1.85]	[-1.77]	[-1.88]
Stunted (HAZ < -2 SD)	0.019	0.057	0.003	0.49	0.48	0.51
	(0.05)	(0.09)	(0.07)	[0.50]	[0.47]	[0.51]
Severely Stunted (HAZ < -3 SD)	-0.058	-0.008	-0.074	0.20	0.19	0.20
	(0.04)	(0.08)	(0.05)	[0.23]	[0.22]	[0.24]
Weight-for-length/height Z-score	0.207	0.085	0.250	-0.30	-0.19	-0.36

	(0.16)	(0.26)	(0.19)	[-0.35]	[-0.23]	[-0.40]
Wasted (WHZ < -2 SD)	-0.055	-0.025	-0.071	0.09	0.08	0.10
	(0.04)	(0.05)	(0.05)	[0.11]	[0.11]	[0.11]
Severely Wasted (WHZ < -3 SD)	-0.020	-0.019	-0.020	0.04	0.03	0.04
	(0.02)	(0.05)	(0.02)	[0.04]	[0.04]	[0.05]
Weight-for-age Z-score	0.231	0.011	0.297*	-1.26	-1.11	-1.35
	(0.14)	(0.24)	(0.15)	[-1.31]	[-1.19]	[-1.36]
Underweight (WAZ < -2 SD)	-0.085	-0.083	-0.084	0.23	0.18	0.25
	(0.04)	(0.08)	(0.05)	[0.28]	[0.28]	[0.28]
Severely Underweight (WAZ < -3 SD)	-0.052	-0.031	-0.058	0.06	0.05	0.07
	(0.03)	(0.06)	(0.03)	[0.08]	[0.07]	[0.08]
N	3,020	953	2,067	3,020	953	2,067

Note: Means adjust for the sampling weights. Standard error in parenthesis for impact columns. Baseline values in parenthesis for means columns. * 10% significance ** 5% significance; *** 1% significance.

Appendix C: Quantitative Survey instruments

HOUSEHOLD INSTRUMENT

SECTION 0: IDENTIFICATION
SECTION 0.1: COVER SHEET

METADATA

Visits

1 Date of interview |___|___|- |___|___|- |___|___| Time Start (HH:MM) |___|___| : |___|___| 24-hour clock Time End (HH:MM) |___|___| : |___|___| 24-hour clock

2 Date of interview |___|___|- |___|___|- |___|___| Time Start (HH:MM) |___|___| : |___|___| 24-hour clock Time End (HH:MM) |___|___| : |___|___| 24-hour clock

3 Date of interview |___|___|- |___|___|- |___|___| Time Start (HH:MM) |___|___| : |___|___| 24-hour clock Time End (HH:MM) |___|___| : |___|___| 24-hour clock

4 Woreda _____ |___|___|

5 Kebele _____ |___|___|

7 Name of household head _____

7a Household ID |___|___|___|___|___|___|___|___|

7c Phone number of Household Head _____

8 Name of main respondent and PID _____ |___|___|

8c Phone number of respondent/ other household member
1. ----------
2. ----------

9 Language used by respondent
Amharic 1
Oromifa 2
Other specify..... 3

10 Interpreter used?
Yes 1
No 2

15 LAST ITEM AFTER INTERVIEW
Response status
Complete interview 1
Partially complete (reason) 2
Unable to find the hh 3
Refusal 4

11 [READ CONSENT FORM TO RESPONDENT AT THIS POINT]

Consent form: Did household consent to the interview?

Yes 1
No .....2 >> End Interview

12 Supervisor name and code _____ |___|___|

13 Enumerator name and code _____ |___|___|

14 GPS coordinates

14a Latitude N |___||___||___|.|___||___||___||___||___|

14b Longitude E /W |___||___||___|.|___||___||___||___||___|

If answered 2,3,4 on Q15, give reason
_____
_____

Woreda: Libo Kemkem 1 Ebinat 2 Dewa Chefa 3 Artuma Fursi 4

SECTION 0.2 FUTURE CONTACT INFORMATION

Enumerator: please ask household, in the event that we may wish to contact them in the future, we are going to ask them for two people who can be contacted in the future should the family move from the village. If you left this place, who would be the most likely people to know where you are?

	Contact 1	Contact 2
1. Name of contact person		
2. Relationship to you 1=Spouse (not a household member) 2=Son/daughter 3=Daughter/son-in-law 4=Grandson/daughter 5=Father/mother 6=Brother/sister 7=Niece/Nephew/Cousin 8=Father-in-law/mother-in-law 9=Brother/Sister-in-law 10=Friend/Neighbour 11=Community/Religious Leader 12=Other		
3. Where does [NAME] currently live? 1=In this village/Community 2=In this kebele but out of this village 4=Out of this woreda but the same zone 5=Out of this zone		

3=In this woreda but in other kebele 6=Out of this region		
4. Phone number(s) of [NAME]		
5. How best would we be able to contact these people? (Pls. feel free to give as many options as necessary) e.g. 1. landmarks, 2. nicknames	1. landmarks 2. nicknames	1. landmarks 2. nicknames

Question 0:	I would like to ask you a very important question about how you feel about your life. Taking all things into consideration, are you happy with your life?	Yes..... 1 No..... 2

SECTION 1A: CONFIRMATION OF HOUSEHOLD COMPOSITION

[ENUMERATOR: REVIEW THE INFORMATION FILLED IN THE BASELINE ABOUT HOUSEHOLD MEMBERS. USE THIS INFORMATION TO CONFIRM THAT THE PERSON IS A STILL A MEMBER OF THIS HOUSEHOLD. CHECK THE ANSWERS TO QUESTIONS 1-5]

Instructions: *Please confirm the list of household members starting from the household head who were present at baseline and have been pre-loaded to the template. Do not include new household members such as newborns or those that joined after baseline data collection. Ask questions 1-6 for all members who have been pre-loaded to the template. Please ask questions 7-10 ONLY for members who no longer member of the household are.*

1	2	3	4	5		6	7	8	9		10
IDENTIFICATION	Member name	Gender 1 = Male 2 =Female	What is [NAME's] relationship with the head of the household? 1 = Head of the family 2 = Spouse 3 = Son 4 = Grandson 5 = Father-in-law 6 = Son-in-law/Nora 7 = Other family member	What is the age of [NAME]? Record the exact age, in full years, of all members. For children under 36 months, also record the number of months since the last birthday (use the child health book or birth certificate, if available).		Is [NAME] currently a member of the household? 1 = Yes >> **Next member/section** 2 = No	Why is [NAME] no longer in the household? SEE CODES FOR Q7	Whom does [NAME] live with now? 1= Father or mother 2= Brother or sister 3= Other family members/relatives 4= Alone 5= With friends 6= Husband/wife/partner/boyfriend/girlfriend 7=Other	When did [NAME] leave the household? **[ENUMERATOR: CHECK THE DATE. SHOULD NOT BE BEFORE DECEMBER 2018**		Will [NAME] return to live in this household for the next three years? 1= Yes 2=No 99= Don't know
				AGE IN YEARS	**IF <36 MONTHS: MONTHS SINCE LAST BIRTHDAY**				**MONTH**	**YEAR**	

			8 =Adopted/ Welcomed/Stepson 9 = Maid 10 = Unfamiliar								
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											

Codes for Q7
1 = To be with parent
2 = To be near school / get better education
3 = Parents were too sick/unable to care for him/her
4 = Sent to relative/friends for other reason/adopted/Gudifetcha
5 = Sick, went for treatment
6 = To live with spouse/marriage
7 = Divorced out of family
8 = Returned home

9 = To look for work / Start own household
10 = Dead >> Next person
11 = To be near their place of work
12 = To run own farm or enterprise
13 = Contract ended
14 = Land shortage
15 = To look after other relatives
16 = Conscripted into army
17 = Conflict with a household member
18 = Migrated, intentions unknown
19 = Never been a member of the household/don’t know name >> Next person
88 = Other

SECTION 1B: ENLISTING OF NEW HOUSEHOLD MEMBERS

Q0: Has any new person joined the household since **Tahsas** 2011 apart from those I have mentioned? 1=YES 2=NO >> (Section 1: Roster)

[ENUMERATOR: ADD NEW HOUSEHOLD MEMBERS THAT WERE NOT PRESENT AT BASELINE]

Instructions: Please *provide the names of all people who usually live with this family, share the same food, or share economic resources that were not listed at baseline. These include newborns and visitors who have lived with the family for six months or more. Include the usual members, who are away to travel, in the hospital, in boarding school, college or university, etc., but who may not be here at this time and not listed at baseline.*

1	2	3	4	5		5		6
IDENTIFICATION	Member name	Gender 1 = Male 2 =Female	What is [NAME's] relationship with the head of the household? 1 = Head of household 2 = Spouse 3 = Child 4 = Grandchild 5 = Father-in-law / Mother-in-Law 6 = Son-in-law/Daughter-in-law 7 = Other family member 8 =Adopted/ Welcomed/Stephchild 9 = Maid			When did [NAME] join the household? [PLEASE WRITE MONTH AND YEAR]		What was the main reason [NAME] joined this household? [SEE CODES]
						Month	Year	

			10 = Other Non-Family member					
201								
202								
203								
204								

Codes for Q6
1 = Child of household member
2 = Came with parent/other adult
3 = To be near school / get better education
4 = Orphaned or abandoned / adopted
5 = Parents are unable to care for him/her
6 = Came to live with spouse
7 = To look for employment/to work
8 = To be near place of employment
9 = To help work on farm or other enterprise
10 = To look after other relatives
11 = Sick, came to be looked after
12 = Returned from army
13 = Divorced/separated
14 = To live with relatives
15 = Expelled from settlement
16 = Returned home to live with parents
17 = Job contract terminated
18 = To help with domestic work
19 = Member not captured in baseline
88 = Other

SECTION 1: HOUSEHOLD ROSTER

Instruction: *Please give me the names of all persons who usually live with this household and eat from the same pot. Start with the head of the household and include visitors who have lived with the household for six months or more. Include usual members, who are away visiting, in hospital, at boarding schools or college or university, etc.*

1	2	3	4	5a	5b				6	7	8	9	10	11
AUTOFILL IN ID CODES FOR CURRENT HOUSEHOLD MEMBERS FROM SECTION 1ª & 1B										For those 10 years or older				
ID	Name of the HH member [Start from the household head and followed by the spouse, children, others]	Sex 1=Male 2=Female	What is [NAME'S] relationship with the head? 1=Household head 2=Spouse of household head 3=Son/daughter 4=Daughter/son-in-law 5=Grandson/daughter 6=Father/mother 7=Brother/sister 8=Niece/Nephew 9=Household head's cousin 10=Father-in-law/mother-in-law	How old is [NAME] now? Record exact age in completed years for all household members. If age is less than 1 year write zero. For those under 5 years old, also record birth date (use birth certificate if available). AGE IN YEARS	IF <5YRS: RECORD BIRTH DATE			Using birth certificate? 1=Yes 2=No	What is [NAME'S] main religion? 1=Orthodox 2=Catholic 3=Protestant 4=Muslim 5=Traditional 6=Pagan 7=Wakifata 8=Other (specify)	What is [NAME'S] current marital status? 1=Married or living together (monogamous) 2=Married or living together (polygamous) 3=Divorced or separated or deserted (>> Q12) 4=Widowed (>> Q12) 5=Never married (>> Q14 if aged 10-17,	Does [NAME'S] spouse live in this household? 1 =Yes (>>Q11) 2 = No	How old is [NAME]'s spouse? (AGE IN YEARS) IF DON'T KNOW, RECORD '-9'	What is the highest level of education completed by [NAME]'s spouse? [USE CODES FROM EDUCATION SECTION] (>>Q12 if aged 10-17, otherwise next person)	COPY THE I.D. CODE OF THE SPOUSE [IF MORE THAN ONE SPOUSE, THE FIRST ONE]
					DD	MM	YYYY							

			11=Brother/Sister-in-law 12=Spouse's niece/nephew 13=Spouse's cousin 14=Primary caregiver 15=Other						otherwise next person)				
01														
02														
03														
04														
05														
06														
07														
08														
09														
10														

SECTION 1: HOUSEHOLD ROSTER (Continued)

	12	13	14	14a	15	16	16a	17	18	19	20
			For those aged 0 – 17 years						For those aged 5 – 17 years		
ID	At what age did (NAME) first get married or started living with a partner? (AGE IN YEARS)	Was the marriage arranged? 1=Yes 2=No	Is the biological mother of [NAME] alive? 1=YES, MOTHER LIVES IN HOUSEHOLD 2=YES, BUT MOTHER NOT IN HOUSEHOLD (>> Q15) 3=NO, MOTHER IS DEAD (>>Q15) -9=DON'T KNOW (>>Q15)	WRITE PID if the mother lives in the household (>>Q16)	What is/was the highest level of education completed by [NAME]'s biological mother? [USE CODES FROM EDUCATION SECTION]	Is the biological father of [NAME] alive? 1=YES, FATHER LIVES IN HOUSEHOLD () 2=YES, BUT FATHER NOT IN HOUSEHOLD>> Q17 3=NO, FATHER IS DEAD>>Q17 -9=DON'T KNOW>>Q17	WRITE PID if the father lives in the household (>>Q18)	What is/was the highest level of education completed by [NAME]'s biological father? [USE CODES FROM EDUCATION SECTION]	Does [NAME] have a pair of shoes or sandals? 1=YES 2=NO -9=DON'T KNOW	Does [NAME] have at least 2 sets of clothes? 1=YES 2=NO -9=DON'T KNOW	Does [NAME] have a blanket that he/she can use in the household? 1=Yes, has his own 2=Yes, but shared with other household members 3=NO -9=DON'T KNOW
01											
02											

03											
04											
05											
06											
07											
08											
09											
10											
11											
12											

SECTION 2: EDUCATION OF ALL HOUSEHOLD MEMBERS AGED 4 YEARS OR OLDER

	1	2	3	4a	4b	5	6	7	8	9	10	11
						For those aged 4 to 24						
ID	Can [NAME] read and write in any language? 1=Yes 2=No	Has [NAME] ever attended formal school? 1=Yes (>>Q4a) 2=No	What was the main reason [NAME] never attended formal school? (>>NEXT MEMBER) [SEE CODES BELOW]	What is the curriculum of the highest grade completed 1=Previous 2=Current	What is the highest grade [NAME] completed? [SEE CODES BELOW]	Is [NAME] currently attending formal school? 1=Yes>>Q7 2=No	Why is [NAME] not currently in school? [SEE CODES BELOW] (>>NEXT MEMBER)	Which grade is [NAME] attending? [SEE CODES BELOW FOR NEW CURRICULUM]	Is [NAME] taken out of school at certain times of the year to help with farm activities or other household responsibilities? If YES, for how many weeks in the past 12 months. (Ignore school breaks.) If NO, write 0	Was [NAME] absent from school last semester for more than a week continuously? 1=Yes 2=No(>>Q11) 3=Not enrolled last semester (>>Q11)	What was the main reason for being absent from school? 1=Sick 2=Death in the family 3=Had to work 4=Other (specify)	How much was spent on educational expenses for [NAME] during the past 12 months? (Include: registration and school fees, contributions to parent/ teacher associations (PTA), uniforms, books and school supplies, transportation, food, boarding & lodging, etc. DO NOT INCLUDE BURSARY AND SCHOLARSHIP)

Codes for Q4b & Q7		Codes for Q3 & Q6:
Based on previous curriculum	Based on new curriculum	Too young 1
Kindergarten or 0 grade 0	Kindergarten or 0 grade 0	Required for farm activities 2
1st grade 1	1st grade 1	Required for other household activities 3
2nd grade 2	2nd grade 2	Required to care for sick/elderly 4
3rd grade 3	3rd grade 3	Required to work for wages 5
4th grade 4	4th grade 4	Too expensive to go to school 6
5th grade 5	5th grade 5	School too distant 7
6th grade 6	6th grade 6	Not appropriate for female children to go to school (culture) 8
7th grade 7	7th grade 7	Schooling believed not to increase income 9
8th grade 8	8th grade 8	Could learn everything useful at home 10
9th grade 9	9th grade 21	Too sickly to attend 11
10th grade 10	10th grade 22	Children Health/Age reasons 12
11th grade 11	11th grade 23	No places available in local school 13
12th grade 12	12th grade 24	No school of appropriate religion available 14
12th grade + 1 (certificate) 13	Certificate (10+1) vocational and technical course 25	Not safe 15
Teaching training certificate 14	Level 2 vocational and technical course 26	Got married 16
1st year college 15	Certificate (10+2) vocational and technical course 27	Got pregnant/had a baby 17

2nd year college ..... 16 Diploma ..... 17 3rd year college..... 18 Bachelor's degree program (including MD)..... 19 Postgraduate diploma (MA, PHD, MPHIL, etc.)..... 20	1 year in 10+3 or level 3 vocational training and technical course ..... 28 2 years in 10+3 or level 3 vocational training and technical course..... 29 Diploma in 10+3 or level 3 vocational and technical course ..... 30 1st year university ..... 31 2nd year university ..... 32 3rd year university ..... 33 4th year university ..... 34 5th year university ..... 35 6th year university ..... 36 7th year university ..... 37 Bachelor's degree ..... 38 Above bachelor's degree (MA, PHD, etc.)..... 39 Satellite ..... 40 Don't know ..... -9	Did not pass to next grade ..... 18 Too old to attend school..... 19 Other reason (specify) 20

SECTION 4A: HEALTH INSURANCE

	Record PID for respondent	|___|___|___|
	Question	**Answers**
	READ TO THE RESPONDENT You may be aware that in many places of Ethiopia, including Amhara, a Community Based Health Insurance (CBHI) is in place. The idea of a health insurance is that you make regular payments towards the future cost of medical care (treatment, hospitalisation, drugs, and so on). That is, you pay a premium once every year to enrol your household (all members) into the insurance. Then, in case of sickness, the health insurance scheme pays fees related to consultations at health facilities. It saves you the financial burden of personally bearing all the medical bills if you get sick. Members pay small premiums on a regular basis, usually monthly. Insured persons who do not need medical treatment do not get the premiums back at the end of the insurance period; instead, the premiums are kept by the insurance to pay for the medical bills of other insured persons or for expenditures in future years. In some cases, however, individuals are offered to become members at no cost and are exempted from paying premiums if these premiums are subsidized by the government. Services like diagnosis, laboratory tests, surgeries, drugs, delivery, consultations, etc. are offered to the insured household once they are enrolled in the system. If you and your household decided to enrol in a CBHI, or if you are already enrolled at no cost but suddenly you had to pay to be part of the insurance system: how much would you be willing to pay for you and your household? Before answering the questions below, consider the advantages associated with the proposed scheme, your monthly income, and also that, there are other things your money could be spent on. Before I proceed, do you have any question?	
1	[Participants are randomly given one amount among the following: 200,250,300,350,400 Br] Please indicate whether you would be willing to pay this price to buy the health insurance package (for the whole household) for one year.	Yes..... 1 No..... 2
2	[Give a second bid amount of half of the first bid if the respondent said "no" in 1 and twice if he said "yes"] Now would you be willing to buy the health insurance package for the whole household for one year?	Yes..... 1 No..... 2
2a	What is the maximum amount you would be willing to pay to buy the health insurance package (for the whole household) for one year?	_____ BIRR
3	Imagine you and your household enrol in the CBHI:	
a	If you or somebody from your household need medical consultation, to purchase drugs, or obtain a medical check-up due to pregnancy, would CBHI cover the costs for this	Yes..... 1

	consultation for you or the other members of your household?	No..... 2
b	If you need access to certain drugs, or you need surgery, would CBHI cover these costs?	Yes, I would be completely covered at no cost... 1 Yes, but I would need to pay part of the cost myself..... 2 No, CBHI does not cover surgeries or expensive drugs 3
4	If you are paying premiums every year and nobody from your household needs medical assistance in that year, would you get the amount of the premium back at the end of the year?	Yes..... 1 No..... 2
5	If you are registered with CBHI and go to a health facility, do you have to pay in advance some of the costs/fees related to the consultation?	Yes..... 1 No..... 2
6	What types of facilities can you go to using CBHI? [MULTIPLE ANSWER ALLOWED, RECORD ALL MENTIONED	Government hospital.....A Government health station/center .....B Government health post .....C Other public sector (including pharmacy) .....D NGO Health facility ..... E Other NGO health facility..... F Private hospital .....G Private clinic .....H Other private medical sector (including pharmacy, traditional healer)..... I Other (specify).....J
7	Do you believe that enrolling in CBHI will make it easier for members of your household to seek health care when needed?	Yes..... 1 No..... 2
8	Do you believe that being enrolled in the CBHI plan will make health care more affordable for you and the members of your household?	Yes..... 1 No..... 2

SECTION 4B: HEALTH INSURANCE OF HOUSEHOLD

	Question	Answers	Skip
1	Is this household currently registered or covered by health insurance (including informal schemes)?	Yes, all member1	→Q3
		Yes, some members 2	→Q3
		No 3	
2	What is the main reason why this household (is not currently covered by health insurance? [Allow for multiple answers]	Fees/Premium too expensive 1	→Q12
		Travel time/cost too high 2	→Q12
		Waiting time at enrolment site too long 3	→Q12
		Poor quality care for those with HI 4	→Q12
		Preferred services not covered 5	→Q12
		Use clinics/ traditional healers that don't accept HI 6	→Q12
		Don't understand HI 7	→Q12
		Never heard about insurance 8	→Next section
		Eligible for health care fee waiver (certificate for free health service) 9	→Q12
		Other (specify) 10	→Q12
3	What type of health insurance scheme is the household registered with/covered by? [Allow for multiple answers]	Community-based Health Insurance (CBHI) 1	→Q6
		Health insurance through employer 2	
		Social security 3	
		Other Privately Purchased Commercial Health Insurance 4	
		Other Informal Saving/Loan Schemes for Health (specify) 5	
		Other informal insurance schemes not specific for health (specify) 6	
4	Has this household ever been enrolled in CBHI?	Yes 1	→Q6
		No 2	
5	Why has the household never enrolled in CBHI?	Does not know about it 1	→Q12
		Members have not been sick 2	→Q12
		Enrolment fee/premium too expensive 3	→Q12
		Travel time/cost too high 4	→Q12

		Waiting time at renewal site too long 5	→Q12
		Use clinics / traditional healers that don't accepts CBHI 6	→Q12
		Preferred services not covered 7	→Q12
		Not needed as eligible for free health care (certificate for free health service) 8	→Q12
		Other (specify) 9	→Q12
6	Does the household hold a valid CBHI card?	Yes, seen it 1	→Q8
		Yes, not seen it 2	→Q8
		No 3	
7	Why has the household not renewed CBHI for the current year?	Does not know it has to be renewed annually 1	→Q12
		Members have not been sick 2	→Q12
		Enrolment fee/premium too expensive 3	→Q12
		Travel time/cost too high 4	→Q12
		Waiting time at renewal site too long 5	→Q12
		Use clinics / traditional healers that don't accepts CBHI 6	→Q12
		Preferred services not covered 7	→Q12
		Not needed as eligible for free health care (certificate for free health service) 8	→Q12
		Other (specify) 9	→Q12
8	Did the household receive a Health Fee Waiver for the insurance (i.e. did not pay anything to obtain the insurance)?	Yes 1	→Q11
		No 2	
9	Did the household pay a unique premium for the entire household?	Yes 1	
		No 2	

10	How much is the fee/ premium for the health insurance per year for the household?	Amount in Birr	
11	On a scale from 1 to 10, how satisfied are you with CBHI? [Instruction: Satisfaction increase in ascending order]	1 2 3 4 5 6 7 8 9 10	
12	Have you received information about enrolling in CBHI or other health insurance scheme?	Yes, CBHI 1	
		Yes, Other health insurance 2	
		Yes, CBHI and other health insurance scheme 3	
		No 4	→Next sect
13	From where/who did you receive information about enrolling in health insurance? [Allow for multiple answers]	Health Workers……..1	
		Development Agents(DA)…….2	
		Kebele/government experts/officers….3	
		Family/relatives/friends/neighbors…. 4	
		Religious organization…5	
		NGO…6	
		Mass media (Radio, TV, printed materials)….7	
		Awareness creation campaign (Meetings, workshops, conference, etc.).....8	
		Other, specify….99	

SECTION 4C: HEALTH OF ALL HOUSEHOLD MEMBERS

	1	2		3	3a	4	5	6	7	8	9	10
ID	Has [NAME] been sick or injured during the **last month?** 1=Yes, sick/ injured 2=No (>>Q12) 9=Don't know (>>Q12)	What was the sickness or injury? [LIST UPTO 2 ILLNESSES] [SEE CODES BELOW]		During the last month, did [NAME] have to stop usual activities because of this/these condition(s)? 1=Yes 2=No>>Q4	For how many days did [NAME] have to stop usual activities because of this condition?	During the past month has [NAME] consulted a health practitioner or traditional healer or visited a health facility to care for this/these condition(s)? 1=Yes 2=No (>>Q11)	Whom did [NAME] consult on the most recent visit? 01=Doctor 02=Dentist 03=Nurse 04=Medical assistant 05=Midwife 06=Pharmacist 07=Drug/ chemical seller 08=Traditional Healer 09=Spiritualist 10=Holy water 11=Other (specify)	Where did the most recent consultation take place? [SEE CODES BELOW]	Did [NAME] use CBHI to pay for these services? 1=Yes (>>Q9) 2=No ([NAME] does not have CBHI) (>>Q9 3=No ([NAME] has CBHI but did not use it) 4=No, [NAME] has health care fee waiver (certificate for free health service) (>>Q9)	What was the main reason [NAME] didn't use CBHI to pay for these services? [SEE CODE BELOW]	How much did the household spend for [NAME]'s consultation? **[INCLUDE BOTH CASH AND IN KIND]** [GIVE AMOUNT IN BIRR] [ENTER '00' IF NONE]	How much in total did the household spend on [NAME]'s medicine or medical supplies **in the last month?** [GIVE AMOUNT IN BIRR] (>> GOTO Q12)
		1st	2nd									

SECTION 4C: HEALTH OF ALL HOUSEHOLD MEMBERS (CONTINUED)

	11	12	13	14	15	16	17	18	19	20	21
ID	Why didn't [NAME] go for a consultation for this condition? [SEE CODES BELOW]	During the last month has [NAME] consulted a health practitioner or traditional healer or visited a health facility for a reason other than the sickness/injury mentioned previously? 1=Yes 2=No (>>Q20)	What was the reason for the last visit? [SEE CODES BELOW]	Whom did [NAME] consult? 01=Doctor 02=Dentist 03=Nurse 04=Medical assistant 05=Midwife 06=Pharmacist 07=Drug/ chemical seller 08=Traditional Healer 09=Spiritualist 10=Other (specify)	Where did the consultation take place? [SEE CODES BELOW]	Did [NAME] use CBHI to pay for these services? 1=Yes, [NAME] did not have to pay any money for this service (>>Q18) 2=Yes, but [NMAE] had to pay some money for the service (>>Q18) 3=No ([NAME] does not have CBHI) (>>Q18) 4=No ([NAME] has CBHI but did not use it) 5=No, [NAME] has health care fee waiver (certificate for free health service) (>>Q18)	Why didn't [NAME] use CBHI to pay for this consultation? [SEE CODE BELOW]	How much did the household spend on [NAME]'s consultation? **[INCLUDE BOTH CASH AND IN KIND]** [GIVE AMOUNT IN BIRR] [ENTER '0' IF NONE]	How much in total did the household spend on [NAME]'s medicine or medical supplies **in the last month,** in addition to what you reported above under sickness/injury expenditures? [OTHER THAN ALREADY INCLUDED IN Q9!] [GIVE AMOUNT IN BIRR]	Has [NAME] consulted any medical assistance or consulted from health facilities or traditional healers during the last 12 months? (Regardless of whether sick or not) 1=Yes 2=No (>>Q31 if age 5 or above or next person)	How many times has [NAME] consulted any medical assistance or consulted from health facilities or traditional healers during the last 12 months? [ENTER NUMBER OF TIMES]

Codes for Q2	Codes for Q6/Q15	Codes for Q8/Q17	Codes for Q11
Malaria.....1	**Public sector**	Did not know how to use the CBHI.....1	Lack of money.....1
Prolonged fever (other than Malaria).....2	Government hospital 1	The quality of the service received through CBHI is lower than when you pay 2	Expensive 2
(Chronic) diarrhoea 3	Government health station/center 2	The health facility did not accept the CBHI 3	Too far.....3
Injury.....4	Government health post 3	The informal facility where [NAME] went to did not accept CBHI.....4	Do not believe in medicine.....4
Dental issues.....5	Other public sector 4	Other (Specify) 5	Lack of health professional 5
Ophthalmic (problem with eyesight) 6	**NGO**		Poor quality/service 6
Skin disease or rash 7	Health facility 5		Did not require medical assistance 7
Ear/nose/throat (ENT) infection 8	Other NGO health facility 6		Other (specify).....8
Persistent cough 9	**Private medical sector**		
Tuberculosis 10	Private hospital 7		
Heart pain or palpitations.....11	Private clinic 8		
Asthma.....12	Other private medical sector (including pharmacy, traditional healer).....9		
Problems with breathing.....13	Other (specify) 10		
Sexually transmitted diseases 14	Don't know .....-9		
Other (specify).....15			

Codes for Q13			
Checkup or other preventive care (not linked to pregnancy) ..... 1 Prenatal checkup ..... 2 Postnatal checkup ..... 3 Giving birth ..... 4 Follow up appointment for earlier or chronic illness ..... 5 Follow up appointment for earlier accident ..... 6 Other (specify) 7			

SECTION 4C: HEALTH OF ALL HOUSEHOLD MEMBERS (CONTINUED)

	22	23	24	25	26	27		28	29	30	
ID	Did the household have to borrow any money to cover expenditures related to [NAME]'s medicines, health care visits/consultations in the last 12 months? 1=Yes 2=No (>>Q24)	How much did your household have to borrow to cover for [NAME]'s health related expenditures in the last 12 months? [GIVE AMOUNT IN BIRR]	Were any of [NAME]'s consultations inpatient visits (i.e. [NAME] spent the night in the health facility)? 1=Yes 2=No (>>Q26)	How many nights did [NAME] spend in any health facility in the last 12 months? [ENTER NUMBER OF NIGHTS]	How much did [NAME] pay for travelling (round trip) the last time [NAME] went to a health facility? [GIVE AMOUNT IN BIRR] If on foot, please write 0	How long did [NAME] have to wait at the facility before being seen by the provider the last time [NAME] went to a health facility?		How much in total did the household spend on other expenditures related to [NAME]'s health (for instance, if hospitalised, for patient's and escorts' accommodation and/or meals) in the last month? [GIVE AMOUNT IN BIRR]	What is the main type of transportation mode do you use to travel to reach the health facility? 1=Foot/ Walking 2=Animal 3=Animal Cart 4=Car (Bajaj/ public bus) 5=Other	How long did [NAME] spend travelling to reach the health facility the last time [NAME] went?	
						HRS	MIN			HRS	MIN

	31	32	33	34	35	36	37	38
	For household members 5 years and older							
ID	Does [NAME] have difficulty seeing, even if wearing glasses? 1=No difficulty 2=Yes – some difficulty 3=Yes – a lot of difficulty 4=Cannot perform activity at all	Does [NAME] have difficulty hearing, even if wearing a hearing aid? 1=No difficulty 2=Yes – some difficulty 3=Yes – a lot of difficulty 4=Cannot perform activity at all	Does [NAME] have difficulty walking or climbing steps? 1=No difficulty 2=Yes – some difficulty 3=Yes – a lot of difficulty 4=Cannot perform activity at all	Does [NAME] have difficulty remembering or concentrating? 1=No difficulty 2=Yes – some difficulty 3=Yes – a lot of difficulty 4=Cannot perform activity at all	Does [NAME] have difficulty (with self care such as) washing all over or dressing, feeding, toileting etc.? 1=No difficulty 2=Yes – some difficulty 3=Yes – a lot of difficulty 4=Cannot perform activity at all	Using [NAME]'s usual language, does [NAME] have difficulty communicating; for example understanding or being understood? 1=No difficulty 2=Yes – some difficulty 3=Yes – a lot of difficulty 4=Cannot perform activity at all	ENUMERATOR: CHECK Q31 – Q36. Did [NAME] have any difficulty? 1=YES 2=NO >> Q39	Does this difficulty reduce the amount of work [NAME] can do at home, at work or at school? 1=Yes, all the time 2=Yes, sometimes 3=No 4=N/A (if not working or attending school)

SECTION 4C: HEALTH OF ALL HOUSEHOLD MEMBERS (CONTINUED)

	39	40	41	42	43
				For households members aged 12 and above	
ID	Has [NAME] ever taken clinical (PCR/Antigen) COVID-19 test? 1=Yes 2=No ➔42	How many times has [NAME] been clinically tested for COVID-19?	Has [NAME] ever received a positive COVID-19 results? 1=Yes, once 2=Yes, more than once 3=No	What is [NAME] vaccination status? 1= Fully vaccinated, card seen 2= Fully vaccinated, card not seen ➔ *next person/section* 3= Partially vaccinated, card seen 4= Partially vaccinated, card not seen 5=No, not vaccinated *NOTE: Single-dose vaccines are considered full vaccination*	What is the main reason [NAME] has not been vaccinated or fully vaccinated? 1= Recently tested positive for COVID-19 2= Vaccines not available in community/village 3= Long distance to vaccination center 4= Cost of travel to vaccination centre 5= S(he) doesn't trust COVID-19 vaccines to be safe and effective 99= Other, specify

SECTION 5A: HOUSING CONDITIONS AND WASH

	Question	Answers	Skip
1	How many rooms does this household occupy? Count living rooms, dining rooms, bed rooms but not bathrooms, toilet & kitchen	ROOMS.....|___|___|	
2	What is the main source of lighting for your dwelling?	Electricity meter – private .....1 Electricity meter – shared .....2 Electricity from generator .....3 Solar energy .....4 Bio –gas.....5 Electrical battery .....6 Lantern .....7 Light from dry cell with switch.....8 Kerosene light lamp (imported).....9 Local kerosene lamp(kuraz).....10 Candle/wax .....11 Fire wood .....12 Other (specify) 13	
3	What is the main construction material used for the outer wall of the household's dwelling?	**Natural walls** No walls.....1 Cane/palm/trunks/bamboo/reed.....2 Dirt .....3 **Rudimentary walls** Bamboo/ wood with mud .....4 Stone with mud .....5 Uncovered adobe .....6 Plywood 7	

		Cardboard .....8 Reused wood .....9 **Finished walls** Cement .....10 Stone with lime/cement .....11 Bricks .....12 Cement blocks .....13 Covered adobe .....14 Wood planks/shingles .....15 Other 16	
4	What is the main material used for the roof of the household's dwelling?	**Natural roofing** No roof .....1 Thatch/mud .....2 Sod .....3 **Rudimentary roofing** Rustic mat/plastic sheet.....4 Reed/bamboo.....5 Wood planks .....6 Cardboard.....7 **Finished roofing** Metal/corrugated iron.....8 Wood.....9 Calamine/cement fiber/asbestos .....10 Ceramic tiles .....11 Cement/Concrete.....12 Roofing shingles .....13 Other (specify) 14	

5	What is the main construction material used for the floor of the household's dwelling?	Earth/sand ..... 1 Dung ..... 2 Wood planks ..... 3 Palm/bamboo ..... 4 Parquet or polished wood ..... 5 Vinyl or asphalt strips/plastic tile ..... 6 Ceramic tiles ..... 7 Cement/Concrete ..... 8 Carpet ..... 9 Other (specify) 10	
	Question	**Answers**	**Skip**
6	What is the main source of drinking water for members of your household in summer? [USE CODES BELOW]	Answer ..... |__|__|	
7	What is the main source of drinking water for members of your household in winter? [USE CODES BELOW]	Answer ..... |__|__|	
8	Do you do anything to the water to make it safer to drink?	Yes ..... 1 No ..... 2 Don't know ..... -9	 → Q10 → Q10
9	What do you usually do to make it safer to drink? Multiple Answer RECORD ALL ITEMS MENTIONED	Boil ..... 1 Add bleach / chlorine ..... 2 Strain it through a cloth ..... 3 Use water filter (ceramic, sand, composite, etc.) ..... 4 Solar disinfection ..... 5 Let it stand and settle ..... 6 Add camphor/naphthalene 7	

		Add water tablet ..... 8 Other (specify) ..... 9 Don't know ..... -9	
10	What is the main source of water used by your household for other purposes such as cooking and hand washing? [USE CODES BELOW]	Answer ..... |__|__|	
11	What type of toilet facility is usually used by members of your household? If "flush", probe: WHERE DOES IT FLUSH TO?	Flush Flush to piped sewer system ..... 11 Flush to septic tank ..... 12 Flush to pit (latrine) ..... 13 Flush to somewhere else ..... 14 Flush, don't know where ..... 15 Pit latrine Ventilated Improved Pit latrine (VIP) ..... 21 Pit latrine with slab ..... 22 Pit latrine without slab / Open pit ..... 23 Composting toilet ..... 31 Hanging toilet, Hanging latrine ..... 41 Mobile Toilet ..... 51 Bucket toilet ..... 61 No facility, Bush, Field ..... 95 Other (specify) 96	 → Q11b → Q11b → Q11b → Q11b → Q11b → Q12 → Q12 → Q12 → Q12 → Q12 → Q12 →Q12 →Q13 → Q13 → Q13
11b	Ask permission to observe the facility: 1. Yes, saw the flush toilet 2. No did not see the flush toiler		

Codes QUESTIONS 6 / 7 / 10

Piped water

- Piped into dwelling 11
- Piped into compound, yard, or plot..... 12
- Piped to neighbor 13
- Public tap / standpipe 14
- Tube Well, Borehole..... 15

Dug well

- Protected well..... 31
- Unprotected well 32

Protected spring 41

Unprotected spring 42

Rainwater collection..... 51

Tanker-truck (Botti)..... 61

Cart with small tank / drum 71

Surface water

- River/ stream 81
- Dam, lake, pond, canal, irrigation channel) .. 82

Bottled water 91

Other (specify) 96

	Question	Answers	Skip
12	Is this toilet facility used only by your household, or is it shared with others?	Private (for exclusive use by household members) ..... 1 Shared – no pay per use ..... 2 Public – pay per use ..... 3 Public –no pay per use 4	
13	What type of fuel does your household mainly use for cooking?	Electricity ..... 01 Liquefied Petroleum Gas (LPG) ..... 02 Natural gas ..... 03 Biogas ..... 04 Kerosene ..... 05 Charcoal ..... 06 Wood/Firewood ..... 07 Straw / Shrubs / Grass ..... 08 Agricultural crop residue/sawdust ..... 09 Animal dung/waste ..... 10 No food cooked in household ..... 11 Other (specify) 96	→ Q16 → Q16 → Q16 → Q16 → Q16 → Q16
14	In this household, is food cooked on an open fire, a coal pot, or a closed stove?	Open fire ..... 1 Coal pot ..... 2 Closed stove ..... 3 Improved stove ..... 4 Other (specify) 5	
15	Is the cooking usually done in the house, in a separate building, or outdoors?	In the house In a separate room used as kitchen ..... 1 Elsewhere in the house ..... 2 In a separate building 3	

		Outdoors ..... 4 Other (specify) 6	
16	We would like to learn about the places that households use to wash their hands. Can you please show me where members of your household most often wash their hands?	Observed, fixed place ..... 1 Observed, mobile ..... 2 Not observed Not in dwelling / plot / yard ..... 3 No permission to see ..... 4 Other reason 5	 → Q19 → Q19 → Q19
17	Observe presence of water at the specific place for hand washing. VERIFY BY CHECKING THE TAP/PUMP, OR BASIN, BUCKET, WATER CONTAINER OR SIMILAR OBJECTS FOR PRESENCE OF WATER	Specific place available and Water is available 1 Specific place available but Water is not available 2	
18	Record if soap or detergent or other traditional detergents are present at the specific place for hand washing. Multiple response	Soap or detergent (bar, liquid, powder, paste) ..... 1 Ash, mud, sand ..... 2 None 3	→ NEXT SECTION
19	Do you have any soap or detergent or any other traditional detergents in your household for washing hands?	Yes ..... 1 No 2	 → NEXT SECTION
20	Can you please show it to me? CIRCLE ALL THAT APPLY	Soap or detergent (bar, liquid, powder, paste) ..... 1 Ash, mud, sand ..... 2 Other (specify) ..... 3 Not able / Does not want to show 4	

SECTION 5B: FOOD SECURITY

	Question	Answers	Skip
1	How many meals excluding snacks do you normally have in a day?	One ..... 1 Two ..... 2 Three ..... 3 More than three 4	
2	In the **past four weeks**, did you worry that your household would not have enough food?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
3	In the past **four** weeks, were you or any household member not able to eat the kinds of foods you preferred because of lack of resources?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
4	In the past **four** weeks, did you or any household member have to eat a limited variety of foods due to a lack of resources?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
5	In the past **four** weeks, did you or any household member have to eat some foods that you really did not want to eat because of a lack of resources to obtain other types of food?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
6	In the past **four** weeks, did you or any household member have to eat a smaller meal than you felt you needed because there was not enough food?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	

7	In the past **four** weeks, did you or any household member have to eat fewer meals in a day because there was not enough food?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
8	In the past **four** weeks, was there ever no food to eat of any kind in your household because of lack of resources to get food?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
9	In the past **four** weeks, did you or any household member go to sleep at night hungry because there was not enough food?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
10	In the **past four weeks**, did you or any household member go a whole day and night without eating anything because there was not enough food?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
	CHECK HOUSEHOLD ROSTER: ANY CHILDREN YOUNGER THAN 5 YEARS IN THE HOUSEHOLD? ☐ YES → Q11 ☐ NO → Q13		
11	In the **past four weeks**, was there a time when any of the children younger than 5 years old did not eat healthy and nutritious foods because of a lack of money or other resources?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	
12	In the **past four weeks**, was there a time when any of the children younger than 5 years old was not given enough food because of a lack of money or other resources?	Never ..... 1 Rarely (once or twice) ..... 2 Sometimes (3 – 10 times) ..... 3 Often (more than 10 times) 4	

13	In the **past 12 months**, have you been faced with a situation when you did not have enough food to feed the household?	Yes ..... 1 No 2	→ NEXT SECTION

	Question	Answers			Skip
14	During which months did you experience this incident in the **past 12 months**? MARK 'YES' OR 'NO' FOR EACH MONTH OF 2021 AND 2022THE HOUSEHOLD DID NOT HAVE ENOUGH FOOD.	MONTH	YES	NO	
		Tahesase 2014 (December 2021)	1	2	
		Tire 2014 (January 2022)	1	2	
		Yekatite 2014 (February 2022)	1	2	
		Megabite 2014 (March 2022)	1	2	
		Miyaziya 2014 (April 2022)	1	2	
		Genbot 2014 (May 2022)	1	2	
		Sene 2014 (June 2022)	1	2	
		Hamele 2014 (July 2022)	1	2	
		Nehase 2014 (August 2022)	1	2	
		Meskerem 2015 (September 2022)	1	2	
		Tikimet 2015 (October 2022)	1	2	
		Hidare 2015 (November 2022)	1	2	
15	What was the cause of this situation? Inadequate household stocks due to drought/poor rains..... 1 Inadequate household food stocks due to crop pest damage..... 2 Inadequate household food stocks due to small land size ..... 3 Inadequate household food stocks due to lack of farm inputs..... 4 Inadequate household food stocks due to lack of farm Tools/drought animals, plough etc ... 5 Food in the market was very expensive..... 6	*LIST UPTO 3 REASONS IN ORDER OF IMPORTANCE:* A. Most important reason..... |___| B. Second reason ..... |___| C. Third reason ..... |___|			

	Not able to reach the market due to high transportation costs ..... 7 Market very far from the village ..... 8 No food in the market..... 9 Floods/water logging/hailstorm/ high rainfall..... ..10 PSPN payment delayed ..... 11 Unexpected decrease in remittances ..... 12 Decrease in other types of transfers ..... 13 Other, specify. 14		

SECTION 5C: TIME USE AND EMPLOYMENT

*Ask of all HH members 5 years of age & above (inclusive). First identify id codes for all HH members **age 5 and above**, then proceed with question 1.*

	1	2	3	4	5	6	7	8	9	10
	Last 24 hours – Domestic chores					Economic activities				
ID	How many hours did [NAME] spend yesterday collecting water? [IF SPENT MORETHAN 0 BUT <1 HOUR, ENTER "1"]	How many hours did [NAME] spend yesterday collecting firewood (or other fuel materials)? [IF SPENT MORETHAN 0, BUT <1 HOUR, ENTER "1"]	How many hours did [NAME] spend yesterday collecting nuts or other tree fruits, honey, or other products form forests, either for food consumption, medicine or sales for the household? [IF SPENT MORETHAN 0, BUT <1 HOUR, ENTER "1"]	How many hours did [NAME] spend yesterday taking care of children, cooking or cleaning? [IF SPENT MORE THAN 0, BUT <1 HOUR, ENTER "1"]	How many hours did you spend yesterday taking care of elderly or sick household members? [IF SPENT MORETHAN 0, BUT <1 HOUR, ENTER "1"]	At any time during the last 12 months, did [NAME] work in farm activities, excluding livestock activities, for the household (either in cultivating crops or in other farming tasks) on a farm owned or rented by a member of the household? 1=Yes 2=No (>>Q8)	How many hours in the last 7 days did [NAME] spend in farm work for the household excluding livestock (e.g. ploughing)?	At any time during the last 12 months, did [NAME] care for livestock belonging to the household? 1=Yes 2=No (>>Q10)	How many hours in the last 7 days did [NAME] spend in livestock herding, preparing fodder or other livestock activities for the household?	At any time in the last 12 months, did [NAME] engaged in fishing business activities? 1=Yes 2=No (>>Q12)
	HOURS	HOURS	HOURS	HOURS	HOURS		HOURS		HOURS	

	11	12	13	14	15	16	17	18	19
							PSNP Labour		
ID	How many hours in the last 7 days did [NAME] spent in fishing business activities?	At any time in the last 12 months, did [NAME] work on any of the household's non-agricultural or non-fishing household businesses? 1=Yes 2=No (>>Q14)	How many hours in the last 7 days did [NAME] run or help in any of the household's non-agricultural or non-fishing household businesses?	At any time in the last 12 months, did [NAME] work for someone who is not a member of the household (for example an enterprise, company, the government or any other individual)? 1=Yes 2=No (>>Q17)	How many hours in the last 7 days did [NAME] work for someone who is not a member of the household (for example an enterprise, company, the government or any other individual)?	What was [NAME] main occupation in this work? 1=Agricultural wage labour 2=Transport 3=Commerce (shop, market, etc.) 4=Crafts or trades work 5=Services (cleaning, hotel, waitress, etc.) 6=Teaching 7=Health work 8=Other government work	In the past 12 months, has [NAME] been employed as temporary labourer by the PSNP programme? 1=YES 2=NO (>> next person/section)	For how many days did [NAME] work for the PSNP programme in the last 12 months?	During how many months did you [NAME] worked for PSNP during the last 12 month?
	HOURS		HOURS		HOURS			DAYS	No. of Months

						9=Other (specify)			

SECTION 5D: LIVESTOCK OWNERSHIP

1		2	3	4	5	6	7	8	9	10	11	12	13	14
Live-stock Code and name		Has this household owned any [LIVESTOCK NAME] in the last 12 months? 1=YES 2=NO (>>next livestock)	Number owned and present at your farm **[Enter zero if the hh do not have any of the livestock present]** (If 0 >> 5)	If you sold one of the ..[..].. today, how much would you receive from the sale?	Number owned but away (if none, write 0)	During the last 12 months., how many were born or were found? (if none, write 0)	During the last 12 months., how many were you received in gift or in aid? (if none, write 0)	During the last 12 months., how many died or got lost? (if none, write 0)	During the last 12 months, how many did you buy? (if none, write 0) (If 0 >>11)	Total purchase value of all bought	Did you sell any ..[..].. during the last 12 months? (if none, write 0. If 0>>Q13)	Total sales value of all sold	How many were slaughtered in the last 12 months? (if none, write 0)	How many did you own exactly one year ago (present or away)?
				In BIRR						In BIRR		In BIRR		
1	Calves													
2	Bulls													
3	Oxen													

4	Heifer													
5	Cows													
6	Sheep													
7	Goats													
8	Horses													
9	Donkeys													
10	Mules													
11	Camels													
12	Young Bulls													
13	Chicken													
14	Bees													

SECTION 5E: ASSETS

Item code	Item	Number owned Insert 0 if the hh does not have the item If 0 go to the next item For land, record size in hectares	If you wanted to sell this [ITEM] today, how much would you receive (Birr)? If more than one item is owned, give the value of the most valuable item (give value for just one item)
01	Kerosene stove		
02	Cylinder gas-stove		
03	Electric stove		
04	Blanket/Gabi		
05	Mattress and/or bed		
06	Wristwatch/clock		
07	Fixed line telephone		
08	Mobile telephone		
09	Radio/tape recorder		
10	Television		
11	CD/VCD/DVD/Video deck		
12	Satellite dish		
13	Sofa set		
14	Bicycle		
15	Motor cycle		
16	Cart (hand pushed)		

17	Cart (animal drawn)-for transporting people and goods		
18	Sewing machine		
19	Weaving equipment		
20	Mitad-electric		
21	Mitad-Non electric		
22	Energy saving stove (lakech, mirt, etc.)		
23	Refrigerator		
24	Private car		
25	Jewels – gold (in grams)		
26	Jewels – silver (in grams)		
27	Wardrobe		
28	Shelf for storing goods		
29	Biogas pit		
30	Water storage pit		
31	Sickle (Machid)		
32	Axe (Gejera)		
33	Pick axe (Geso)		
34	Plough (traditional)		
35	Plough (modern)		
36	Water pump		
37	Gun		
38	Farmland (in hectares)		

SECTION 5F: SAVINGS AND MOBILE MONEY

	Question	Answers	Skip
1	Does any member of the household have a bank account or microfinance accounts?	Yes, bank account ..... 1 Yes, informal or microfinance savings account……2 Yes, both……...3 No 4	
2	Did your household use any mobile money services (e.g. M-Birr) during the past 12 months? [*THIS QUESTION INCLUDES BOTH USE THROUGH MOBILE MONEY ACCOUNT OF SOMEONE IN THE HOUSEHOLD AND USE THROUGH THE ACCOUNT OF SOMEONE OUTSIDE THE HOUSEHOLD (OVER-THE-COUNTER)]*	Yes .....1 No 2	>>Q5
3	Why did your household not use mobile money services during the past 12 months? [*ENUMERATOR: ASK FOR THE MOST IMPORTANT REASON*]	Nobody in the household knows/is aware of these services ..... 1 Nobody in the household has a state ID or other required documents to register an account .....2 There is not Point-of-Service (POS) or an agent where we live..... 3 Using such services is difficult, nobody in the household knows how to use them .....4 Nobody in the household owns a mobile phone ..... 5 Nobody in the household has a bank account……...6 Other (Specify) 7	>> Next section
4	Imagine you could use mobile money, for which services would you like to use it? [Multiple Response]	Pay for small purchases at a store (food, clothes, etc.) ..... 1 Airtime top-ups ..... 2 Pay for other services or labor provided to the household . 3 Pay for large acquisitions (e.g. land, dwelling, etc.) 4	NEXT SECTION (applies to everyone)

		Pay for funeral or wedding costs ..... 5 Transfers to friends or other family members ..... 6 Transfers from friends or other family members..... 7 Save money ..... 8 Pay school fees ..... 9 Pay government tax/fine ..... 10 Pay electricity/water/TV bill ..... 11 Receive wages (from private) ..... 12 Receive wages (from government) ..... 13 Receive government welfare ..... 14 Insurance ..... 15 Other (specify) 16	
5	For which services has your household used mobile money in the past 12 months? [Multiple Response]	Pay for small purchases at a store (food, clothes, etc.) ..... 1 Airtime top-ups ..... 2 Pay for other services or labor provided to the household . 3 Pay for large acquisitions (e.g. land, dwelling, etc.) ..... 4 Pay for funeral or wedding costs ..... 5 Transfers to friends or other family members ..... 6 Transfers from friends or other family members ..... 7 Save money ..... 8 Pay school fees ..... 9 Pay government tax/fine ..... 10 Pay electricity/water/TV bill ..... 11 Receive wages (from private) ..... 12 Receive wages (from government) ..... 13 Receive government welfare 14	

		Insurance ..... 15 Other (specify) 16	
6	Does your household have a registered mobile money account, or does it use the account of someone outside the household (friends, local agents)?	Registered account ..... 1 Friends, relatives, neighbours? ..... 2 Local agent..... 3	>>Q8

	Question	Answers	Skip
7	Reason for not registering a mobile money account [*ENUMERATOR: ASK FOR THE MOST IMPORTANT REASON*]	Nobody in the household knows/is aware of these services ..... 1 Nobody in the household has a state ID or other required documents to register an account ..... 2 There is not Point-of-Service (POS) or an agent where we live..... 3 Using such services is difficult, nobody in the household knows how to use them ..... 4 Nobody in the household owns a mobile phone 5	>> NEXT SECTION
8	On whose name is the account registered? [*INDICATE THE ID CODE OF THE HOUSEHOLD MEMBER ON WHOSE NAME THE ACCOUNT IS REGISTERED. IF THE HOUSEHOLD HAS MORE THAN ONE REGISTERED ACCOUNT, REFER TO THE MOST FREQUENTLY USED ONE*]	Member Code: |___|___|	
9	Who controls the mobile phone through which the account is accessed?	Only Head of the hh..... 1 Primarily Head of the hh ..... 2 Head and Spouse equally ..... 3 Primarily spouse..... 4 Only Spouse..... 5 Other household members (Excluding head and spouse).. 6 All adult members equally 7	

10	Who decides how to use mobile money?	Only head decides ..... 1 Spouse have input, but the head makes the final decision 2 Decided with equal consideration between head and spouse ..... 3 Spouse primarily decide, but consult with the head ..... 4 Spouse alone decide ..... 5 Other household member decide ..... 6 Other 7	

SECTION 5G: NON-FARM ENTERPRISES

	Question	Answers	Skip
	Over the past 12 months has anyone in this household…	*NOTE: Ask household business currently functional or household business ventures that have been shut down permanently or temporarily during the past 12 months.*	
1	…owned a non-agricultural business or provided a non-agricultural service from home or a household-owned shop, as a carwash owner, metal worker, mechanic, carpenter, tailor, barber, etc.?	Yes ..... 1 No 2	
2	…processed and sold any agricultural by-products, including flour, local beer (tella), areke, enjera, seed, etc., but excluding livestock by-products, fresh/processed fish?	Yes ..... 1 No 2	
3	…owned a trading business on a street or in a market?	Yes ..... 1 No 2	
4	…offered any service or sold anything on a street or in a market, including firewood, home-made charcoal, construction timber, wood poles, traditional medicine, mats, bricks, cane furniture, weave baskets, thatch grass etc.?	Yes ..... 1 No 2	
5	…owned a professional office or offered professional services from home as a doctor, accountant, lawyer, translator, private tutor, midwife, mason, etc.?	Yes ..... 1 No 2	
6	…driven a household-owned taxi or pick-up truck to provide transportation or moving services?	Yes ..... 1 No 2	

6a	…horse driven carts and pack animals for transportation	Yes ..... 1 No 2	
7	…owned a bar or restaurant?	Yes ..... 1 No 2	
8	…owned any other non-agricultural business, even if it is a small business run from home or on a street?	Yes ..... 1 No 2	

SECTION 5H: DEBTS, CREDITS AND TRANSFERS

	Question	Answers	Skip
1a	Have any one in the household taken a loan or credit in the past 12 months?	Yes ..... 1 No 2	→ Q5
1b	Does your household have any outstanding debts to other households or institutions obtained in last 12 months (excluding purchases on credit)?	Yes ..... 1 No 2	→ Q5
2	How many outstanding loans does your household have?	NUMBER_____	
3	What is the primary purpose of the loan? [If more than one outstanding loan, report the purpose of the latest loan]	a) **Family** For meeting day-to-day expenses ..... 01 For funeral ..... 02 For health ..... 03 To pay off debts ..... 04 For social reasons such as wedding, travel or bride price ..... 05 For education of self, children, siblings or others ..... 06 b) **Assets** For purchasing/building/improving a house ..... 07 To acquire assets or property ..... 08 c) **Agriculture and fishing** For purchasing of livestock e.g. fish, cattle etc. ..... 09 For agricultural improvements e.g. Irrigation, a dam, fencing, preparing land ..... 10 For agricultural implements/inputs/equipment etc.. .. 11 d) **Business** For expanding/starting a business/buy business stock ..... 12 e) **Other (specify)** 13	
4	What is the main source of the loan?	Relative 1	

		Friend/Neighbour ..... 2 Grocery/local merchant ..... 3 Money lender (katapila) ..... 4 Employer ..... 5 Religious institution ..... 6 Microfinance institutions ..... 7 Bank (commercial) ..... 8 Ngo ..... 9 Other (specify 10	
5	Has the household **sent**/given any money, goods or gifts (including food) to anyone outside the household in the last 12 months?	Yes ..... 1 No 2	→ Q7
6	What is the overall value of all the money, goods or gifts sent by the household to individuals outside the household in the past 12 months? In BIRR	AMOUNT : _____	
7	Has the household **received** any money, goods or gifts (including food) from individuals who were not member of the household in the past 12 months?	Yes ..... 1 No 2	→ NEXT SECTION
8	What is the overall value of all the money, goods or gifts received by the household by individuals who were not members of the household in the past 12 months? In BIRR	AMOUNT: _____	
9	Did you or will you have to give something back in return?	Yes, all ..... 1 Yes, part ..... 2 No 3	

SECTION 6A: REPRODUCTIVE HEALTH OF ALL WOMEN 12 – 49 YEARS OLD

First list all women 12 – 49 years old, then start with question 1

	1	2	3	4	5	6	7	8	9
ID	Is [NAME] pregnant now? 1=YES 2=NO (>>Q7) -9=Do not know (>>Q7)	Has [NAME] seen anyone for antenatal care during this pregnancy? 1=YES (>>Q4) 2=NO	Why has [NAME] not gone for any antenatal care for this pregnancy? 1=Can't afford 2=No health care available 3=Health care too far 4=Not necessary 5=Health personnel not friendly 6=Not aware about ANC 7=Pregnancy too early	Whom did [NAME] see? Health professional: 1=Doctor 2=Nurse 3=Midwife 4=Health officer 5=Health extension worker 6=Traditional birth attendant 7=Other (specify) Multiple Response	How many months pregnant was [NAME] when she first received antenatal care for this pregnancy? [MONTHS] -9= DON'T KNOW	How many times has [NAME] received antenatal care during this pregnancy? [NUMBER] -9= DON'T KNOW	Does [NAME] have any living children (biological children)? 1=YES 2=NO >>Q10	How many children to whom [NAME] has given birth are currently living in this household? [number]	How many children to whom [NAME] has given birth are alive but do not live in this household? [number]

			8=Other (specify) (>>Q7)						

10	11	12	13	13a	14	15	16	17	18
Has [NAME] ever given birth to a boy or girl who was born alive but later died? [IF NO, PROBE: I mean, to a child who ever breathed or cried or showed other signs of life – even if he or she lived only a few minutes or hours?] 1=YES 2=NO>>Q12	What is the total number of children that have died?	ENUMERATOR: Sum the answers to Q8, Q9 and Q11	So just to make sure I have this correct, [NAME] has had in total (*Q12*) live births during her life, is this correct? IF 'YES' >>Q13a) IF 'NO' >> CHECK RESPONSES Q7 – Q11 AND MAKE CORRECTIONS	Is [NAME] currently pregnant or gave birth in the last 2 years? 1=YES 2=NO (>> Next person)	The last time [NAME] was pregnant, was she a PSNP client? 1=YES, a Public Works Client 2=YES, a Permanent Direct Support beneficiary (>> next person) 3=NO (>> next person) -9=Don't know (>> next person)	Did [NAME] move from Public Works to be a Temporary Direct Support while she was pregnant/when she gave birth? 1=Yes, while she was pregnant 2=Yes, but only after gave birth (>> Q17) 3=No (>>Next person)	How many months was [NAME] pregnant when she moved from Public Works to be a Temporary Direct Support? -9=Don't know [MONTHS] >>Q18	After how many months since she gave birth was [NAME] moved to be a Temporary Direct Support? -9=Don't know [MONTHS]	When did [NAME] start receiving payments as Temporary Direct Support beneficiary? [Report number of months since she was shifted from Public Works to Temporary Direct Support] -9=Don't know [MONTHS]

SECTION 6B: BIRTH HISTORY SCHEDULE

Enter ID code of woman: |___|___|

ENUMERATOR CHECK: For this person, check response to Q12, Module 6A: |___|___|

- ☐ No live births in the past 5 years……..1 → NEXT SECTION
- ☐ One or more live births in the past 5 years……..2 → CONTINUE BELOW

Now I would like to record the names of all of your births **in the past 5 years** whether still alive or not, starting with first birth.

Record names of all of the births in Q1. Record twins and triplets on separate lines.

	1	2	3	4	5	6	7	8	9	10
Birth history ID	What name was given to your first/next baby?	Was this a single, twin or multiple birth? 1=Single birth 2=Multiple birth	Is (NAME) living with you? 1=YES 2=NO→ **Q5**	Record line number of child from household roster. **>>Q10**	Is (NAME) a boy or a girl? 1=Boy 2=Girl	What is (NAME)'s birthday? **(DD/MM/YYYY)** **RECORD FROM HEALTH CARD OR BIRTH REGISTRATION DOCUMENT IF AVAILABLE.** -9=Don't Know	Is (NAME) still alive? 1=YES 2=NO **>> Q9**	How old was (NAME) at his/her last birthday? **Record age in completed years. If Age less than 1 insert 0** **>>Q10**	IF DEAD: How old was (NAME) when he/she died? **Record days if less than 1 months, record months if less than 2 years, otherwise record years** 1=Days 2=Months	Has there been any other birth after the birth of [NAME] even if not alive 1=YES 2=NO (>>NEXT SECTION)

									3=Years		
									NUMBER	UNIT	
01						|___|___||___|___|___|___|___|___|					
02						|___|___||___|___|___|___|___|___|					
03						|___|___||___|___|___|___|___|___|					
04						|___|___||___|___|___|___|___|___|					
05						|___|___||___|___|___|___|___|___|					
06						|___|___||___|___|___|___|___|___|					
07						|___|___||___|___|___|___|___|___|					
08						|___|___||___|___|___|___|___|___|					
09						|___|___||___|___|___|___|___|___|					
10						|___|___||___|___|___|___|___|___|					

SECTION 7: MATERNAL AND NEWBORN HEALTH

These questions can be answered only to the mother for each child less than 3 years (36 months).

	1	1a	2	3	4	5	6	7	8
ID of child **[FROM HOUSE-HOLD ROSTER]**	Is the respondent the mother of this child? 1=YES 2=NO (>>NEXT CHILD)	ID of Mother **[FROM HOUSE-HOLD ROSTER]**	Did you see anyone for antenatal care during your pregnancy with (NAME)? 1=YES (>>Q4) 2=NO -9=DK (>>Q7)	Why didn't you go for antenatal care (MAIN Reason)? 1=Can't afford 2=No health care available 3=Health care too far 4=Not necessary 5=Health personnel not friendly 6=I do not have the awareness 7=Partner objects 8=Other (specify)	Whom did you see? Health professional: 1=Doctor 2=Nurse 3=Midwife 4=Health officer 5=Health extension worker Other person: 6=Traditional birth attendant 7=Other (specify)	How many months pregnant were you when you first received antenatal care for this pregnancy? [MONTHS] -9= DON'T KNOW	How many times did you receive antenatal care during this pregnancy? [NUMBER] -9= DON'T KNOW	Who assisted with the delivery of [NAME]? [IF RESPONDENT SAYS NO ONE, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.] **Multiple Answer** **[RECORD ALL PERSONS MENTIONED]** Health professional: 1=Doctor 2=Nurse 3=Midwife 4=Health officer 5=Health extension worker	Where did you give birth to [NAME]? 1=Home 2=Other home **Public sector** 3=Government hospital 4=Government health center 5=Government health post 6=Other public sector NGO 7=Health facility 8=Other NGO health facility **Private medical sector**

				(>>Q7)	Multiple Answer			Other person: 6=Traditional birth attendant 7=Relative or friend 8=Other (specify) 9=No one -9=Don't know	9=Private hospital 10=Private clinic 11=Other private medical sector Other 12=Outside 13=Other, Specify 14=Don't know

	9	10	11	12	13	14	15	16
ID of child **[FROM HOUSE-HOLD ROSTER]**	When [NAME] was born, was s/he very big, bigger than average, average, smaller than average, or very small? 1=Very big 2=Bigger Than Average 3=Average 4=Smaller Than Average 5=Very Small 9=Don't know	Was [NAME] weighed at birth? 1=YES 2=NO (>>Q12) 9=DK (>>Q12)	How much did [NAME] weigh at birth? **RECORD WEIGHT FROM HEALTH CARD, IF AVAILABLE.** **RECORD IN KG AND USE APPROPRIATE CODE:** 1=From health card 2=From recall 98=DK/Don't remember	Was [NAME] taken for a postnatal check-up? 1=Yes, within 4 hours 2=Yes, between 4 and 23 hours 3=Yes, within 2 days 4=Yes, within 3-6 days 5=More than a week later 6=No	How long after birth did you first put (NAME) to the breast? If less than 1 hour, record '0' hours. If less than 24 hours, record hours. Otherwise, record days. 0=Immediately 1=Hours 2=Days 8=Never breastfed -9=Don't know	In the first three days after delivery, was (NAME) given anything to drink other than breast milk? 1=YES 2=NO **(>>Q16)** -9=DK (>>Q16)	What was (NAME) given to drink? Probe: Anything else? **[RECORD ALL MENTIONED]** 1=Honey 2=Fruit juice 3=Plain water 4=Sugar water 5=Tea 6=Milk (other than breastmilk) 7=Infant formula	How many times did you take [NAME] to growth monitoring sessions since birth?

						If Code is 0,8 or 9 (>>14)			8=Raw butter 9=Ersho 10=Abish water 11=Water with rue, thyme, other herbal extract 12=Other (specify)	
			Kilograms	Code		Code	Number			
			|___|.|___|___|							
			|___|.|___|___|							
			|___|.|___|___|							
			|___|.|___|___|							
			|___|.|___|___|							
			|___|.|___|___|							

SECTION 8: PREVENTIVE CARE AND CHILD HEALTH

This part covers all children under 5 (0- 59 months)

	1	2	3	4	5	6	7	8	9
ID of child **[FROM HOUSE-HOLD ROSTER]**	Did you or someone else take (NAME) to a health facility in the past 12 months? 1=YES 2=NO (>>Q3)	How many times was (NAME) there for consultations in the past 12 months?	In the last seven days, was (NAME) given iron pills, sprinkles with iron, or iron syrup like [this/any of these]? SHOW COMMON TYPES OF PILLS/ SPRINKLES/ SYRUPS. 1=YES 2=NO	Was (NAME) given any drug for intestinal worms in the last six months? 1=YES 2=NO	In the last four weeks, has (NAME) had diarrhoea? 1=YES 2=NO (>>Q13)	During the time (NAME) had diarrhoea, was he/she given less than usual to drink (including breastmilk), about the same amount, or more than usual? **If less, probe:** **Was he/she given much less than usual to drink, or somewhat less?** 1=Much less 2=Somewhat less 3=About the same 4=More 5=Nothing to drink	During the time (NAME) had diarrhoea, was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? **If less, probe:** **Was he/she given much less than usual to eat, or somewhat less?** 1=Much less 2=Somewhat less 3=About the same 4=More 5=Stopped food	Did you seek advice or treatment for the diarrhea from any source? 1=YES 2=NO (>>Q10)	Where did (NAME) seek treatment for this condition? **Public sector** 1= Government hospital 2= Government health center 3= Government health post 4 = Other public sector **NGO** 5= Health facility 6= Other NGO health facility **Private medical sector** 7= Private hospital 8= Private clinic

						9=Don't Know	6=Never gave food 9=Don't Know		9= Other private medical sector Other 10= Shop/drug vendor 11=Traditional practitioner 12= Market 13= Other, Specify -9= Don't know

SECTION 8: PREVENTIVE CARE AND CHILD HEALTH (CONTINUED)

This part covers all children under 5 (0- 59 months)

10			11	12	13	14	15
During the episode of diarrhoea, was (NAME) given to drink any of the following:			Was anything else given to treat the diarrhoea? 1=YES 2=NO (>>Q13)	What else was given to treat the diarrhoea? Multiple Answer **Pill or Syrup** 1=Antibiotic 2=Antimotility (anti-diarrhoeal) 3=Other (Not antibiotic, or antimotility) 4=Unknown pill or syrup **Injection** 5=Antibiotic 6=Non-antibiotic 7=Unknown injection	At any time in the last two weeks, has (NAME) had an illness with a cough? 1=YES 2=NO	Has (NAME) had fast, short, rapid breaths or difficulty breathing at any time in the last 2 weeks? 1=YES 2=NO (>>Q18)	Was the fast or difficult breathing due to a problem in the chest or a blocked or runny nose? 1=Problem in chest only 2=Blocked or runny nose only 3=Both 6=Other (specify) 8=Don't know
a. A fluid made from a special packet called LEMLEM? 1=YES 2=NO 8=DK	b. A government-recommended homemade fluid? 1=YES 2=NO 8=DK	c. Zinc tablets or syrup? 1=YES 2=NO 8=DK					

				8=Intravenous 9=Home remedy / Herbal medicine 10=Other (specify)			

SECTION 8: PREVENTIVE CARE AND CHILD HEALTH (CONTINUED)

This part covers all children under 5 (0- 59 months)

	16	17	18	19	20	21	22	23	24
ID of child [FROM HOUSE-HOLD ROSTER]	Did you seek advice or treatment for this condition from any source? 1=YES 2=NO (>>Q18)	Where did (NAME) seek treatment for this condition? **Public sector** 1= Government hospital 2= Government health center 3= Government health post 4 = Other public sector **NGO** 5= Fixed Health facility 6= Mobile health facility 7= Other **Private medical sector**	Has (NAME) been ill with fever in the last 2 weeks? 1=YES 2=NO (>>Q21)	Did you seek advice or treatment for this fever from any source? 1=YES 2=NO (>>Q21)	Where did (NAME) seek treatment for this condition? **Public sector** 1= Government hospital 2= Government health center 3= Government health post 4 = Other public sector **NGO** 5= Health facility 6= Other NGO health facility **Private medical sector** 7= Private hospital	How much was spent on (NAME) for health related services including medicines and consultations **in the last two weeks?** **[GIVE AMOUNT IN BIRR]**	The last time (NAME) passed stools, what was done to dispose of the stools? 1=Child used toilet / latrine 2=Put / Rinsed into toilet or latrine 3=Put / Rinsed into drain or ditch 4=Thrown into garbage (solid waste) 5=Buried 6=Left in the open	Did (NAME) sleep under a mosquito net last night? 1=YES 2=NO	How much was spent on medications, medical supplies, consultations for (NAME) **in the last 1 month**?

		8= Private hospital 9= Private clinic 10= Other private medical sector Other 11= Shop/drug vendor 12=Traditional practitioner 13= Market 14= Other, Specify -9= Don't know			8= Private clinic 9= Other private medical sector Other 10= Shop/drug vendor 11=Traditional practitioner 12= Market 13= Other, Specify 14= Don't know		7=Other (specify) 8=Don't Know		

SECTION 9: IMMUNIZATIONS

This part covers all children under 5 (0- 59 months)

	1	2														3	4	
ID of child [FROM HOUSE-HOLD ROSTER]	Do you have a card where (name)'s vaccinations are written down? (IF YES) may I see it please? 1=Yes, seen 2=Yes, not seen 3=No	Check health card for vaccination history. If health card not available inquire from respondent. For PEN, OPV and Pneumococcal and Rotavirus vaccinations record "YES" for each dose received. Indicate DK of respondent does not know. 1=YES 2=NO -9=DK														Has (NAME) received a Vitamin A dose like this within the last 6 months? [SHOW COMMON TYPES OF AMPULES /CAPSULES / SYRUPS] 1=YES 2=NO	In the last 7 days was (NAME) given A: Plumpy'nut B: Plumpy'doz [SHOW PACKAGE] 1=YES 2=NO	
		BCG Vaccination against tuberculosis – that is, an injection in the arm or shoulder that usually causes a scar	POLIO Vaccination drops in the mouth to protect him/her from getting polio				PENTA An injection in the thigh or buttocks to prevent him/her from getting tetanus, whooping cough, or diphtheria			PNEUMO-COCCAL An injection usually given on the right upper thigh to prevent pneumonia?			ROTA-VIRUS Liquid in the mouth to prevent diarrhea?			MEASLES A shot in the arm at the age of 9 months or older to prevent him/her from getting measles			
			OPV0	OPV1	OPV2	OPV3	PEN1	PEN2	PEN3	1	2	3	1	2	3			A	B

SECTION 10: CHILD NUTRITION AND FEEDING

This part covers all children under 5 (0- 59 months)

	1	2	3	4	5										
ID of child [FROM HOUSE-HOLD ROSTER]	Are you still breast-feeding (NAME)? 1=YES (>>Q3) 2=NO	At what age did you stop breast-feeding (NAME)? [Record age in completed months]	Did (NAME) drink anything from a bottle with a nipple yesterday during the day or night? 1=YES 2=NO	At what age (in months) did you first give (NAME) water or other fluids besides breast milk? [00=LESS THAN ONE MONTH] [97=NOT YET](>>Q6)	Now I would like to ask you about liquids or foods that (NAME) had yesterday during the day or at night. I am interested in whether your child had the item I mention even if it was combined with other foods. [For milk products, infant formula and yoghurt, ask how many times the child had the item] 1=YES 2=NO										
					a. Plain water? 1=Yes 2=No	b. Juice or juice drinks? 1=Yes 2=No	c. Clear broth? 1=Yes 2=No	d. Milk such as tinned, powdered, or fresh animal milk? 1=Yes 2=No (>>Q5e)	d2. How many times? Number	e. Infant formula (Plan, S-26)? 1=Yes 2=No (>>Q5f)	e2. How many times? Number	f. Yoghurt? 1=Yes 2=No (>>Q5g)	f2. How many times? Number	g. . Any other liquids? 1=Yes 2=No	h. Any commercially fortified baby food like Fafa, Hilina, Cerilak, Cerifam, Mother Choice?

SECTION 10: CHILD NUTRITION AND FEEDING (CONTINUED)

This part covers all children under 5 (0- 59 months)

	6	7												
ID	At what age (in months) did you first give (NAME) solid or semi-solid food?	Now I would like to ask you about (other) liquids and foods that (NAME) may have had yesterday during the day or the night. I am interested to know whether your child had the item even if combined with other foods. Did (NAME) eat (name of food) during the day or the night before: 1=YES 2=NO												
		7a.	7b.	7c.	7d.	7e.	7f.	7g.	7h.	7i.	7j.	7k.	7l.	7m.	7n.	7o.
	[00=LESS THAN ONE MONTH] [97=NOT YET] >> NEXT CHILD/ SECTION Age in Month	Injera, bread, rice, noodles, porridge, or other foods made from grains such as tef, oats,	Pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside?	White potatoes, white yams, bulla, kocho, manioc, cassava, or any other foods made from roots?	Any dark green, leafy vegetables like kale, spinach,	Ripe mangoes, papayas?	Any other fruits or vegetables?	Liver, kidney, heart or other organ meats?	Any meat such as beef, pork, lamb, goat, chicken, or duck?	Eggs?	Fresh or dried fish or shellfish?	Any foods made from beans, peas, lentils, or nuts?	Cheese or other food made from milk?	Any oil, fats or butter, or foods made with any of this?	Any sugary foods as chocolate, sweet candies, pastries, cakes or biscuits?	Any other solid, semi-solid or soft foods?

		maize, barley,														

SECTION 10: CHILD NUTRITION AND FEEDING (CONTINUED)

This part covers all children under 5 (0- 59 months)

	8	9	10	11	12a	12b
ID of child [FROM HOUSE-HOLD ROSTER]	IF ALL 'NO' IN Q7 >> Q9 IF AT LEAST 1 'YES' IN Q7 SKIPTO Q10	Did (NAME) eat any solid, semi-solid, or soft foods yesterday during the day or at night? 1= 'YES' PROBE: What kind of solid, semi-solid or soft foods did (NAME) eat? [GO BACKTO Q7 AND RECORD FOOD EATENYESTERDAY] 2= 'NO' >> NEXT CHILD/SECTION	How many times did (NAME) eat solid or semi-solid (soft, mushy) food yesterday, during the day and night? [RECORD NUMBER OF TIMES] [IF 7 OR MORE, RECORD '7'] -9= DON'T KNOW	Was this a typical day's of food intake for (NAME)? 1=Yes >> NEXT CHILD/SECTION 2=NO, less than usual 3=NO, more than usual>>12b	If Less than usual, why? 1= Child was not hungry, did not have an appetite 2= Child was sick 3=There was not enough food to feed more 4= Other (specify) -9=DON'T KNOW GOTO NEXT PERSON	If More than usual, why? 1= It was market day 2= It was a holiday/ceremony 3= Just completed harvest 4= Other (specify) -9=DON'T KNOW

SECTION 11: BIRTH REGISTRATION & CHILD DEVELOPMENT

This part covers all children under 5 (0- 59 months).

	1	2	3	4	5	6					
ID of child **[FROM HOUSE-HOLD ROSTER]**	Has (NAME)'s birth been registered with the woreda or kebele? 1=Yes 2=No (>>Q5)	Does (NAME) have a birth certificate? If yes, may I see it? 1=Yes, seen 2=Yes, not seen 3=No	When was (NAME)'s birth registered? 1=Within 90 days from birth 2=Between 3 months and 1 year since birth 3=After 1 year since birth	How much did you pay to register the birth? (Birr) **>>Q6** **If not paid write 0**	What is the main reason why (NAME)'s birth is not registered? 1=Costs too much 2=Must travel too far 3=Did not know it should be registered 4=Did not find it important 5=Do not know where to register 6=Could not fulfil the requirement of the presence of both parents for registration 7=I do not have a valid kebele ID card	In the **past 3 days**, did you or any household member over 15 years of age engage in any of the following activities with [NAME]? Multiple Response possible **[RECORD ALL MENTIONED]** 1=MOTHER 2=FATHER 3=OTHER 4=NO ONE					
						6a. Read books to or looked at pictures with [NAME]?	6b. Told stories to [NAME]?	6c. Sang songs to [NAME] or with NAME including lullabies?	6d. Took [NAME] outside the home, compound, yard or enclosure?	6e. Played with [NAME]?	6f. Named, counted or drew things with [NAME]?

					8=The registrar was not present when I visited the kebele/registration centre 9=Other (specify)						

SECTION 12: CHILD DISCIPLINE

This part covers all children 1- 4 (12- 59 months).

	1	2												
ID of child [FROM HOUSE-HOLD ROSTER]	Check child's age: 1=AGE 0 >> Next child/section 2=AGE 1, 2, 3, or 4	Adults use certain ways to teach children the right behavior or to address a behavior problem. I will read various methods that are used. Please tell me if <u>you or any other adult in your household</u> has used this method with *(name)* <u>in the past month</u>. 1=YES 2=NO												
		2A. Took away privileges, forbade something *(name)* liked or did not allow (him/her) to leave the house.	2B. Explained why (*name*)'s behaviour was wrong.	2C. Shook (him/ her).	2D. Shouted, yelled at or screamed at (him/ her).	2E. Gave (him/ her) another activity to distract the child from engaging in the problem behaviour.	2F. Spanked, hit or slapped (him/ her) on the bottom with bare hand.	2G. Hit (him/ her) on the bottom or elsewhere on the body with something like a belt, hairbrush, stick or other hard object.	2H. Called (him/ her) dumb, lazy or another name like that.	2I. Hit or slapped (him/ her) on the face, head or ears	2J. Hit or slapped (him/ her) on the hand, arm, or leg.	2K. Beat (him/ her) up, that is hit (him/ her) over and over as hard as one could.	2L. Confined, isolated (him/ her) for a few hours or days.	2M. Tied up (him/ her) and beat them.	2N. Tied (him/ her) up and smoked with fumes to cause burning sensation on eyes and nose.

After completing the questions for each child separately, ask the question below (only *once* per household!):

3	Do you believe that in order to bring up, raise, or educate a child properly, the child needs to be physically punished?	Yes.....1 No.....2 No opinion.....3

SECTION 13: CONTRACEPTION, FERTILITY PREFERENCES AND SUBJECTIVE HEALTH

Respondent for this section should be the respondent in aged 49 years or younger.

	Record PID for respondent	|___|___|___|	
	Question	**Answers**	**Skip**
1	Now I would like to talk with you about another subject –family planning. ENUMERATOR CHECK SECTION 6A, Q1	Currently pregnant ..... 1 Not pregnant ..... 2 Unsure or don't know 8	 → Q3 → Q3
2	Now I would like to ask some questions about the future. After the child you are now expecting, would you like to have another child, or would you prefer not to have any more children?	Have another child ..... 1 No more / none ..... 2 Undecided / Don't know 8	→ Q5 → Q5 → Q5
3	Couples use various ways or methods to delay or avoid a pregnancy. Are you or your partner currently doing something or using any method to delay or avoid getting pregnant?	Yes ..... 1 No ..... 2 NA/No sexual partner.....3 Don't know ..... -9	 → Q5 → Q5
4	What are you and your partner doing to delay or avoid a pregnancy? Multiple Response DO NOT PROMPT. RECORD ALL METHODS MENTIONED	Female sterilization ..... 1 Male sterilization ..... 2 IUD ..... 3 Injectable ..... 4 Implants ..... 5 Pill ..... 6 Male condom ..... 7 Female condom ..... 8 Diaphragm ..... 9 Foam / Jelly ..... 10 Emergency contraception ..... 11 Standard days method ..... 12 Lactational amenorrhoea method (LAM) 13	

		Periodic abstinence ..... 14 Withdrawal..... 15 Other (specify) 16	
5	I will now ask you some questions about your physical health in general: How would you rate your health in general?	Excellent ..... 1 Very Good ..... 2 Good ..... 3 Fair ..... 4 Poor 5	
6	Compared with your health one year ago, would you say that your health is:	Better..... 1 About the same ..... 2 Worse 3	
7	How would you rate yourself when engaging in vigorous activities (such as run, lift a heavy load, lift a bucket of water)? Would you do this …	Easily ..... 1 With Difficulty..... 2 Not at all..... 3	
8	Can you engage in moderate activities (such as work on the farm, carry a baby, or walk 5 km)?	Easily ..... 1 With Difficulty..... 2 Not at all..... 3	
9	Can you carry a 10 KG bag of shopping for 500 meters? Show distance	Easily ..... 1 With Difficulty..... 2 Not at all..... 3	
10	If you had to bend, squat, or kneel, could you do it:	Easily ..... 1 With Difficulty..... 2 Not at all..... 3	
11	Are you able to walk 2 KMS?	Easily ..... 1 With Difficulty..... 2 Not at all..... 3	

SECTION 14: EXPOSURE TO HEALTH AND NUTRITION SERVICES

Respondent for this section: Person identified as the primary caregiver of children in the household.

	Question	Answers	Skip
1	Do you know the Health Extension Worker (HEW) working in your area?	Yes ..... 1 No 2	 → Q15
2	In your opinion, what are the services you can receive from the HEW? Multiple responses possible [SEE CODE A]	Answers.....	
3	Did you have any contact with a HEW in the <u>past 3 months</u>? (at home, at the health post, or in the community)	Yes ..... 1 No 2	
4	Have you ever been visited <u>at home</u> by a HEW?	Yes ..... 1 No 2	 → Q10
5	Were you visited by a HEW at your home in the past 3 months?	Yes ..... 1 No 2	→ Q7 → Q6
6	When was the last time you received a visit from a HEW? (Report the number of months since the last visit)	NO. of MONTHS..... |__|__|	
7	During the last time the HEW visited you at home, what topics did she discuss with you? Multiple responses possible [SEE CODE B]	Answers.....	
8	During the last time the HEW visited you at home, did she talk to you about breastfeeding, child feeding or nutrition?	Yes ..... 1 No 2	 → Q10
9	What did the HEW tell you about breastfeeding or child feeding? Multiple responses possible [SEE CODE C]	Answers.....	
10	Did you have contact with a HEW in the community, outside your home and outside the health post, in the last 3 months?	Yes ..... 1 No 2	→ Q12 →

11	When was the last time you have contact with a HEW in the community, outside your home and outside the health post? (Report the number of months since the last visit)	NO. of MONTHS..... |__|__| Never 99	→ Q15
12	During the last time you met the HEW in the community, what topics did she discuss with you? Multiple responses possible [SEE CODE B]	Answers.....	
13	During the last time you met the HEW in the community, did she talk to you about breastfeeding, child feeding or nutrition?	Yes ..... 1 No 2	→ Q15
14	What did the HEW tell you about breastfeeding or child feeding? Multiple responses possible [SEE CODES C]	Answers.....	
15	Have you ever visited the health post?	Yes ..... 1 No 2	→ Q19
16	Did you visit the health post for any reasons related to your child or yourself in the last 3 months?	Yes ..... 1 No 2	→ Q19
17	During your last visit to the health post, did you receive any advice or information about breastfeeding, child feeding or nutrition?	Yes ..... 1 No 2	→ Q19
18	What advice or information about breastfeeding or child feeding did you receive? Multiple responses possible [SEE CODES C]	Answers.....	
19	Are you a member of a Health Development Army (HDA)?	Yes .....1 No 2	
20	Do you know a HDA/leader working in your area?	Yes .....1 No 2	
21	Did you have any contact with the HDA/leader in the past 3 months? (at home or in the community)	Yes .....1 No 2	

	Question	Answers	Skip
22	Have you ever been visited at home by a HDA/leader?	Yes ..... 1 No 2	 → Q27
23	Were you visited by a HDA/leader at your home in the past 3 months?	Yes ..... 1 No 2	 → Q27
24	During the last time the HDA/leader visited you at home, what topics did she discuss with you? Multiple responses possible [SEE CODES B]	Answers	
25	During the last time the HDA/leader visited you at home, did she talk to you about breastfeeding, child feeding or nutrition?	Yes ..... 1 No 2	 → Q27
26	What did the HDA/leader tell you about breastfeeding or child feeding did you receive? Multiple responses possible [SEE CODE C]	Answers	
27	Did you have contact with a HDA/leader in the community, outside your home and outside the health post, in the last 3 months?	Yes ..... 1 No 2	 → Q31
28	During the last time you met the HDA/leader in the community, what topics did she/he discuss with you? Multiple responses possible [SEE CODES B]	Answers	
29	During the last time you met the HDA/leader in the community, did she talk to you about breastfeeding, child feeding or nutrition?	Yes ..... 1 No ..... 2 Never 99	 →Q31 →Q31
30	What did the HDA/leader tell you about breastfeeding or child feeding? Multiple responses possible [SEE CODE C]	Answers	
31	Do you know the Social Worker working in your area?	Yes ..... 1 No 2	 → Q39

32	Did you have any contact with a Social Worker in the past 3 months? (at home, at the health post, or in the community)	Yes ..... 1 No 2	→
33	Have you ever been visited at home by a Social Worker?	Yes ..... 1 No 2	→ Q36
34	Were you visited by a Social Worker at your home in the past 3 months?	Yes ..... 1 No 2	→ Q36
35	During the last time the Social Worker visited you at home, what services did she refer you to? Multiple responses possible	School/education ..... 1 Health ..... 2 Other (specify) 3	
36	Do you know what types of services a Social Worker can provide to you and your household or other community members? Multiple responses possible	School/education ..... 1 Health ..... 2 Other (specify) ..... 3 DK ..... -9	
37	Did you have contact with a Social Worker <u>in the community</u>, outside your home and outside the health post, in the last 3 months?	Yes ..... 1 No 2	→ Q39
38	During the last time you met the Social Worker in the community, what services did she refer you to? Multiple responses possible	School/education ..... 1 Health ..... 2 Other (specify) 3	
39	Have you ever attended a food demonstration in your community?	Yes ..... 1 No 2	→ Q44
40	Did you attend a food demonstration in your community in the last 3 months?	Yes ..... 1 No 2	→ Q44

	Question	Answers	Skip
41	Who conducted/led food demonstration? Multiple responses possible	HEW ..... 1 Volunteer (HDA/WDA) ..... 2 Social worker ..... 3 Community leader ..... 4 Woreda health officer/ food security desk ..... 5 NGO ..... 6 Other (specify) 7	
42	During the last food demonstration you attended, what was demonstrated/shown? Multiple responses possible [SEE CODES D]	Answers	
43	During the last food demonstration you attended, what advice or message did you receive? Multiple responses possible	Types of locally available food that should be fed to children ..... 1 How to make special porridge for children ..... 2 How to feed the child ..... 3 How to make drinking water safe ..... 4 Hand washing ..... 5 Washing dishes 6	
44	Have you ever attended a community conversation or gathering to talk about breastfeeding, child feeding or nutrition?	Yes ..... 1 No 2	→ Q48
45	Did you attend community conversation or gathering about child nutrition in the last 3 months?	Yes ..... 1 No 2	→ Q48
46	Who conducted/led the community conversation? Multiple responses possible	HEW ..... 1 Volunteer (HDA/WDA) ..... 2 Social worker 3	

		Community leader ..... 4 Woreda health officer ..... 5 NGO ..... 6 Woreda food security desk ..... 7 Other 8	
47	During the last community conversation you attended, what advice or information did you receive? Multiple responses possible [SEE CODES D]	Answers	
48	Do you ever listen to the radio? (in your house or anywhere outside the house)	Yes ..... 1 No 2	→ Q53
49	How often do you listen to the radio?	Almost every day ..... 1 Several times a week ..... 2 About once a week ..... 3 Few times a month ..... 4 Once a month ..... 5 Less than once a month 6	
50	During the past 3 months, did you hear any information about breastfeeding, child feeding or nutrition on the radio?	Yes ..... 1 No 2	→ Q53
51	In the past 3 months, how often did you hear information about child nutrition on the radio?	Almost every day ..... 1 Several times a week ..... 2 About once a week ..... 3 Few times a month ..... 4 Once a month ..... 5 Less than once a month 6	
52	What messages did you hear about child nutrition on the radio?	Answers	

	Multiple responses possible [SEE CODES C]		

	Question	Answers	Skip
53	Do you know where you should go for birth registration in your kebele?	Yes.....1 No.....2	→ Next section
54	Where?	At Kebele Office .....1 At place of worship.....2 At health post .....3 Other (specify).....4	
55	Have you attended a community training/ awareness raising sessions in the last 12 months?	Yes, as part of the PSNP .....1 Yes, not part of the PSNP.....2 No, I did not attend 3	→ Next section
56	On what topics were these trainings/sessions implemented? Multiple answers allowed [SEE Codes B]	Answers	

Code A	Code B	Code C
Family planning ..... A	Family planning..... A	Put baby on the breast immediately after birth, within 1 hour..... A
Immunization..... B	Immunization..... B	Give colostrum to baby ..... B
Vitamin A or iron supplementation .. C	Vitamin A or iron supplementation ... C	Do not feed pre-lacteals..... C
Deworming..... D	Deworming..... D	Feed only breast milk for first 6 months ..... D
Antenatal care ..... E	Antenatal care .....E	Even during hot weather, breast milk is sufficient to quench baby's thirst/do not give water..... E
Delivery care.....F	Delivery care.....F	Breastfeed more often during child Illness .....F
Postnatal care..... G	Postnatal care..... G	Take vitamin A supplements after 45 days of birth..... G
Neonatal care .....H	Neonatal care ..... H	When to start feeding complementary foods ..... H
Growth monitoring I	Growth monitoring I	
Breastfeeding counseling.....J	Nutrition and care during pregnancy . J	
Complementary feeding counseling K	Breastfeeding .....K	

Referral or management of sick child L	Complementary feeding.....L	How to make complementary food such as thick porridge I
Diarrhea treatment (ORS)..... M	Referral or management of sick child ..... M	Enrich porridge with milk, eggs, meat, or vegetables.....J
Malaria treatment.....N	Diarrhea treatment (ORS)..... N	Feed the child at least 3 times a day.. K
Provide or sell bed nets.....O	Malaria treatment or bed net use..... O	Continue breastfeeding until 2 years ..L
Pneumonia treatment ..... P	Pneumonia treatment .....P	When to introduce the family food to the baby ..... M
Management of severe malnutrition (OTP).....Q	Management of severe malnutrition (OTP).....Q	Feed the child more often during and after illness.....N
HIV/ AIDS counseling ..... R	HIV/ AIDS..... R	Feed the child with patience .....O
Health education about sanitation and hygiene ..... S	Sanitation (latrine use) and hygiene ..S	Other ..... P
Information on safe water use .....T	Safe water use.....T	
Information on CBHI.....U	Information about CBHI..... U	
Do Not Know..... X	Early marriage.....V	
Other .....Z	Livelihoods (crops, livestock, etc.)... W	
	Other X	

Codes D

Feed the child a variety of foods 1
Feed the child at least 3 times a day.....2
Add milk into the porridge.....3
Add an egg into the porridge.....4
Add (dried) meat into the porridge 5
Add vegetables into the porridge 6
Thicken the porridge 7
Feed the child with patience 8
When to wash your hands.....9
Information on breastfeeding.....10

Other (specify)..... 11

SECTION 15: WOMEN'S EMPOWERMENT, STRESS, PREFERENCES, AND SOCIAL CAPITAL

Respondent for this section should be the main respondent (if women; if men, skip to next section)

	Record PID for respondent	|___|___|___|	
	Question	**Answers**	**Skip**
1	Some people try to save some money for emergencies or to buy something special in the future. Are you currently saving (in cash), separately from your household?	Yes ..... 1 No ..... 2 Prefer not to answer 3	→Q3 →Q3
2	How much have you saved in cash in the last one month?	Birr: _____	
3	If you needed 150 Birr, what would be your main source to raise this money?	Livestock Products Sale.....0 Sale of livestock or productive assets ..... 1 Sale of consumer durables ..... 2 Borrow from friends and neighbours ..... 3 Rely on household savings ..... 4 Rely on my personal savings ..... 5 Rent out land ..... 6 I would not be able to raise such amount ..... 7 Other (specify) 8	
4	[IF ANSWER TO Q3 IS 5, DOUBLE THE AMOUNT AND ASK THE SAME QUESTION] If you needed 300 Birr, what would be your main source to raise this money? [IF ANSWER TO Q3 IS ANY OTHER ANSWER THAN 5, HALF THE AMOUNT AND ASK THE SAME QUESTION] If you needed 75 Birr, what would be your main source to raise this money? [IF ANSWER IS 4, SKIP TO Q6]	Livestock Products Sale.....0 Sale of livestock or productive assets ..... 1 Sale of consumer durables ..... 2 Borrow from friends and neighbours ..... 3 Rely on household savings ..... 4 Rely on my personal savings ..... 5 Rent out land ..... 6 I would not be able to raise such amount 7	

		Other (specify)..... 8	
5	[IF ANSWERTO Q4 IS 5, DOUBLETHE AMOUNT AND ASKTHE SAME QUESTION] If you needed 600 Birr, what would be your main source to raise this money? [IF ANSWERTO Q4 IS ANY OTHER ANSWER THAN 5, HALFTHE AMOUNT AND ASKTHE SAME QUESTION] If you needed 37 Birr, what would be your main source to raise this money?	Livestock Products Sale.....0 Sale of livestock or productive assets..... 1 Sale of consumer durables..... 2 Borrow from friends and neighbours ..... 3 Rely on household savings..... 4 Rely on my personal savings..... 5 Rent out land..... 6 I would not be able to raise such amount ..... 7 Other (specify)..... 8	
6	Is your household currently saving? [IF SHE IS SAVING, THIS QUESITON IS IN ADDITIONTO HER OWN SAVINGS]	Yes..... 1 No..... 2 DK..... -9	 →Q9 →Q9
7	How much has your household saved in cash in the last one month?	Birr: _____ DK.....-9	
8	Who decides about how to spend household savings?	Only my spouse makes the decision ..... 1 I have input, but my husband makes the final decision ..... 2 Decided with equal consideration between myself and my spouse ..... 3 I primarily decide, but I consult with my spouse ..... 4 I alone decide ..... 5 Other (specify)..... 6	
9	[modified Medical Outcomes Study Social Support Survey]	Answer categories: None of the time ..... 1 A little of the time 2	

	People sometimes look for companionship, assistance or other types of support. If you needed it, how often is someone available…	Some of the time ..... 3 Most of the time ..... 4 All of the time..... 5	
a	to help you if you were confined to bed?	1 2 3 4 5	
b	to take you to the doctor if you need it?	1 2 3 4 5	
c	to prepare your meals if you are unable to do it yourself?	1 2 3 4 5	
d	to help with daily chores if you were sick?	1 2 3 4 5	
e	to have a good time with?	1 2 3 4 5	
f	to turn to for suggestions about how to deal with a personal problem?	1 2 3 4 5	
g	who understands your problems?	1 2 3 4 5	
h	to love and make you feel wanted?	1 2 3 4 5	
10	In the last 12 months, how often did you feel that …	Answer categories: None of the time ..... 1 A little of the time ..... 2 Some of the time ..... 3 Most of the time ..... 4 All of the time..... 5	
a	Your life is determined by your own actions	1 2 3 4 5	
b	You have the power to make important decisions that change the course of your own life	1 2 3 4 5	
c	You have the power to make important decisions that change the wellbeing of your children	1 2 3 4 5	
d	You have the power to make important decisions that change the wellbeing of your household	1 2 3 4 5	
e	You are capable of protecting your own interests within your household	1 2 3 4 5	
f	You are capable of protecting your own interests outside of your household (e.g. in the community, in groups in which you participate)	1 2 3 4 5	

g	You are satisfied with your life	1 2 3 4 5	
11	Have you been concerned about any of the following during the past 7 days? [*show faces for responses*]		
a	you or your household's financial situation?	Yes ..... 1 No 2	>>11b
aa	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
b	failure of you or your household's farm or non-farm business?	Yes ..... 1 No 2	>>11c
	Question	**Answers**	**Skip**
bb	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
c	your employment or that of your family members?	Yes ..... 1 No 2	>>11d
cc	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
d	your access to education or that of your family members?	Yes ..... 1 No 2	>>11e
dd	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
e	you or your family's access to food and clean drinking water?	Yes ..... 1 No 2	>>11f
ee	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
f	your own physical health or that of a family member?	Yes ..... 1 No 2	>>11g
ff	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	

g	your own substance use or that of family members (drug, alcohol)?	Yes..... 1 No..... 2	>>11h
g g	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
h	violence towards you and your family members	Yes..... 1 No..... 2	>>11i
h h	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
i	Theft	Yes..... 1 No..... 2	>>11j
ii	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
j	your own romantic relationship(s) and/or marriage?	Yes..... 1 No..... 2 D	>>11k
jj	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
k	your own relationship with other family members?	Yes..... 1 No..... 2	>>11l
kk	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
l	your own relationships with friends and community members?	Yes..... 1 No..... 2	>>11m
ll	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
m	preventing pregnancy, spacing births, or health of a current pregnancy of you / your partner	Yes..... 1 No..... 2	>>11n

mm	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
n	Other, specify	Yes..... 1 No..... 2	>>12
n_text	[specification]		
nn	During the past 7 days, how distressed did you feel about this? *[show faces for responses]*	1 2 3	
12	WOMEN EMPOWERMENT (vignettes)		
a	Some people feel they have completely free choice and control over their lives, while other people feel that what they do has no real effect on what happens to them. Imagine a ladder where on the bottom step, the first step are people who have no free choice and no control over their lives, and on the highest step, the tenth are people who have completely free choice and total control over their lives. On which step of the ladder would you say you are today? [*Show ladder*]	1 2 3 4 5 6 7 8 9 10	
b	To what extent do you feel able to make decisions in your household, for example, decisions about what to spend money on, decisions about your child's education or health or decisions on if you should work or not? Imagine a ladder where on the bottom step, the first step are people with no decision making power, and on the highest step, the tenth are people who are able to make all decisions they wish. On which step of the ladder would you say you are today? [*Show ladder*]	1 2 3 4 5 6 7 8 9 10	

	GROUP MEMBERSHIP									
	Now I am going to ask you about group membership. These can be either formal or informal and customary groups.									
		a	b	c	d	e	f	g	h	i
		Agricultural/ livestock / fishery producer's group (including marketing groups)	Credit or microfinance group (including SACCOs)	Mutual help or insurance group (including burial societies, Iddir and Equb)	Trade or business groups	Civic groups (improving community) or charitable group (helping others)	Religious group	Other women's or men's group (only if it does not fit into one of the other categories)	Local government group	Other (specify)
13	Is there a [GROUP] in your or a nearby community (where you live)? 1=Yes 2=No 3=DK (>>next one)									
14	Are you/any household member an active member of this group? 1=Yes, respondent 2= Yes, other household member 3=No									

	Question	Answers	Skip
15	COGNITIVE SOCIAL CAPITAL		
	I now want to know whether you agree or disagree with the following statements: Answer with: 1=Strongly disagree; 2=Disagree; 3=Agree; 4=Strongly agree	Answer categories: Strongly disagree ..... 1 Disagree 2	

		Agree..... 3 Strongly agree 4	
a	The majority of people in this community generally get along with each other.	1 2 3 4	
b	I feel part of this community.	1 2 3 4	
c	The majority of people in this community would try to take advantage of you if they got the chance.	1 2 3 4	
16	If you needed to borrow Birr 100 in an emergency, how many people could you go to for this money? Number of people	Number	
17	How many Iddirs do you/other household members belong to? [REPORT ZERO IF THEY DO NOT BELONG TO ANY]	Number Iddir respondent ..... Number other household members.....	
18	How many Eqqub do you/other household members belong to? [REPORT ZERO IF THEY DO NOT BELONG TO ANY]	Number Eqqub respondent..... Number other household members.....	

SECTION 16: PERCEPTIONS AND ATTITUDES TOWARD CHILD MARRIAGE

	Question	Answers	Skip
1	What is the ideal age a girl should get married in your opinion?	Age |__|__|	
2	Why do you think this is the right age for a girl to get married? **[SEE CODES B below]** [**ALLOW UPTO 3 REASONS**]	CODE:.....|___|__|	
3	At what age do adolescent girls normally marry in this community?	Age.....|__|__|	
4	Who decides when (at what age) a girl should get married in your household? [**SEE CODES A below**]	CODE: .....|___|	
5	In your opinion, who SHOULD decide when (at what age) a girl should get married? [**SEE CODES A below**]	CODE: .....|___|	
6	Who decides when/at what age a girl gets married in other households in this community? [**SEE CODES A below**]	CODE: .....|___|	
7	Who decides who a girl gets married to in this household? [**SEE CODES A below**]	CODE: .....|___|	
8	In your opinion, who do you think SHOULD decide who a girl gets married to? [**SEE CODES A below**]	CODE: .....|___|	
9	What is the ideal age a boy should get married?	Age..... |__|__|	
10	Is there a legal age for marriage in Ethiopia?	Yes, for girls..... 1 Yes, for boys,..... 2 Yes, for boys and girls ..... 3 No..... 4 Don't know..... -9	 →Q12 →Q12
11a	What is the legal age for marriage for girls in Ethiopia?	Age..... |__|__| Don't know.....-9	
11b	What is the legal age for marriage for boys in Ethiopia?	Age..... |__|__| Don't know.....-9	

12	I now want to know whether you agree or disagree with the following statements: Answer with: 1=Strongly disagree; 2=Disagree; 3=Agree; 4=Strongly agree	Answer categories: Strongly disagree ..... 1 Disagree..... 2 Agree ..... 3 Strongly agree..... 4	
a	Most people in this community expect girls to marry before the age of 18.	1 2 3 4	
b	Marrying early avoids social stigma.	1 2 3 4	
c	If girls do not get married early, their families will not be respected in the community.	1 2 3 4	
d	Girls should have the final decision over their decision to marry.	1 2 3 4	
e	Girls should have a say whether or not they want to marry.	1 2 3 4	
f	Girls should have a say about who they want to marry.	1 2 3 4	
g	Marrying girls at a young age can help provide them security.	1 2 3 4	
h	Marrying girls young can help prevent sexual violence, assault, and harassment.	1 2 3 4	
i	Marriage of girls under 18 years sometimes happens for financial reasons.	1 2 3 4	
j	Marriage of girls under 18 years mostly happens because there is a lack of education and job opportunities.	1 2 3 4	
k	Unmarried a girls should have access to contraception/family planning services.	1 2 3 4	
l	Married girls should have access to contraception/family planning services.	1 2 3 4	

Codes A for Q4, Q5, Q6,Q7, and Q8		Codes B for Q2	
1=The father alone 2=The mother alone	5=The parents with the person who is getting married	1=Everyone marries at this age	7=It is the age at which the community expects to get married

3=The parents together 4=The person who is getting married	6=Peers 7=The household head (if not a parent) 8=Other relatives	2=Will have finished desired schooling 3=Will be physically matured enough 4=Will be mentally matured enough 5=Will be time to start having children 6=To be financially independent	8=It is encouraged by religion 9=It is the legal age 10=To avoid pre-marital sexual relationships 11=No reason

SECTION 17: FOOD CONSUMPTION BY CAREGIVER

	Question		Answers	Skip
	Now I would like to ask about your own food consumption. Thinking about what you have eaten yesterday, did you consume the following types of foods:			
	FOOD TYPE	Examples of foods in this group		
1	Injera		Yes .....1 No 2	
2	Other foods made with grains	Bread, biscuits, cookies, macaroni	Yes .....1 No 2	
3	Roots and tubers	Potatoes, cassava	Yes .....1 No 2	
4	Orange coloured vegetables	Sweet potatoes, pumpkin, carrots, squash	Yes .....1 No 2	
5	Leafy dark green vegetables	Spinach	Yes .....1 No 2	
6	Other vegetables	Tomato, onion	Yes .....1 No 2	
7	Fruit	Mango, banana, orange, pineapple	Yes .....1 No 2	
8	Meat	Beef, mutton, lamb, goat, chicken	Yes .....1 No 2	
9	Eggs		Yes .....1 No 2	
10	Fresh, canned or dried fish or other seafood	Tuna, Nile Perch	Yes .....1 No 2	

11	Legumes	Horse beans, lentils, cow, field or chick peas	Yes .....1 No 2	
12	Nuts, seeds		Yes .....1 No 2	
13	Dairy product	Milk, yoghurt, cheese	Yes .....1 No 2	
14	Fats and oils	Foods made with oils, fats, ghee, butter (like fried foods)	Yes .....1 No 2	
15	Sugar, honey, sweets (incl. Cakes, cookies, chocolate)		Yes .....1 No 2	
16	Coffee, tea, soft drinks		Yes .....1 No 2	
17	Did you consume any alcoholic beverages yesterday?		Yes .....1 No 2	
18	Was this a typical day's food intake for you?		Yes .....1 No, more than usual .....2 No, less than usual 3	→ Next section 3→19b
19a	If more than usual, why?		It was market day .....1 It was a holiday/ceremony .....2 Just completed harvest .....3 Other (specify) 4	NEXT SECTION
19b	If less than usual, why?		I was not hungry, did not have an appetite.....1 I was sick .....2 There was not enough food to eat more .....3 I was fasting.....4	

SECTION 18: NUTRITION & FEEDING KNOWLEDGE

DO NOT PROMPT OR PROVIDE CODES, ALLOW RESPONDENT TO ANSWER AND THEN MARK ALL THAT APPLY

	Record PID for respondent	|___|___|___|	
	Question	**Answers**	**Skip**
1	How long after birth should a baby be first put to the breast?	Immediately/ within one hour ..... 1 Within one day ..... 2 After one day ..... 3 After more than one day ..... 4 Baby should not be breastfed ..... 5 Don't know ..... -9	
2	What should a mother do with the "first milk" or colostrum?	Give to baby by breastfeeding soon after birth . 1 Throw away; start breastfeeding when real milk comes ..... 2 Other ..... 3 Don't know ..... -9	
3	Until what age should a baby by exclusively breastfed (only breastmilk, not even water?)	Age in months: ..... |___|___| Don't know ..... -9	
4	Why should a baby under 6 months be exclusively breastfed? [DO NOT READ RESPONSES; RECORD ALL MENTIONED]	Protects baby from illness/disease ..... 1 Breast milk contains everything a baby needs for the first 6 months ..... 2 Helps baby grow better ..... 3 Mother less likely to get pregnant ..... 4 Delays return of mother's monthly bleeding ..... 5 Breastmilk is clean, safe and convenient ..... 6 Breastmilk is free/affordable ..... 7 Reduces health care cost ..... 8 Other ..... 9 Don't know 9	

5	At what age should a baby first start to receive liquids (including water) other than breast milk?	Age in months: .....|___|___| Don't know .....-9	
6	At what age should a baby first start to receive foods (such as porridge) in addition to breast milk?	Age in months: .....|___|___| Don't know .....-9	
7	What can happen to children if they do not get enough iron (either in their diet or via iron supplements)? [DO NOT READ RESPONSES; RECORD ALL MENTIONED]	Impaired learning .....1 Impaired development.....2 Slow growth/lower height .....3 Low immunity.....4 Feel tired.....5 Become anaemic .....6 Other.....7 Don't know .....-9	
8	Can you tell me some foods that are a good source of iron? [DO NOT READ RESPONSES; RECORD ALL MENTIONED]	Meat (beef, goat, etc.), chicken, fish .....1 Green leafy vegetables .....2 Eggs.....3 Breast milk.....4 Beans/peas .....5 Commercially fortified foods .....6 Other.....7 Don't know .....-9	
9	What can happen to children if they do not eat enough vitamin A-rich foods? [DO NOT READ RESPONSES; RECORD ALL MENTIONED]	Eye disease/vision problems .....1 Low resistance to illness/diseases.....2 Other.....3 Don't know .....-9	

	Question	Answers	Skip
10	Can you tell me some of the foods that are rich in vitamin A? [DO NOT READ RESPONSES; RECORD ALL MENTIONED]	Orange coloured fruits/vegetables ..... 1 Green leafy vegetables ..... 2 Eggs ..... 3 Liver ..... 4 Breast milk ..... 5 Cow's milk ..... 6 Other ..... 7 Don't know ..... -9	
11	What seasoning is often fortified with iodine (a nutrient important for brain development)?	Salt ..... 1 Other ..... 2 Don't know ..... -9	
12	What is a common problem with gruels (in terms of consistency) given as first foods to babies, as they are traditionally prepared? Are gruels traditionally prepared too thin, too thick, or just right?	Too thin ..... 1 Too thick ..... 2 Other ..... 3 No problem/just right ..... 4 Don't know ..... -9	
13	What are special foods a mother could make for her child to complement breast milk? [DO NOT READ RESPONSES; RECORD ALL MENTIONED]	Porridge enriched with breastmilk ..... 1 Porridge enriched with other kinds of milk ..... 2 Porridge enriched with egg ..... 3 Porridge enriched with meat ..... 4 Porridge enriched with vegetables ..... 5 Other ..... 6 Don't know ..... -9	
14	Can a 1-year old child eat alone without any supervision of an adult or an older child?	Yes ..... 1 No 2	

		Don't know ..... -	
15	How many times a day should a 6-8 month old baby that is still breastfeeding eat? (meals and snacks)	Number..... |___|___| Don't know ..... -9	
16	How many times a day should a 9-11 month old baby that is still breastfeeding eat? (meals and snacks)	Number..... |___|___| Don't know ..... -9	
17	How many times a day should a 12-24 month old infant that is still breastfeeding eat? (meals and snacks)	Number..... |___|___| Don't know ..... -9	
18	What should you do when your child older than 6 months old has diarrhea? [DO NOT READ RESPONSES; RECORD ALL MENTIONED]	Give ORS ..... 1 Give less food than usual ..... 2 Give same quantity of food as usual ..... 3 Give more food than usual ..... 4 Give less liquids than usual ..... 5 Give the same amount of liquid as usual..... 6 Give more liquid than usual ..... 7 Keep breastfeeding ..... 8 Increase breastfeeding..... 9 Give syrup ..... 10 Give traditional medication ..... 11 Give treated water ..... 12 Other..... 13 Don't know ..... -9	
19	How <u>much</u> should a child be fed when he/she is sick? Should he/she be fed less, the same, or more than usual?	Less than usual..... 1 Same as usual ..... 2 More than usual..... 3 Don't know ..... -9	
20	How <u>often</u> should a child be fed when he/she is sick? Should he/she be fed less often, the same, or more often than usual?	Less than usual..... 1 Same as usual ..... 2 More than usual..... 3 Don't know ..... -9	

SECTION 19A: SHOCKS & COPING MECHANISMS

		1	2	2A
SHOCK ID		During the last 12 months, was your household affected negatively by any of the following [SHOCK]? Yes=1 No=2 (>>NEXT SHOCK)	What did your household do in response to this [SHOCK] to try to regain your former welfare level? NOTE THE TWO MOST IMPORTANT COPING STRATEGIES FOR THE SHOCK. IF SHOCK HAPPENED MORE THAN ONCE DURING THE LAST 12 MONTHS, ASK ABOUT THE MOST RECENT INCIDENT. Use codes below	
			Most important coping strategy	Second most important coping strategy
101	Drought/irregular rains			
102	Floods/Landslides			
103	Unusually high level of crop/livestock pests or disease			
104	Unusually low prices for agricultural output			
105	Unusually high costs of agricultural inputs			
106	Unusually high prices for food			
107	End of regular assistance/aid remittances from outside household			
108	Serious illness or accident of household member(s)			
109	Health expenditures			

110	Birth in the household			
111	Death of household income earner			
112	Break-up of household (divorce/separation/death/migration)			
113	Theft of money/valuables/assets/agricultural output			
114	High education costs			
115	House destroyed (for example, burning, flood, winds)			
116	Conflict			
117	Crop/harvest destroyed (ex. Fire, Fulani)			
201	Death of any household member due to COVID-19			
202	Illness of any household member due to COVID-19			
203	Lost of livelihood due to COVID-19			
204	Lost or reduced remittances due to COVID-19			

COPING STRATEGY ID:				
Relied on own savings 1			Sold land/building 14	
Received unconditional help from relatives/friends 2			Sold crops stock 15	
Received unconditional help from government 3			Sold livestock 16	
Received unconditional help from NGO/religious institution 4			Intensified fishing/farming 17	
Changed eating patterns (relied on les preferred food options, reduced the proportion or number of meals per day, or household members skipped days of easting, etc.) 5			Sent children to live elsewhere 18	
Household members took on more employment 6			Engaged in spiritual efforts – prayer, sacrifices, diviner consultation 19	
Adult household members who were previously not working had to find work 7			PSNP payment 20	
Household members migrated 8			Planted trees or built conservation structures 21	
Reduced expenditures on health and/or education 9			Children sent to work 22	
Obtained credit/took loan 10			Children worked more 23	
Borrowed livestock 11			Did not do anything 24	
Sold agricultural assets 12			Other (specify) 25	
Sold durable assets 13				

SECTION 19B: DISTRESS ASSET SALE

	Question	Answers
1	In the last two years, have you or your household been forced to sell any productive assets (tools, machinery, etc.; EXCLUDE livestock) in order to meet the food needs of this household?	Yes ..... 1 No 2
2	In the last two years, have you or your household been forced to sell any productive assets (tools, machinery, etc.; EXCLUDE livestock) in order to raise cash for emergency cash needs such as health expenditures?	Yes ..... 1 No 2
3	In the last two years, have you or your household been forced to sell any consumer durables in order to meet the food needs of this household?	Yes ..... 1 No 2
4	In the last two years, have you or your household been forced to sell any consumer durables in order to raise cash for emergency cash needs such as health expenditures?	Yes ..... 1 No 2

5	In the last two years, have you or your household been forced to rent out or exchange any land in order to meet the food needs of this household?	Yes ..... 1 No 2
6	In the last two years, have you or your household been forced to rent out or exchange any land in order to in order to raise cash for emergency cash needs such as health expenditures?	Yes ..... 1 No 2
7	In the last two years, have you or your household been forced to sell or rent out any livestock in order to meet the food needs of this household?	Yes ..... 1 No 2
8	In the last two years, have you or your household been forced to sell or rent out any livestock in order to in order to raise cash for emergency cash needs such as health expenditures?	Yes ..... 1 No 2
9	If your **household** was faced with an emergency expenditure of 500 Birr for instance, because of a shock, what would be your main source to raise this money?	Answer (see code A below) _____
10	[IF ANSWER TO Q9 IS 4, DOUBLE THE AMOUNT AND ASK THE SAME QUESTION]	Answer (see code A below) _____

	If your household was faced with an emergency expenditure of 1,000 Birr for instance, because of a shock, what would be your main source to raise this money? [IF ANSWER TO Q9 IS ANY OTHER ANSWER THAN 4, HALF THE AMOUNT AND ASK THE SAME QUESTION] If your household was faced with an emergency expenditure of 250 Birr for instance, because of a shock, what would be your main source to raise this money? [IF ANSWER IS 4, SKIP TO Q12]	
11	[IF ANSWER TO Q10 IS 4, DOUBLE THE AMOUNT AND ASK THE SAME QUESTION] If your household was faced with an emergency expenditure of 2,000 Birr for instance, because of a shock, what would be your main source to raise this money? [IF ANSWER TO Q10 IS ANY OTHER ANSWER THAN 4, HALF THE AMOUNT AND ASK THE SAME QUESTION] If your household was faced with an emergency expenditure of 125 Birr for instance, because of a shock, what would be your main source to raise this money?	Answer (see code A below) _____

Code A	
Sale of livestock or productive assets 1	Rent out land 5
Sale of consumer durables 2	I would not be able to raise such amount 6
Borrow from friends and neighbours 3	Other (specify) 7
Rely on household savings 4	

SECTION 20A: PSNP

	Question	Answers
1	Has your household ever been a client of PSNP public works? IF ANSWER IS 'NO' >> SKIP TO Q12	Yes ..... 1 No 2
2	Did this household participate in a PSNP public works activity between TAHESASE 2014 and HIDARE 2015?	Yes ..... 1 No 2
3	Did this household participate in a PSNP public works activity between TAHESASE 2013 and HIDARE 2014?	Yes ..... 1 No 2
4	Did this household participate in a PSNP public works activity between TAHESASE 2012 and HIDARE 2013?	Yes ..... 1 No 2
5	Did this household participate in a PSNP public works activity between TAHESASE 2011 and HIDARE 2012?	Yes ..... 1 No 2
6	Did this household participate in a PSNP public works activity between TAHESASE 2010 and HIDARE 2011?	Yes ..... 1 No 2
	[CHECK: IF NO TO QUESTION 2, SKIP TO Q10	
7	Does this household have a client card showing days worked and payments for PSNP public works activity between TAHESASE 2014 and HIDARE 2015? [ASK ONLY IF THEY ANSWERED 'YES' TO Q2]	Yes, seen ..... 1 Yes, not seen 2

		No 3
8	How often, on average, does the household get paid by PSNP for work done on public works? CHOOSE THE OPTION THAT IS CLOSEST TO THE FREQUENCY OF PAYMENT. IF CARD IS AVAILABLE, CONFIRM FROM CARD.	Monthly .....1 Bi-Monthly .....2 Quarterly .....3 Half-yearly .....4 Other (specify) 5
9	How much has your household received as payment as a PSNP public work client in the last 12 months (in Birr)? [IF PART OF THE PAYMENT WAS RECEIVED IN-KIND, PROVIDE A MONETARY ESTIMATE] [IF NOT PARTICIPATED IN PSNP THE LAST 12 MONTHS, REPORT '0']	Birr _____
10	When was the last time you received payment?	Month:_____ Year_____
11	How did you receive the last payment?	M-Birr (household/personal account) .....1 M-Birr (friend or relative account) .....2 M-Birr (local agent) .....3 In cash .....4 In-kind .....5 Mix in cash and in-kind .....6 Other (specify) 7

12	Has your household ever been a beneficiary of PSNP Permanent Direct Support?? IF ANSWER IS 'NO' >> SKIP TO Q24a	Yes .....1 No 2
13	Has anyone in this household received transfers from PSNP Permanent Direct Support between TAHESASE 2014 and HIDARE 2015?	Yes .....1 No 2
14	Has anyone in this household received transfers from PSNP Permanent Direct Support between TAHESASE 2013 and HIDARE 2014?	Yes .....1 No 2
15	Has anyone in this household received transfers from PSNP Permanent Direct Support between TAHESASE 2012 and HIDARE 2013?	Yes .....1 No 2
16	Has anyone in this household received transfers from PSNP Permanent Direct Support between TAHESASE 2011 and HIDARE 2012?	Yes .....1 No 2
17	Has anyone in this household received transfers from PSNP Permanent Direct Support between TAHESASE 2010 and HIDARE 2011?	Yes .....1 No 2
	[CHECK: IF NO TO Q13, SKIP TO Q21	
18	Does this household have a client card showing payments for PSNP between TAHESASE 2014 and HIDARE 2015? [ASK ONLY IF THEY ANSWERED 'YES' TO Q13]	Yes, seen.....1 Yes, not seen .....2 No 3

19	How often, on average, does the household get paid by PSNP for direct support? CHOOSE THE OPTION THAT IS CLOSEST TO THE FREQUENCY OF PAYMENT. IF CARD IS AVAILABLE, CONFIRM FROM CARD.	Monthly ..... 1 Bi-Monthly ..... 2 Quarterly ..... 3 Half-yearly ..... 4 Other (specify) 5
20	How much has the household received from PSNP as a Direct Support beneficiary in the last 12 months (in Birr)? [IF PART OF THE PAYMENT WAS RECEIVED IN-KIND, PROVIDE A MONETARY ESTIMATE]	Birr _____
21	When was the last time you received payment?	Month:_____ Year_____
22	How did you receive the last payment?	M-Birr (household/personal account) ..... 1 M-Birr (friend or relative account) ..... 2 M-Birr (local agent) ..... 3 In cash ..... 4 In-kind ..... 5 Mix in cash and in-kind ..... 6 Other (specify) 7
23	How many members in the household are Permanent Direct Support Beneficiaries?	Number_____

24	How many months did the household received payments for in the last 12 months?	Number_____
24a	Have you been encouraged by service providers to enrol your children in school?	Yes .....1 No 2
25	Is the household receiving payment from the PNSP program due to the presence of a malnourished child/children in the household? [IF NO, SKIPTO 28]	Yes .....1 No 2
26	How many months has the household being receiving such payments?	Number of months:_____
27	How much has the household received as payment from PSNP due to the presence of the malnourished child (TDS) in the last 12 months?	Birr_____

	Question	Answers
28	Who in your household makes the decision on how to spend the PSNP money?	Head alone .....1 Spouse alone .....2 Head and spouse jointly.....3 Adult children .....4 Head and adult children .....5 Spouse and adult children.....6

		Head and parent ..... 7 Head and brothers ..... 8 Other (specify) 9	

29	Have you heard about the new PSNP "Livelihoods Component"? [Just to be sure about your response, the PSNP Livelihoods Component are led by DA. Beneficiaries of components receive, in groups or individually, financial literacy training, encouragements to save, development of new livelihoods activities, a livelihood checklist, technical training, development of a business plan and referrals to financial institutions. Have you heard about these new activities?	Yes .....1 No 2	→Q31
30	Have you or a member of the household joined a PSNP 'Livelihood Group', or received it individually?	Yes .....1 No 2	
31	Did this household receive other support NOT related to the PSNP between TAHESASE 2014 and HIDARE 2015? [REPORT ALL THAT APPLY]	Training (agriculture, business, health, nutrition) .....1 Scholarship .....2 Insurance (livestock, crop).....3 Health insurance .....4 Cash transfers.....5 Seeds.....6 In-kind transfers/emergency aid.....7	→Q32

		Other (specify) .....8 No additional support 9	
32	[IF HOUSEHOLD RECEIVED ANY RELIEF/EMERGENCY/IN-KINDTANSFERS INTHE LAST 12 MONTHS, ASNWERTHIS QUESTION. OTHERWISE, NEXT SECTION]	Amount.....	

SECTION 20B: PSNP DURING PREGNANCY AND LACTATION (UP TO 2 YRS AFTER CHILD BIRTH)

Respondent should be women respondent only (if main respondent male, skip to next section)

	Question	Answers	Skip
1	At any time between Tahesase EC 2013 (December 2020) and today (last 2 years), were you pregnant?	Yes ..... 1 No 2	→ Next section
2	Have you given birth since Tahesase EC 2013 (in the last 2 years)?	Yes ..... 1 No 2	→Q23
3c	When did you last give birth? (MM/YYYY)	__ __ / __ __ __ __	
	I AM NOW GOING TO ASK YOU SOME QUESTIONS ABOUT THE PERGNANCY THAT LED TO THIS LAST BIRTH		
4	Was your household receiving PSNP benefits at any time during your pregnancy?	Yes ..... 1 No 2	→Q18
5	Was your household receiving PSNP benefits when you first learned you were pregnant?	Yes ..... 1 No 2	
6	Were any other household members working on public works at any time during your pregnancy?	Yes ..... 1 No 2	
7	Were <u>you</u> working on public works at any time during your pregnancy (referring to the last completed pregnancy since Tahesase EC 2013)?	Yes ..... 1 No 2	→Q18
8	Did you stop working on public works at any time during your pregnancy (referring to the first pregnancy since Tahesase EC 2013)?	Yes ..... 1 No 2	→Q14
9	How many months pregnant were you when you stopped working?	Number..... |__|__|	
10	Was it your decision to stop working?	Yes, my decision ..... 1 No, I was moved to TDS 2	
11	For how many months did your household receive payments for the work that you should have done but you were exempted from (because of your pregnant status) after you stopped working?	Number.....|__|__|	

12	Did other household members work more days to make up for you no longer working?	Yes ..... 1 No 2	
13	Was your household able to reduce days worked because you began to receive Direct Support?	Yes ..... 1 No 2	
14	Were you advised by a health worker to stop work?	Yes ..... 1 No 2	
15	Were you advised by a Development Agent to stop work?	Yes ..... 1 No 2	
16	Were you discouraged from stopping working by anyone on the Community Food Security Task Force?	Yes ..... 1 No 2	
17	[IF YES TO Q8] Did you wish you could have stopped working earlier than you did? [IF NO TO Q8] Did you wish you could have stopped working?	Yes ..... 1 No 2	
18	Did you work on public works after you gave birth?	Yes ..... 1 No 2	→Q22
19	How many months after giving birth did you start working on public works?	Number..... |__|__|	
20	Did working on public works affect your ability to breastfeed your child?	Yes ..... 1 No 2	→ Q23
21	How did working on public works affect your ability to breastfeed your child? [Allow multiple responses]	**Code (a)**	→ Q23
22	Why did you <u>not</u> work on public works after you gave birth?	**Code (b)**	→Q23
23	I AM NOW GOING TO ASK YOU SOME QUESTIONS ABOUT YOUR CURRENT PERGNANCY Are you currently pregnant?	Yes ..... 1 No 2	→ Next section
24	Is your household being receiving PSNP benefits at any time during your pregnancy?	Yes ..... 1 No 2	→ Next section
25	Was your household receiving PSNP benefits when you first learned you were pregnant?	Yes 1	

		No 2	
26	Is any other household members working on public works?	Yes ..... 1 No 2	
27	Have you worked on public works at any time during this pregnancy?	Yes ..... 1 No 2	→Next section
28	Have you stopped working on public works during this pregnancy?	Yes ..... 1 No 2	→Q35
29	How many months pregnant were you when you stopped working?	Number..... |__|__|	
30	How many months pregnant are you now?	Number..... |__|__|	
31	Was it your decision to stop working?	Yes, my decision ..... 1 No, I was moved to TDS 2	
32	For how many months has your household received payments for the work that you should have done but you were exempted from (because of your pregnant status) after you stopped working?	Number.....|__|__|	
33	Did other household members work more days to make up for you no longer working?	Yes ..... 1 No 2	
34	Was your household able to reduce days worked because you began to receive Direct Support?	Yes ..... 1 No 2	
35	Were you advised by a health worker to stop work?	Yes ..... 1 No 2	
36	Were you advised by a Development Agent to stop work?	Yes ..... 1 No 2	
37	Were you discouraged from stopping working by anyone on the Community Food Security Task Force?	Yes ..... 1 No 2	
38	[IF YES TO Q28] Did you wish you could have stopped working earlier than you did? [IF NO TO Q28] Did you wish you could have stopped working?	Yes ..... 1 No 2	

Code (a), Interference with breastfeeding	Code (b), Why not return to work?
1 Had to leave child at home	1 Public works were not operating
2 Could take child to work site, but no place to feed child	2 Household received Direct Support
3 Worksite supervisors would not let me breastfed child during work hours	3 Household was no longer receiving PSNP benefits
4 Was too tired from working to breastfeed child	4 Did not wish to return to work
5 Was not producing enough milk	5 Was advised by health worker not to return to work
6 Other	6 Was not healthy enough to return to work
	7 Other

Section 22: CONFLICT SHOCKS ON HOUSHOLDS

	Question	Answers	Skip
1	Has this household suffered death of any household member due to the ongoing conflict?	1= Yes 2= No	
2	Has any member of this household suffered injury due to the conflict?	1= Yes 2= No	➔Q4
3	How would you rate the intensity of the injury? [MULTIPLE CHOICES]	1= Injury resulted in permanent body damage 2= Injury resulted in disability 3= Serious injury but not permanent damage/disability 4= Minor injury	
4	Has this household lost any property due to the conflict?	1= Yes 2= No	➔Q6
5	What type of property was lost or destroyed? [MULTIPLE CHOICES]	1= House 2= Farms/lands 3= Crop harvest 4= Livestock 99= Other, specify	
6	Has any child in this household lost or missed health checks or assistance due to the conflict?	1=Yes 2= No	➔Next section
7	What type of health checks or assistance was lost or missed? [MULTIPLE CHOICES]	1= Vaccination 2= Routine health checks 3= Medical surgery 4= Medications	

SECTION 22: ANTHROPOMETRICS

MEASURE ALL CHILDREN 4 – 59 MONTHS OLD AND THEIR MOTHERS.

[FOR CHILDREN 4-23 MONTHS MEASURE HEIGHT LYING DOWN. FOR CHILDREN AGE 24-59 MONTHS MEASURE HEIGHT STANDING UP]

INSTRUCTIONS:

1. Enumerators will fill in questions 1 to 6 of the anthropometric section on the hard copy using the information from the roster. Make sure the information inserted in the CAPI and in the hard copy sheet are the same.

2. The information should be entered only for the household members that are eligible to be measured, all children under five years of age and their mothers.

3. Once the information from the CAPI is reported on the hard copy of Section 21, the enumerators will leave the hard copy with the household and instruct to keep it for the visit of the anthropometrics.

4. The person in charge of taking the anthropometric measurement will then reach the household and will use the sheet. The sheet will indicate the household members to be measured.

5. Anthropometric measures will be then taken. Weight and length/height will be taken and recorded, taking care to record the measurements on the correct line for each child and mother. Check the individual's name and line number on the household listing before recording measurements. For children, also observe and record whether the child has oedema or not.

6. Two measurements of height and weight will be taken for each individual and if the difference is > 0.5 cm or 0.5 kg a third measurement should be taken to verify the first two measurements. Take the average of the two most reliable measurements and record in the table.

7. For more information on how to conduct the measurement, refer to the enumerator manual.

SECTION 21: ANTHROPOMETRICS

Record ID enumerator |__|__|__| Record ID Anthropometric enumerator |__|__|__| Date of the measurement (DD/MM/YYYY): |___|___|/|___|___|/|___|___|___|___|							
Woreda ID |__| Kebele ID |__|__|__| Household ID |__|__|__|							
	Question	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
1	Individual (child) ID	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|
2	Name of the child						
3	Name of the mother						
4	ID of the mother	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|	|__|__|__|
5	Sex of the child 1=Male 2=Female						
6	Age of child in completed years						
7	Birth date (DD / MM / YYYY)	|__|__|/__|__|/ |__|__|__|__|	|__|__|/__|__|/ |__|__|__|__|	|__|__|/__|__|/ |__|__|__|__|	|__|__|/__|__|/ |__|__|__|__|	|__|__|/__|__|/ |__|__|__|__|	|__|__|/__|__|/ |__|__|__|__|
8	What is the source of information on the individual's birth date? 1=Birth certificate 2=Baptismal record 3=Clinic card 4=Home record 5=Determined using local calendar of events 6=Mother/caregiver recall						

	7=Recollection by other persons 8=Other (specify)						
9	Was (NAME) measured? 1=Yes (>>Q11) 2=No						
10	Why not? 1=Not home during survey period 2=Too ill 3=Handicapped or deformed 4=Not willing 5=Other (specify) (>> NEXT PERSON)						
11	Weight in kilograms [USE ONE DECIMAL PLACE]	|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|
12	Was (NAME) weighed with clothes on or off? 1=No clothes 2=Light clothing 3=Mid-weight clothing 4=Heavy clothing						
13	How was [NAME]'s weight measured? 1=Alone (without mother/caregiver)						

	2=Carried by mother/ caregiver						
14	Height in centimeters [USE ONE DECIMAL PLACE]	|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|
15	How was height captured? 1=Lying down 2=Standing up						
16	Check for oedema 1=Oedema present 2=Oedema not present 3=Unsure 9=Not checked (specify reason)						

HEALTH FACILITY QUESTIONNAIRE

To be completed for all primary health care facilities in the district. Do not complete for tertiary care facilities such as local, district or regional hospital.

Region	_____	Region code	| | |
Woreda	_____	Woreda code	| | |
Kebele	_____	Kebele code	| | |
Village/Community	_____	Village/Community Code	| | |
Primary Health Care Facility	_____	MoH Code	| | |

Facility type
1=Health Center
2=Health post
3=Hospital
4=Other (specify)*/* | |

Name of Respondent _____

Position of the respondent in the facility _____

Phone number _____

GPS coordinates
Latitude N |___||___||___|.|___||___||___||___||___|
Longitude E / W |___||___||___|.|___||___||___||___||___|

Supervisor	_____	Supervisor Code	| |
Interviewer	_____	Interviewer Code	| |

Date of interview (DD/MM/YY) | | / | / | |

Time started (24 hour clock) | | | : | | |

Time ended (24 hour clock) | | | : | | |

PART A: CHARACTERISTICS OF FACILITY

	QUESTION	CATEGORY AND CODE	RESPONSE
1	What year was this facility built? EC	(YYYY)	|__|__|__|__|
2	How many days per week is this facility open for outpatient adult and/or child curative services?	(Enter number of days) Don't know……-9	|__|
2b	How many hours per day is this facility open for services?	[Enter number of hours]	
3	Is there a trained health provider present at the facility at all times (24 hours/day)	Yes, always present.....1 No.....2	|__|
4	Is there a trained health provider available on call at all times after hours? IFYES, ASKTO SEE DUTY SCHEDULE	Yes, duty schedule seen .....1 Yes, duty schedule not seen .....2 No.....3	|__|
5	Do you have an estimated size of the catchment population that this facility serves, that is, the target population or total population living in the area served by this facility?	(Enter estimated catchment population) Don't know.....-9	|__|__|__|__|__|__|__|__|
6	Does this facility have electricity?	(Yes…….1; No……..2)	|__|
7	Does this facility have a (back-up) generator?	(Yes…….1; No……..2)	|__|
8	Does this facility have solar power as back-up?	(Yes…….1; No……..2)	|__|
9	Does this facility have a functioning landline telephone?	(Yes…….1; No……..2)	|__|

10	Does this facility have a functioning cellular telephone (either private or supported by the facility)?	(Yes…….1; No……..2)	|__|
11	What is the main source of water for this facility?	River/Lake/Stream/Rainwater.....1 Borehole.....2 Protected Well.....3 Unprotected well.....4 Public tap.....5 Private tap .....6 Purchased from vendor 7	|__|
12	Is housing provided by this facility for its employees?	Yes…….1; No……..2	|__|
13	Do the facility have a functional computer?	Yes…….1; No……..2 >>Section B	|__|
14	Is this facility entering client data into a computerized system?	Yes…….1; No……..2	|__|
15	If yes, does this system get fed into a larger MIS?	Yes…….1; No……..2	|__|

PART B: FACILITY EQUIPMENT

	QUESTION	CATEGORY AND CODE	RESPONSE
1	Is there any operating room/theatre at this facility?	Yes……1 No…….2	|__|
2	Can circumcisions be performed in this facility?	Yes……...1 No…….2 >>Q3	
2a	How much is the surgical fee? Write 0 if there is no fee	In Ethiopian Birr	|__|__|__|__|__|__|__|
3	Can caesarean sections be performed in this facility?	Yes……...1 No…….2 >>Q3c	
3a	How much is the surgical fee? Write 0 if there is no fee	In Ethiopian Birr	|__|__|__|__|__|__|__|
3c	Is there any pharmacy/chemist in this facility?	Yes……...1 No…….2 >>Q4	
4	Is there a laboratory to do tests?	Yes……..1 No……..2 >>Q6	|__|
5	Do you perform the following tests? (Yes……1; No……2) READ EACH OPTION….	A. Stools B. Blood test for malaria- RDT C. Blood test for malaria – MPS D. HIV test E. Pregnancy test F. Urine test G. Skin snip test H. STIs other than HIV (Chlamydia, RPR for syphilis, etc.) I. Pap smear (HPV) J. Anemia K. Other test not listed	|__| |__| |__| |__| |__| |__| |__| |__| |__|

			|__| |__| |__| |__|
6	Does this facility have a working refrigerator to store biomedical samples and medications?	Yes…….1; No……..2	|__|
7	Does his facility have any vehicles?	Yes…….1 No…….2 >>Q9	|__|
8	How many of each vehicle do you have in working condition? Write 0 if none in working condition.	A. Car/jeep/4WD B. Buses C. Ambulances D. Motorcycles/moped E. Bicycles F. Other	|__|__| |__|__| |__|__| |__|__| |__|__| |__|__|
9	Does this facility have the following functioning instruments and equipment available: (Yes……1; No……2)	A. Blood pressure machine B. Stethoscope(s) C. Microscope D. Slides E. Weighing scale for adults F. Weighing equipment (i.e. Salter scale or similar hanging scale) for under-five-year-olds G. Height measurement equipment for under-five-year-olds H. Clinical thermometer I. Latex gloves in stock	|__| |__| |__| |__| |__| |__| |__| |__|

			|__|
10	Do you use disposal syringes and needles or you re-use syringes and needles	A. Use each disposable syringes only once B. Use disposable syringes more than once C. Use reusable syringes	>>Q11 |__|

	QUESTION	CATEGORY AND CODE	RESPONSE
10a	What methods are used for disinfecting syringes and needles? (Yes……1; No……2) Check categories A-C	A. Autoclave B. Dry heat sterilization C. Steam sterilization D. Boiling only E. Chemical only F. Boil and chemical G. None H. Other_____	|__|
11	What methods are used for disinfecting other medical equipment (e.g. surgical instruments)? (Yes……1; No……2)	A. Autoclave B. Dry heat sterilization C. Steam sterilization D. Boiling only E. Chemical only F. Boil and chemical G. Other_____ H. None	|__| |__| |__| |__| |__| |__| |__| |__|

PART C: SERVICES

Now I would like to know about the services and drugs offered at this facility.

1. Do you offer.....? Yes.....1 No.....2 >>next service		2. How many hours do you offer each service during a regular week? [Indicate number of hours each day. Round to nearest hour. Enter 0 for no service on that day.]							3. How many clients were seen in the previous month?
		SUN	MON	TUE	WED	THU	FRI	SAT	
A. Outpatient consultations									
B. Deliveries									
C. Well baby clinics									
D. Ante-natal clinics									
E. Family Planning									
F. Mobile clinics									
G. Treatment for acute malnutrition for children									
G. HIV testing/counseling									
H. HIV treatment									

I. Gender Based Violence (GBV) services									
J. OTHER (Specify)									

	QUESTION	CATEGORY AND CODE	RESPONSE
4	Did the facility participate in a child health day/immunization campaign in the last 6 months?	Yes..... 1 No..... 2	|__|
5	Does your facility participate in or collaborate with NGOs or health outreach providers??	Yes..... 1 No..... 2	|__|
6	Did any of your health workers participate in training provided by NGOs or heath outreach provides (in the last 12 months?)	No..... 00 Yes, (enter number of staff trained by Fives Alive)	|__|__|
7	Does your facility participate in or collaborate with SPRING?	Yes..... 1 No..... 2	|__|
8	Did any of your health workers participate in training provided by SPRING (in the last 12 months?)	No..... 00 Yes, (enter number of staff trained by SPRING)	|__|__|
9	What were the topics of these trainings? (Yes…..1, No……2)	A. CMAM (Community Management of Acute Malnutrition) B. IYCF (Infant and Young Child Feeding practices) C. Other (Specify)	|__|

			⎸⎯⎸ ⎸⎯⎸

PART D: DRUGS AND MEDICAL SUPPLIES

1. Does this facility normally carry……..? (Yes…..1, No……2 >>next item)		2. Is […..] in stock today? (Yes…..1 >> next item No……2)	3. How many days does it normally take to replenish the stock?
A. Condoms	|__|	|__|	|__|__|
B. Spermicides	|__|	|__|	|__|__|
C. Contraceptive Pills	|__|	|__|	|__|__|
D. Intra-uterine device (IUD)	|__|	|__|	|__|__|
E. Injectable contraceptive (Depro-provera, etc.)	|__|	|__|	|__|__|
F. Contraceptive implants (Implanon, nexplanon, etc.)	|__|	|__|	|__|__|
G. Paracetamol/Panadol	|__|	|__|	|__|__|
H. Aspirin	|__|	|__|	|__|__|
I. Oral Rehydration Salt	|__|	|__|	|__|__|
J. Coartem	|__|	|__|	|__|__|
K. Fansidar	|__|	|__|	|__|__|
L. Iron tablets for pregnant women	|__|	|__|	|__|__|
M. Folic Acid tablets	|__|	|__|	|__|__|

N. Penicillin injection/tablets	|__|	|__|	|__|__|
O. Cotrimoxazole	|__|	|__|	|__|__|
P. ARVs for adults	|__|	|__|	|__|__|
Q. BCG injection	|__|	|__|	|__|__|
R. DPT injection	|__|	|__|	|__|__|
S. Tetanus injection	|__|	|__|	|__|__|
T. Measles injection	|__|	|__|	|__|__|
U. Polio injection	|__|	|__|	|__|__|
V. Meningitis injection	|__|	|__|	|__|__|
W. IT mosquito bed nets	|__|	|__|	|__|__|
X. Micronutrient Powder (MNP)	|__|	|__|	|__|__|
Y. Ready-to-use Therapeutic Food (RUTF)	|__|	|__|	|__|__|
Z. Deworming medicines (mebendazole /albendazole)	|__|	|__|	|__|__|
AA. Vitamin A droplets	|__|	|__|	|__|__|

PART E: PERSONNEL

	1.Do the facility have the following personnel either part-time or full time worker? 1=Yes 2=No >>Go to next personnel	2.How many …….work at this facility currently?	3. Number working part-time	4. Number working full-time	5. Number present today
A. Medical Doctors					
B. Medical Assistants					
C. Public Health Nurses					
D. Professional Midwives					
E. Professional Nurses					
F. Midwives Assistants					
G. Auxiliary Nurses					
H. Physiotherapist					
I. Pharmacists					
J. Pharmaceutical attendants/assistants					
K. Dispensing Technicians					

L. Lab Technicians/technologists					
M. Nutrition Technician Officers					
N. Ward Assistants					
O. Environmental Health Officers					
P. Classified daily employees (CDE)					
Q. Others: SPECIFY					

COMMUNITY INSTRUMENT

COVER

1a. COMMUNITY IDENTIFICATION

1	Date of interview	|___|___|- |___|___|- |___|___|	4	Zone	_____ |___|___|
2	Supervisor name and code	_____ |___|___|	5	Woreda	_____ |___|___|
3	Enumerator name and code	_____ |___|___|	6	Kebele	_____ |___|___|___|___|
			7	Village/Peasant Association (PA)/EA/Community name	_____ |___|___|___|___|

1b. ROSTER OF INFORMANTS					
ID	Age	Sex	For how many years have you lived in this community?	Respondents Status/Role in the Community	
	[Years]	1 = Male 2 = Female	[CUMULATIVE YEARS]	1=Chairman/woman 2=Representative (Women, Youth, etc.) 3=Health Worker 4= School Teacher/Principal 5=Religious Leader	10=Community Elder 11=Police 12=Business man/woman 13=Others (specify) 14=Kebele Manager
1					
2					
3					
4					
5					
6					
7					
8					

DIRECT OBSERVATION BY SUPERVISOR

1	2	3	4	5	6	7
Do the children in this kebele typically wear neat clothes? 1=Yes, all 2=Yes, but not all 3=No	Do children under 10 in this kebele typically wear shoes? 1=Yes, all 2=Yes, but not all 3=No	Do the adults in this kebele typically wear neat clothes? 1=Yes, all 2=Yes, but not all 3=No	Do adults in this kebele typically wear shoes? 1=Yes, all 2=Yes, but not all 3=No	What material is most commonly used for the outside walls of the houses in this kebele? See WALL codes	What material is most commonly used for the outside roofs of the houses in this kebele? See ROOF codes	Is there a woreda office in this kebele? 1=Yes 2=No

WALL codes	ROOF codes
Wood and mud.....01	Corrugated iron sheet.....01
Wood and thatch.....01	Concrete/cement.....02
Wood only 03	Thatch.....03
Stone only 04	Wood and mud 04
Stone and mud 05	Bamboo/Reed.....05
Stone and cement 06	Plastic canvas 06

Blocks, plastered with cement 07	Asbestos....07
Blocks, unplastered 08	Bricks....08
Bricks 09	Other 09
Mud bricks (traditional)....10	
Steel....11	
Cargo container....12	
Parquet or polished wood....13	
Chip wood 14	
Corrugated iron sheet 15	
Asbestos 16	
Reed/bamboo....17	
Other....18	

BASIC INFORMATION

1	2	3	4						5	6						
What is the population of this kebele?	How many households are found in this kebele?	In the last five years, have there been more people who moved into this kebele or more people who moved away? 1=More moved in 2=More moved out 3=About the same of both 4=Neither arrivals nor departures -9=DK	What are the religions practiced by residents of this kebele? [*Select all that apply in order of most common*] **Religion codes** 1=Orthodox 2=Protestant 3=Catholic 4=Muslim 5=Traditional 6=Other (specify)						What percentage of households within this kebele are polygamous?	What are the common types of marriages witnessed in this kebele? Approximately what proportion of households are united through each type of marriage? [*Select in order of most common*] **Marriage codes** 1=Traditional 2=Municipality 3=Religious 4=Abduction					
			1st most common		2nd most common		3rd most common			1st most common		2nd most common		3rd most common	
			Code	% of HHs	Code	% of HHs	Code	% of HHs	% of HHs	Code	% of marriages	Code	% of marriages	Code	% of marriages

7	8	9	10	11	12			13	14
What proportion of WOMEN aged 18-24 in this kebele were married/cohabitating before age 18? 1=Almost none 2=25% 3=50% 4=75% 5=Almost all	If her husband dies, can the wife inherit their or his property? 1=Yes 2=No (>>Q10)	What types of property is the wife entitled to inherit? [*Select all that apply*] 1=House 2=Land 3=Livestock 4=Jewelry 5=Other (specify)	What is the most common use of land in this kebele? 1=Pasture 2=Farming 3=Planned housing 4=Squatter settlement 5=Industry or manufacture 6=Shops or trade 7=Other	Is the land of the kebele…? 1=Flat 2=Slightly sloping 3=Moderately sloping 4=Steeply sloping 5=Both flat & hilly	What percentage of Men, Women and Youth drink alcohol in this kebele? 1=Almost none 2=25% 3=50% 4=75% 5=Almost all			How many orphaned children live in this kebele? -9=DK	How many elders live alone in this kebele? -9=DK
					Men	Women	Youth		

ACCESS TO BASIC SERVICES

1	2	3	4	5	6	7	8	9
What is the type of main access road surface in this kebele town/village? (If there is no road, report on road that passes closest to community) 1=Tar/Asphalt 2=Gravels 3=Dirt road (maintained) 4=Dirt track	How far is the nearest tar/asphalt road? [*Write '0 if there is a tar/asphalt road in the kebele*]	Do vehicles pass on the main road in this kebele town/village throughout the year? 1=Yes(>>Q5) 2=No	During the past 12 months, **how many months** was the main road passable by a mini-bus?	How far is the nearest bus station from this kebele town/village?	How far is the nearest road where public transport can be accessed from this kebele town/village? [*Write '0 if this e is a tar/asphalt road in the kebele*]	How far is the nearest woreda capital of this kebele from this kebele town/village? [*Write '0 if this is a woreda capital*]	Does the kebele have access to electricity through the public grid? 1=Yes 2=No(>>Q10)	What percentage of households are connected to the public grid?
	KILOMETERS		NUMBER	KILOMETERS	KILOMETERS	KILOMETERS		% of HHs

10	11	12	13	14	15	16	17	18

Does the nearest town have access to electricity? 1=Yes 2=No	Does the kebele have access to public piped water? 1=Yes 2=No	What is the most important source of drinking water in the kebele during the dry season? (*One answer only*) 1=Piped water 2=Wells/boreholes 3=Spring protected 4=Spring unprotected 5=Lake 6=River 7=Rain	What are the other sources of drinking water in the kebele during the dry season? (*More than one answer is possible*) 1=Piped water 2=Wells/boreholes 3=Spring protected 4=Spring unprotected5=Lake 6=River 7=Rain	In the last 5 years, has access to drinking water improved? 1=Yes 2=No, the same 3=No, it deteriorated	Does this kebele have veterinary vaccination center? 1=Yes, with permanent service 2=Yes, with service available only upon appointment 3=No, veterinary center/service not available in the kebele	Is there mobile network in this kebele? 1=Yes, in all kebele 2=Yes, in most of the kebele 3=Yes, in some areas of the kebele 4=Yes, in few areas of the kebele 5=No, this kebele is not covered by mobile network (>>Q19)	How is usually the quality of the network? 1=Slow 2=Somehow ok 3=Decent 4=Fast	How often is the network available? 1=Not available 2=It works only few days a week (or less) 3=It works most the days 4=It is always available

	Service Type	19	20	21
		Is [*service*] available in this kebele town/village? 1=Yes (>>Q21 2=No	What is the distance to the nearest one? KILOMETERS	In the last 5 years, has access to these services improved, stayed the same or deteriorated? 1=Improved 2=Stayed the same 3=Deteriorated
a	Post office			
b	Bank			
c	Agricultural extension officer			
d	Agricultural Cooperative			
e	NGO office			
f	Daily market			
g	Weekly market			

ACCESS TO HEALTH SERIVCES

1	2	3	4	5	6	7	8
Is there a place in this kebele to purchase common medicines such as pain killers and malaria tablets? 1=Yes (>>Q3) 2=No	What is the distance to the nearest place where one can purchase common medicines such as pain killers and malaria table from this kebele town/villages? KILOMETERS	What is the distance to the nearest health center from this kebele town/village? [*If in kebele, write '01*] KILOMETERS	How satisfied are the members in this kebele with the quality of the services offered at the nearest health post? 1=Very dissatisfied 2=Dissatisfied 3=Satisfied 4=Very satisfied	Is there a nurse, midwife or trained health extension agents working at this health post? 1=Always available 2=Sometimes available 3=Never available	Who runs this health post? 1=Government facility 2=Religious facility 3=Private facility	What is the distance to the nearest hospital/ health center from this kebele town/village? [*If in kebele town/village, write '01*] KILOMETERS	What is the distance to the nearest hospital/health facility where there is a medical doctor or health officer from this kebele town/village?? KILOMETERS

9	10	11	12	13	14	15	16

Who runs the facility where the nearest doctor is located? 1=Government 2=Religious 3=Private 4=NGO/civil society organization	Where do most of the women in this kebele give birth? 1=At home 2=Maternity home 3=Hospital/Clinic/Health center/Health post/etc. 4=Traditional birth attendant (TBA) house 5=Other (specify)	Has there been an immunization campaign in this kebele in the last 6 months? 1=Yes 2=No	Are there any groups or programmes in this kebele providing insecticide-treated mosquito bed nets free or at low cost? 1=Yes 2=No	What are the **TWO most common problems** with health services delivery for the people of this kebele? [*Enumerator: read list and ask respondent to rank top two*] 1=Lack of health facilities 2=Lack of qualified personnel 3= Lack of medicine and medical supplies from government facilities 4=Inability to pay for health services 5=Health center too far 6=Lack of accommodation for health personnel 7=Inadequate health facilities 8=Other		Does the nearest health facility (post/clinic/hospital) admit people who have been covered under CBHI? 1=Yes 2=No	What is the **distance** to the nearest administrative office where one can **register** for CBHI? [*If in kebele town/village, write '0'*]	What are the main reasons that residents in this area are not registered with CBHI in this kebele? 1=Fees/Premium too expensive 2=Travel time/cost too high 3=Waiting time at enrollment site too long 4=Poor quality care for those with HI 5=Preferred services not covered 6=Use clinics/ traditional healers that don't accept HI 7=Don't understand HI 8=Other (specify)
				1st	2nd			

17	18						19	20	21
Are there any groups working in this kebele to provide support and care to people who are chronically ill from diseases such as HIV/AIDS or tuberculosis? 1=Yes 2=No (>>Q20)	What sort of support do they provide? Do they provide: 1=Yes 2=No						Are there any formal insurance providers in the kebele, other than CBHI? 1=Yes 2=No	Are there any informal schemes/arrangements people have to informally insure themselves for health or emergencies in general (a part from Iddir)? 1=Yes 2=No (>>Q23)	Which are these schemes/ institutions?
	a	b	c	d	e	f			
	Medical care & medicine	Cash grants	Food or in-kind gifts?	Mental & spiritual counselling	Support & care for orphaned children	Other (specify)			

22	23	24	25	26
From either your experience or understanding, how would you rate the potential financial protection by community-based health insurance against the cost of illness?	What do you think is the potential level of access by households to affordable healthcare due to community-based health insurance? 0 = none 1 = low	How would you rate the potential of community-based health insurance to improve household health consumption patterns by ensuring that healthcare costs are reduced? 0 = none 1 = low	How would you rate the potential of CBHI to improve the quality of services provided by healthcare givers? 0 = none 1 = low 2 = medium	How would rate the potential of CBHI to ensure constant availability of drugs at health facilities in your community? 0 = none 1 = low

0 = none 1 = low 2 = medium 3 = high	2 = medium 3 = high	2 = medium 3 = high	3 = high	2 = medium 3 = high

SCHOOLING ACCESS

1	2	3	3a	4	5	6		7	8
What is the distance to the nearest public nursery? [*If in kebele town/village, write '01*] 99=DK	What is the distance to the nearest public pre-school? [*If in kebele town/village, write '01*] 99=DK	What is the distance to the nearest govt/public first cycle primary school? [*If in kebele town/village, write '01*]	What is the distance to the nearest govt/public second cycle primary school? [*If in kebele town/village, write '01*]	How many primary schools are run by private\religious organizations in this kebele?	How satisfied are members of the community with the nearest government primary school? 1=Very dissatisfied 2=Dissatisfied 3=Neither satisfied nor dissatisfied 4=Satisfied 5=Very satisfied	How much would it cost for one uniform, for a child at this school? [*This question refers to a child in Grade 4. Record the price for boys and girls.]*		What is the distance to the nearest public Junior school from this kebele/town? [*If in kebele, write '01*]	What are the estimated fees for one year to attend a government junior high school in this area? This includes tuition, boarding and lodging and any other fees (e.g., parent teacher association fees).
KILOMTERS	KILOMTERS	KILOMTERS	KILOMTERS			Girls	Boys	KILOMTERS	BIRR

9	10	11	12	13	14

How many junior high schools are run by private/religious organizations in this kebele?	What proportion of the students of junior high school going age (15-16 years) in this community are enrolled in school (any level)?	What are the **three main reasons** why some children in this community are not attending junior high school? 1=Inability of parents to fund child's education 2=Lack of parental interest (including gender differences) 3=Lack of interest in schooling by children 4=School too far away 5= Inadequate schools/classrooms 6=Inadequate teachers and learning materials 7=Dangers faced by children on their way to school 8=Early marriage 9=Other (specify)	Could a child go to junior high school without a uniform? 1=Yes 2=No 99=DK	What is the distance to the nearest public Senior secondary school from this kebele town/village? [*If in community, write '01*] KILOMTERS	What proportion of the students of senior high School going age (17-18 years) in this kebele are enrolled in school (any level)?

ECONOMIC ACTIVITIES

1	2	3	4	5	6
Are there any factories or big farms in or close to the kebele that employ a lot of kebele residents (for example more than 50 people) 1=Yes, within kebele 2=Yes, outside kebele in 5KMs radius 3=No	What kind of factory or farm employs the most people from the locality? 1=Farm extensive (Flower, Cereal, Tea, Coffee, etc.) 2=Mining (Rock, Clay, Other minerals) 3=Construction workers 4=Manufacturing industry/Factory (Textile, Leather, Metal, etc.) 5=Services (Wholesale, Hotel Retail sales, Garage, etc.)	Which activities are the most important sources of employment for individuals in this kebele? 1=Farming 2=Fishing 3=Firewood, charcoal selling 4=Small-scale trade & service provision (excluding transport) 5=Beer brewing, tella 6=Handicraft production, small-scale industry 7=Transport 8=Large-scale commercial industry 9=Professional occupations 10=Civil service 11=other (specify)	Do people in this kebele leave temporarily during certain times of the year to look for work elsewhere? 1=Yes 2=No	Where do most of them go? 1=Rural areas 2=Urban centers 3=Outside Ethiopia	Do people come to this kebele leave temporarily during certain times of the year to look for work? 1=Yes 2=No

7	8	9	10	11			12
Where do most of them come from? 1=Rural areas 2=Urban centers 3=Outside Ethiopia	Is there a cooperative/enterprise in this kebele to create opportunities or hire residents who are in need of work? 1=Yes 2=No (>>Q11)	What share of adult males in this kebele participate in the cooperative /microenterprise project?	What share of adult females in this kebele participate in the cooperative /microenterprise project?	What is the **average daily wage** for men, women and children doing casual labour in agriculture (to prepare land, planting, sow, to harvest, etc.) in this kebele? (in Birr) [*Specify that wage should not include food whilst working should be for 100% pay-in-cash (not paid-in-kind) and be for someone in no debt with the employer*] Wage in birr			What is the **monthly wage** for a health extension worker? Wage in birr
		% adult males	% adult females	Men	Women	Children	

COMMUNITY EVENTS

	Type of event										
		Was there any […] in 2007?	Did this event have a significant impact on many (more than half) members of the kebele? 1=Yes 2=No	Was there any […] in 2008?	Did this event have a significant impact on many (more than half) members of the kebele? 1=Yes 2=No	Was there any […] in 2009?	Did this event have a significant impact on many (more than half) members of the kebele? 1=Yes 2=No	Was there any […] in 2010?	Did this event have a significant impact on many (more than half) members of the kebele? 1=Yes 2=No	Duration of event of events. Number of weeks over the past 12 months	Number of people/households affected by event
1	Drought or too little rain										
2	Flood or too much rain										
3	Crop disease/pests										
4	Livestock disease										
5	Human epidemic disease (CSM, cholera, etc.)										
6	Interruption in water supply										
7	Sharp change in prices										
8	Massive job lay-offs										
9	Loss of key social service(s)										

10	Power outage(s)										
11	Religious conflict										
12	Ethnic/tribal conflict										
14	New employment opportunity										
15	New health facility										
16	New road										
17	New school										
18	Improved transportation services										
19	Improved electricity (i.e. solar, national grid)										
20	PSNP										
21	Development programme (specify)										

PSNP

	Question	Answers			Skip
1	Has the PSNP ever operated in this kebele (since 1998)?	Yes ..... 1 No..... 2			>>NEXT SECTION
2	In which years has the PSNP operated in this community?	YEAR EC	Yes	No	
		1998	1	2	
		1999	1	2	
		2000	1	2	
		2001	1	2	
		2002	1	2	
		2003	1	2	
		2004	1	2	
		2005	1	2	
		2006	1	2	
		2007	1	2	
		2008	1	2	
		2009	1	2	
		2010	1	2	
		2011	1	2	
3	How many households are currently PSNP beneficiaries (until Hidar 2011)?	Public Works.....|__| Permanent Direct Support.....|__| Temporary Direct Support .....|__|			
4	Does the Kebele Food Security Task Force (KFSTF) contain:				

a	The Chairperson of the kebele council	Yes ..... 1 No..... 2	
b	A member of the kebele council (apart from the Chairperson)	Yes ..... 1 No..... 2	
c	An elected representative from elders	Yes ..... 1 No..... 2	
5	How many elected representatives from women's groups are in the KFSTF?	Number ..... |__|	
6	Is re-targeting conducted for PWs and PDS at the same time?	Yes ..... 1 No..... 2	→Q7c
7	How often is re-targeting conducted?		
a	Public Works	More than once a year..... 1 Yearly..... 2 Every five years 3	
b	Direct Support	More than once a year..... 1 Yearly..... 2 Every five years 3	
c	Both	More than once a year..... 1 Yearly..... 2 Every five years 3	
8	Have community trainings or awareness raising and sensitization events (BCC sessions) been conducted at the community level as part of the PSNP activities?	Yes ..... 1 No..... 2	→9

8a	On what topics were these trainings/sessions implemented? [ALLOW FOR MULTIPLE ANSWERS]	Livelihoods (agriculture, livestock, etc.) ..... 1 nutrition ..... 2 Child feeding ..... 3 CBHI enrollment ..... 4 Cooking demonstration ..... 5 Early marriage ..... 6 Harmful traditional practices (i.e. Female genital mutilation) 7	

	Question	Answers	Skip
9	Have community trainings or awareness raising and sensitization events (BCC sessions) **not part of the PSNP** being conducted?	Yes ..... 1 No..... 2	
9a	On what topics were these trainings/sessions implemented? [ALLOW FOR MULTIPLE ANSWERS]	Livelihoods (agriculture, livestock, etc.) ..... 1 nutrition ..... 2 Child feeding ..... 3 CBHI enrollment..... 4 Cooking demonstration ..... 5 Early marriage ..... 6 Harmful traditional practices (i.e. Female genital mutilation) 7	
10	Is there a creche/child care center for those who work on public works in this kebele?	Yes, there is a specific child care center for PWs client.. 1 Yes, there is a child center, not specific for PSNP clients2 No, there is no child care center..... 3	→Next section
11	Who works in the creche/child care center?	Public works clients (as part of their work for PSNP) ..... 1 Other community member doing work not part of the PSNP 2	

PERCEPTIONS ABOUT MARRIAGE

	Question	**Answers**	Skip
1	How common is it for girls under 18 to be married in your kebele?	Never..... 1 Rare..... 2	

		Common ..... 3 Very common ..... 4 Don't know 98	
2	From what you know, how does your religion view early marriage?	It supports early marriage ..... 1 It is against early marriage ..... 2 It doesn't address it ..... 3 Don't know 98	
3	In your opinion, how do religious leaders in your kebele perceive marriage below age 18?	Support/accept and practice it ..... 1 Do not address it ..... 2 Do not support it and advise against it ..... 3 Other (specify) 96	
4	In your opinion, who is most influential in determining how marriage under the age of 18 is perceived by the kebele?	Community Elders (Shimaggile) ..... 1 Priests (religious leaders) ..... 2 Parents (mother and father) ..... 3 Iddir members ..... 4 School teachers ..... 5 Boys ..... 6 Girls ..... 7 Others (specify) 96	

Appendix D: Qualitative interview guides

1. IDI: PW client – Female caregiver with at least one child <18

Interviewee information

- Date
- Respondent category
- Location [woreda and kebele]
- Interviewee:
  * Name
  * Male/ female
  * Age
  * Number of children, sex and ages

1. Health status and health seeking behaviour

- What are the main health problems that affect your household?
- What are the main health problems that affect your children in your household?
- Do they get sick frequently?
- What do you think are the possible causes for your children to get sick?
- Where do you go to seek treatment when your children get sick?

Think about the last time you or someone else in the household was sick. Tell me about this…

- What symptoms did you/did he/she have?
- Did you seek medical treatment beyond the household? Tell me about your experience.
- If you did not seek treatment, can you give reasons why not?
- Who in your household makes the decisions about when and where to seek medical treatment?
- What remedies/drugs did you take for yourself/provide to the other sick member in the household?
- Did you pay for the treatment and remedies that you received? How much did you have to pay?
- Did you receive any support to cover the costs? If so, who provided this support?
- If there was not enough money to pay for this care and medicines, what did you do to cope with this situation?
- Did you face any other barriers, apart from financial ones, to access the treatment?
- Did you or anyone else in your household, experience any other implications of this sickness, which affected the household well-being?

2. Enrolment in the CBHI

- Is your household currently enrolled in any medical insurance scheme? Which one?
- Do you regularly save money for health-related costs?

- Are you part of any association or entity, which would help you to cover health-related costs?
- Who in your household makes the decisions about whether to enrol into health insurance scheme?
- Does the CBHI scheme operate in this community?
- How did you find out about the CBHI scheme operating in your community? (probe on insurance education and clients needs for support).
- Are you enrolled in the CBHI?

[f the client household is enrolled in the CBHI probe on]:

- When did you enrol?
- Do you pay a premium to join or you have joined for free? If you paid a premium, how much did you pay? Probe also on the initial registration cost and the regular fee, and access to premium waiver.
- Did you face difficulties to pay your premium? How did you overcome them?
- Please describe the type of services that you are entitled to as a member of the CBHI?
- What do you see as the main advantages of being a member of the CBHI scheme?
- Are there any drawbacks of being enrolled into CBHI?
- Have you or anyone in your household sought care at a health facility since enrolling in the CBHI? Tell me about your experience.
- Have you renewed your insurance? Do you plan to renew your membership into CBHI? If not, why not?
- Can the CBHI scheme be improved? If so, how?

[If the client household is not enrolled in the CBHI probe on]:

- Why your household is not currently enrolled in any health insurance scheme?
- Did you receive any information about the CBHI scheme operating in your community? (probe on insurance education and clients needs for support).
- Can you explain how the CBHI scheme functions?
- Would you like to be enrolled? If so, why?
- What barriers do you face in enrolling, if any?
- What type of support can help you enrol in the CBHI?

3. Access to education

- Are any of your children currently enrolled in school?
- Are they attending school regularly? If not, what is the reason(s)?
- What barriers do your children face in enrolling into school, if any?
- Do you receive any support to keep your children at school?

4. Participation in the PSNP

- When did your household enrol in the PSNP?
- Who in your household typically works in the PW scheme?
- Do you receive your PSNP payments on time?
- Do you receive full amounts of benefits?
- What do you think are the main advantages of being enrolled into the PSNP for your household?
- Are there any drawbacks of being enrolled into the PSNP for you/your household?
- Did your household experience any challenges with the program implementation, since you enrolled in the PSNP? If so, what are they?
- Have you been informed about your rights as a PSNP client since your enrolment in the program?
- Is it possible to make a complaint about the PSNP? If so, to whom?
- Have you ever made a complaint? Please explain your experience.

5. BCC sessions

- Have you attended any of the BCC sessions implemented by the PSNP?
- Are you required to attend these sessions to receive the program benefits?
- What is discussed during the BCC sessions?
- Who in the household usually participates in the BCC sessions?
- Did you face any constraints in attending the BCC sessions?
- Think about the last time you attended the BCC event, how did it affect you personally?
- Have your attitudes and behaviour towards a specific issue changed, as a result of attending these sessions?
- Can the implementation of BCC sessions be improved? If so, how?

6. Complimentary services and linkages

6.1. Support from Social Workers

- What services do social workers provide in your community?
- What services and support do/have you and your household receive (d) from social worker?
- When did case management support start? Do you still receive support from social worker?
- Has the support from social workers helped you? How? Has the case management addressed your needs? If not, why not?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from social worker? If so, what are they?
- Can the support from Social Workers be improved? If so, how?

6.2. Support from HEWs

- What services do HEW(s) provide in your community?
- What services and support do/have you and your household receive(d) from HEW(s)?
- Has the support from HEW(s) helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from HEW(s)? If so, what are they?
- Can the support from HEW(s) be improved? If so, how?

6.3. Support from the CCCs

- What services do CCCs provide in your community?
- What services and support do/have you and your household receive (d) from the CCCs?
- Haw has the support from the CCCs helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from the CCCs? If so, what are they?

2. IDIs: PDS client – Female caregiver with at least one child <18

Interviewee information

- Date
- Respondent category
- Location [woreda and kebele]
- Interviewee:
  * Name
  * Male/ female
  * Age
  * Number of children, sex and ages

1. HH health status and health seeking behaviour

- What are the main health problems that affect your household?
- What are the main health problems that affect your children in your household?
- Do they get sick frequently?
- What do you think are the possible causes for your children to get sick?
- Where do you go to seek treatment when your children get sick?

Think about the last time you or someone else in the household was sick. Tell me about this…

- What symptoms did you/did he/she have?
- Did you seek medical treatment beyond the household? Tell me about your experience.
- If you did not seek treatment, can you give reasons why not?
- Who in your household makes the decisions about when and where to seek medical treatment?
- What remedies/drugs did you take for yourself/provide to the other sick member in the household?
- Did you pay for the treatment and remedies that you received? How much did you have to pay?
- How did you pay?
- Did you receive any support to cover the costs? If so, who provided support to you?
- If there was not enough money to pay for this care and medicines, what did you do to cope with this situation?
- Did you face any other barriers, apart from financial ones, to access the treatment?
- Did you or anyone else in your household experience any other implications of this sickness, which affected the household well-being?

2. Enrolment in the CBHI

- Is your household currently enrolled in any medical insurance scheme? Which one?
- Do you regularly save money for health-related costs?

- Are you part of any association or entity, which would help you to cover health-related costs?
- Who in your household makes the decisions about whether to enrol into health insurance scheme?
- Does the CBHI scheme operate in this community?
- How did you find out about the CBHI scheme operating in your community? (probe on insurance education and clients needs for support).
- Are you enrolled in the CBHI?

[If the client household is enrolled in the CBHI probe on]:

- When did you enrol?
- Do you pay a premium to join or used a premium waiver? If you paid a premium, how much did you pay? Probe also on the initial registration cost and the regular fee.
- Did you face difficulties to pay your premium? How did you overcome them?
- If the respondent used a premium waiver, ask them to describe the process of registering for the waiver etc.
- Please describe the type of services that you are entitled to as a member of the CBHI?
- What do you see as the main advantages of being a member of the CBHI scheme?
- Are there any drawbacks of being enrolled into CBHI?
- Have you or anyone in your household sought care at a health facility since enrolling in the CBHI? Tell me about your experience.
- Have you renewed your insurance? Do you plan to renew your membership into CBHI? If not, why not?
- Can the CBHI scheme be improved? If so, how?

[If the client household is not enrolled in the CBHI probe on]:

- Why your household is not currently enrolled in any health insurance scheme?
- Did you receive any information about the CBHI scheme operating in your community? (probe on insurance education and clients needs for support).
- Are you aware that you are eligible for a premium waiver?
- Can you explain how the CBHI scheme functions?
- Would you like to be enrolled? If so, why?
- What barriers do you face in enrolling, if any?
- What type of support can help you enrol in the CBHI?

3. Access to education

- Are any of your children currently enrolled in school?
- Are you required to send your children to school to receive the program benefits?
- Are they attending school regularly? If not, what is the reason(s)?
- What barriers do your children face in enrolling into school, if any?
- Do you receive any support to keep your children at school?

4. Participation in the PSNP

- When did your household enrol in the PSNP? Has your client status changed since you enrolled originally in the program?
- Do you receive your PSNP payments on time?
- Do you receive full amounts of benefits?
- What do you think are the main advantages of being enrolled into the PSNP for your household?
- Are there any drawbacks of being enrolled into the PSNP for you/your household?
- Did your household experience any challenges with the program implementation, since you enrolled in the PSNP? If so, what are they?
- Have you been informed about your rights as a PSNP client since your enrolment in the program?
- Is it possible to make a complaint about the PSNP? If so, to whom?
- Have you ever made a complaint? Please explain your experience.

5. Co-responsibilities

- As the PSNP client, are you required to perform any activities to receive the program benefits, such as health check-ups, child school enrolment/attendance, growth monitoring etc..
- Who in your household is responsible for fulfilling the co-responsibilities?
- Did you receive information about what exactly you are expected to do? Who delivers this information?
- Have there been any changes in your and your children's welfare status as a result of these co-responsibilities?
- What kind of changes? (Probe: changes in health seeking behaviour, school enrolment/attendance, knowledge on nutrition, and awareness about risks associated with early marriage).
- Have you experienced any challenges in fulfilling the co-responsibilities? Please provide example.

6. BCC sessions

- Have you attended any of the BCC sessions implemented by the PSNP?
- Are you required to attend these sessions to receive the program benefits?
- What is discussed during the BCC sessions? Who facilitates these sessions?
- Who in the household usually participates in the BCC sessions?
- Did you face any constraints in attending the BCC sessions?
- Think about the last time you attended the BCC event, how did it affect you personally?
- Have your attitudes and behaviour towards a specific issue changed, as a result of attending these sessions?
- Can the implementation of BCC sessions be improved? If so, how?

7. Complimentary services and linkages

7.1. Support from Social Workers

- What services do social workers provide in your community?
- What services and support do/have you and your household receive (d) from social worker?
- When did case management support start? Do you still receive support from social worker?
- Has the support from social workers helped you? How? Has the case management addressed your needs? If not, why not?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from social worker? If so, what are they?
- Can the support from Social Workers be improved? If so, how?

7.2. Support from HEWs

- What services do HEW(s) provide in your community?
- What services and support do/have you and your household receive(d) from HEW(s)?
- Has the support from HEW(s) helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from HEW(s)? If so, what are they?
- Can the support from HEW(s) be improved? If so, how?

7.3. Support from the CCCs

- What services do CCCs provide in your community?
- What services and support do/have you and your household receive (d) from the CCCs?
- Haw has the support from the CCCs helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from the CCCs? If so, what are they?

3. IDI: TDS Client - Pregnant woman

Interviewee information

- Date
- Respondent category
- Location [woreda and kebele]
- Interviewee:
  * Name
  * Male/ female
  * Age
  * Number of children, sex and ages

1. Health status and health seeking behaviour

- What are the main health problems that affect your household?
- What are the main health problems that affect your children in your household?
- Do they get sick frequently?
- What do you think are the possible causes for your children to get sick?
- Where do you go to seek treatment when your children get sick?

Think about the last time you or someone else in the household was sick. Tell me about this…

- What symptoms did you/did he/she have?
- Did you seek medical treatment beyond the household? Tell me about your experience.
- If you did not seek treatment, can you give reasons why not?
- Who in your household makes the decisions about when and where to seek medical treatment?
- What remedies/drugs did you take for yourself/provide to the other sick member in the household?
- Did you pay for the treatment and remedies that you received? How much did you have to pay?
- How did you pay?
- Did you receive any support to cover the costs? If so, who provided support to you?
- If there was not enough money to pay for this care and medicines, what did you do to cope with this situation?
- Did you face any other barriers, apart from financial ones, to access the treatment?
- Did you or anyone else in your household experience any other implications of this sickness, which affected the household well-being?

2. Enrolment in the CBHI

- Is your household currently enrolled in any medical insurance scheme? Which one?
- Do you regularly save money for health-related costs?
- Are you part of any association or entity, which would help you to cover health-related costs?

- Who in your household makes the decisions about whether to enrol into health insurance scheme?
- Does the CBHI scheme operate in this community?
- How did you find out about the CBHI scheme operating in your community?
- Are you enrolled in the CBHI?

[If the client household is enrolled in the CBHI probe on]:

- When did you enrol?
- Do you pay a premium to join or used a premium waiver? If you paid a premium, how much did you pay? Probe also on the initial registration cost and the regular fee.
- Did you face difficulties to pay your premium? How did you overcome them?
- If the respondent used a premium waiver, ask them to describe the process of registering for the waiver etc.
- Please describe the type of services that you are entitled to as a member of the CBHI? (probe specifically on services related to maternal and child healthcare).
- What do you see as the main advantages of being a member of the CBHI scheme?
- Are there any drawbacks of being enrolled into CBHI?
- Have you or anyone in your household sought care at a health facility since enrolling in the CBHI? Tell me about your experience.
- Have you renewed your insurance? Do you plan to renew your membership into CBHI? If not, why not?
- Can the CBHI scheme be improved? If so, how?

[If the client household is not enrolled in the CBHI probe on]:

- Why your household is not currently enrolled in any health insurance scheme?
- Did you receive any information about the CBHI scheme operating in your community? (Probe on insurance education etc.)
- Are you aware that you are eligible for a premium waiver?
- Can you explain how the CBHI scheme functions?
- Would you like to be enrolled? If so, why?
- What barriers do you face in enrolling, if any?
- What type of support can help you enrol in the CBHI?

3. Experience with pregnancy and access to ante-natal care (ANC)

Now I would like to talk to you about your current pregnancy:

- When did you get pregnant?
- Who are/were the people who supported you during and how?
- How was your health during your last/current pregnancy?
- What do/did you do to stay healthy during your pregnancy?
- Did your diet/eating patterns change during your pregnancy? How? Why did you change your diet?

- Did you experience food shortages during your current/last pregnancy? Did you receive any support to improve your food intake?
- Did you work patterns change during your pregnancy? How and why?
- During your last/current pregnancy did you seek/receive any antenatal care? Tell me about your experience.
- During your last/current pregnancy did you seek/receive relevant information about available skilled care at childbirth?
- Who in your household makes the decisions about seeking medical care or advice, including family planning, ANC and skilled/institutional delivery?
- If you did not seek ANC, can you give reasons why not?
- As the PSNP client, are you required to attend any health check-ups? Please explain.
- What barriers, if any, did you face in accessing antenatal care?
- What did you do to overcome these barriers? What type of support could help you to improve your access to ANC?

4. Participation in the PSNP

- When did your household enrol in the PSNP?
- Did your household transition into the TDS? When?
- Do you receive your PSNP payments on time?
- Do you receive full amounts of benefits?
- What do you think are the main advantages of being enrolled into the PSNP for your household? Probe also specifically on TDS client status.
- Are there any drawbacks of being enrolled into the PSNP for you/your household? Probe also specifically on TDS client status.
- Did your household experience any challenges with the program implementation, since you enrolled in the PSNP? If so, what are they?
- Have you been informed about your rights as a PSNP client since your enrolment in the program?
- Is it possible to make a complaint about the PSNP? If so, to whom?
- Have you ever made a complaint? Please explain your experience.

5. Co-responsibilities

- As the PSNP client, are you required to perform any activities to receive the program benefits, such as health check-ups, child school enrolment/attendance, growth monitoring etc.
- Who in your household is responsible for fulfilling the co-responsibilities?
- Did you receive clear information about what exactly you are expected to do? Who delivers this information?
- Have there been any changes in your and your children's welfare status as a result of these co-responsibilities?
- What kind of changes? (Probe: changes in health seeking behaviour, school enrolment/attendance, knowledge on nutrition, and awareness about risks associated with early marriage, or increased work burdens).
- Have you experienced any challenges in fulfilling the co-responsibilities? Please provide example.

5. BCC sessions

- Have you attended any of the BCC sessions implemented by the PSNP?
- Are you required to attend these sessions to receive the program benefits?
- What is discussed during the BCC sessions? Who facilitates these sessions?
- Who in the household usually participates in the BCC sessions?
- Did you face any constraints in attending the BCC sessions?
- Think about the last time you attended the BCC event, how did it affect you personally?
- Have your attitudes and behaviour towards a specific issue changed, as a result of attending these sessions?
- Can the implementation of BCC sessions be improved? If so, how?

6. Complimentary services and linkages

6.1. Support from Social Workers

- What services do social workers provide in your community?
- What services and support do/have you and your household receive (d) from social worker?
- When did case management support start? Do you still receive support from social worker?
- Has the support from social workers helped you? How? Has the case management addressed your needs? If not, why not?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from social worker? If so, what are they?
- Can the support from Social Workers be improved? If so, how?

6.2. Support from HEWs

- What services do HEW(s) provide in your community?
- What services and support do/have you and your household receive(d) from HEW(s)?
- Has the support from HEW(s) helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from HEW(s)? If so, what are they?
- Can the support from HEW(s) be improved? If so, how?

6.3. Support from the CCCs

- What services do CCCs provide in your community?
- What services and support do/have you and your household receive (d) from the CCCs?
- Haw has the support from the CCCs helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from the CCCs? If so, what are they?

4. IDI: TDS Client - Lactating women with a child <6 months

Interviewee information

- Date
- Respondent category
- Location [woreda and kebele]
- Interviewee:
  * Name
  * Male/ female
  * Age
  * Number of children, sex and ages

1. Health status and health seeking behaviour

- What are the main health problems that affect your household?
- What are the main health problems that affect your children in your household?
- Do they get sick frequently?
- What do you think are the possible causes for your children to get sick?
- Where do you go to seek treatment when your children get sick?

Think about the last time you or someone else in the household was sick. Tell me about this…

- What symptoms did you/did he/she have?
- Did you seek medical treatment beyond the household? Tell me about your experience.
- If you did not seek treatment, can you give reasons why not?
- Who in your household makes the decisions about when and where to seek medical treatment?
- What remedies/drugs did you take for yourself/provide to the other sick member in the household?
- Did you pay for the treatment and remedies that you received? How much did you have to pay?
- How did you pay?
- Did you receive any support to cover the costs? If so, who provided support to you?
- If there was not enough money to pay for this care and medicines, what did you do to cope with this situation?
- Did you face any other barriers, apart from financial ones, to access the treatment?
- Did you or anyone else in your household experience any other implications of this sickness, which affected the household well-being?

2. Enrolment in the CBHI

- Is your household currently enrolled in any medical insurance scheme? Which one?
- Do you regularly save money for health-related costs?

- Are you part of any association or entity, which would help you to cover health-related costs?
- Who in your household makes the decisions about whether to enrol into health insurance scheme?
- Does the CBHI scheme operate in this community?
- How did you find out about the CBHI scheme operating in your community?
- Are you enrolled in the CBHI?

[If the client household is enrolled in the CBHI probe on]:

- When did you enrol?
- Do you pay a premium to join or used a premium waiver? If you paid a premium, how much did you pay? Probe also on the initial registration cost and the regular fee.
- Did you face difficulties to pay your premium? How did you overcome them?
- If the respondent used a premium waiver, ask them to describe the process of registering for the waiver etc.
- Please describe the type of services that you are entitled to as a member of the CBHI? (probe specifically on services related to maternal and child healthcare).
- What do you see as the main advantages of being a member of the CBHI scheme?
- Are there any drawbacks of being enrolled into CBHI?
- Have you or anyone in your household sought care at a health facility since enrolling in the CBHI? Tell me about your experience.
- Have you renewed your insurance? Do you plan to renew your membership into CBHI? If not, why not?
- Can the CBHI scheme be improved? If so, how?

[If the client household is not enrolled in the CBHI probe on]:

- Why your household is not currently enrolled in any health insurance scheme?
- Did you receive any information about the CBHI scheme operating in your community? Please describe.
- Are you aware that you are eligible for a premium waiver?
- Can you explain how the CBHI scheme functions?
- Would you like to be enrolled? If so, why?
- What barriers do you face in enrolling, if any?
- What type of support can help you enrol in the CBHI?

3. Experience with pregnancy

Now I would like to talk to you about your current pregnancy:

- When did you get pregnant?
- Who are/were the people who supported you during and how?
- How was your health during your last/current pregnancy?
- What do/did you do to stay healthy during your pregnancy?

- Did your diet/eating patterns change during your pregnancy? How? Why did you change your diet?
- Did you experience food shortages during your current/last pregnancy? Did you receive any support to improve your food intake?
- Did you work patterns change during your pregnancy? How and why?

4. Access to ANC and post-natal care (PNC)

- During your last/current pregnancy did you seek/receive any antenatal care?
- Who in your household makes the decisions about seeking medical care or advice, including family planning, ANC and skilled/institutional delivery?
- If you did not seek ANC, can you give reasons why not?
- As the PSNP client, are you required to seek antenatal care? Please explain.
- During your last/current pregnancy did you seek/receive relevant information about available skilled care at childbirth?
- Where did you give birth?
- Did you seek any PNC after childbirth? Please describe the type of services that you have received.
- As the PSNP client, are you required to attend any health check-ups for you or your child? Please explain.
- What barriers, if any, did you face in maternal health services?
- What did you do to overcome these barriers? What type of support could help you to improve your access to maternal health services?

5. Child nutrition and feeding practices

- What has been your experience with breastfeeding? Tell me about this.
- How do you feed your youngest child? Please provide the example.
- Who in the household makes decisions about how to feed youngest children?
- Where and how did you learn about child feeding?
- Where do you get information about good nutrition for children?
- Did you receive any support on child-nutrition? Please provide example.
- In general, do you face any difficulties in feeding your youngest child? Please explain.

6. Participation in the PSNP

- When did your household enrol in the PSNP?
- Did your household transition into the TDS? When?
- Do you receive your PSNP payments on time?
- Do you receive full amounts of benefits?
- What do you think are the main advantages of being enrolled into the PSNP for your household? Probe also specifically on TDS client status.
- Are there any drawbacks of being enrolled into the PSNP for you/your household? Probe also specifically on TDS client status.

- Did your household experience any challenges with the program implementation, since you enrolled in the PSNP? If so, what are they?
- Have you been informed about your rights as a PSNP client since your enrolment in the program?
- Is it possible to make a complaint about the PSNP? If so, to whom?
- Have you ever made a complaint? Please explain your experience.

7. Co-responsibilities

- As the PSNP client, are you required to perform any activities to receive the program benefits, such as health check-ups, child school enrolment/attendance, growth monitoring etc.
- Who in your household is responsible for fulfilling the co-responsibilities?
- Did you receive clear information about what exactly you are expected to do? Who delivers this information?
- Have there been any changes in your and your children's welfare status as a result of these co-responsibilities?
- What kind of changes? (Probe: changes in health seeking behaviour, school enrolment/attendance, knowledge on nutrition, and awareness about risks associated with early marriage, or increased work burdens).
- Have you experienced any challenges in fulfilling the co-responsibilities? Please provide example.

8. BCC sessions

- Have you attended any of the BCC sessions implemented by the PSNP?
- Are you required to attend these sessions to receive the program benefits?
- What is discussed during the BCC sessions? Who facilitates these sessions?
- Who in the household usually participates in the BCC sessions?
- Did you face any constraints in attending the BCC sessions?
- Think about the last time you attended the BCC event, how did it affect you personally?
- Have your attitudes and behaviour towards a specific issue changed, as a result of attending these sessions?
- Can the implementation of BCC sessions be improved? If so, how?

9. Complimentary services and linkages

9.1. Support from Social Workers

- What services do social workers provide in your community?
- What services and support do/have you and your household receive (d) from social worker?
- When did case management support start? Do you still receive support from social worker?

- Has the support from social workers helped you? How? Has the case management addressed your needs? If not, why not?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from social worker? If so, what are they?
- Can the support from Social Workers be improved? If so, how?

9.2. Support from HEWs

- What services do HEW(s) provide in your community?
- What services and support do/have you and your household receive(d) from HEW(s)?
- Has the support from HEW(s) helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from HEW(s)? If so, what are they?
- Can the support from HEW(s) be improved? If so, how?

9.3. Support from the CCCs

- What services do CCCs provide in your community?
- What services and support do/have you and your household receive (d) from the CCCs?
- Haw has the support from the CCCs helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from the CCCs? If so, what are they?

5. IDI: TDS Client – Female caregiver with malnourished child aged 6-59 months

Interviewee information

- Date
- Respondent category
- Location [woreda and kebele]
- Interviewee:
  * Name
  * Male/ female
  * Age
  * Number of children, sex and ages

1. Health status and health seeking behaviour

- What are the main health problems that affect your household?
- What are the main health problems that affect your children in your household?
- Do they get sick frequently?
- What do you think are the possible causes for your children to get sick?
- Where do you go to seek treatment when your children get sick?

Now I would like to ask you specifically about the last time a child in this household was sick/malnourished.

- What symptoms did he/she have?
- Did you seek medical treatment beyond the household? Tell me about your experience.
- If you did not seek treatment, can you give reasons why not?
- Who in your household makes the decisions about when and where to seek medical treatment?
- What remedies/drugs/food supplements did you provide to the child?
- Did you pay for the treatment and remedies that your child received? How much did you have to pay?
- How did you pay?
- Did you receive any support to cover the costs? If so, who provided support to you?
- Did you face any other barriers, apart from financial ones, to access the treatment?
- Has the health/nutrition situation of your child improved?
- Did you or anyone else in your household experience any other implications of this sickness, which affected the household well-being?

2. Enrolment in the CBHI

- Is your household currently enrolled in any medical insurance scheme? Which one?
- Do you regularly save money for health-related costs?
- Are you part of any association or entity, which would help you to cover health-related costs?
- Who in your household makes the decisions about whether to enrol into health insurance scheme?
- Does the CBHI scheme operate in this community?
- How did you find out about the CBHI scheme operating in your community? (probe on social marketing and insurance education).
- Are you enrolled in the CBHI?

[If the client household is enrolled in the CBHI probe on]:

- When did you enrol?
- Do you pay a premium to join or used a premium waiver? If you paid a premium, how much did you pay? Probe also on the initial registration cost and the regular fee.
- Did you face difficulties to pay your premium? How did you overcome them?
- If the respondent used a premium waiver, ask them to describe the process of registering for the waiver etc.
- Please describe the type of services that you are entitled to as a member of the CBHI? (probe specifically on services related to maternal and child health care).
- What do you see as the main advantages of being a member of the CBHI scheme?
- Are there any drawbacks of being enrolled into CBHI?
- Have you or anyone in your household sought care at a health facility since enrolling in the CBHI? Tell me about your experience.
- Have you renewed your insurance? Do you plan to renew your membership into CBHI? If not, why not?
- Can the CBHI scheme be improved? If so, how?

[If the client household is not enrolled in the CBHI probe on]:

- Why your household is not currently enrolled in any health insurance scheme?
- Did you receive any information about the CBHI scheme operating in your community? Please describe.
- Are you aware that you are eligible for a premium waiver?
- Can you explain how the CBHI scheme functions?
- Would you like to be enrolled? If so, why?
- What barriers do you face in enrolling, if any?
- What type of support can help you enrol in the CBHI?

3. Child nutrition and feeding practices

- What has been your experience with breastfeeding? Tell me about this.
- How do you feed your youngest child? Please provide the example.
- Who in the household makes decisions about how to feed youngest children?
- Where and how did you learn about child feeding?
- Where do you get information about good nutrition for children?
- Did you receive any support on child-nutrition? Please provide example.
- In general, do you face any difficulties in feeding your youngest child? Please explain.

4. Participation in the PSNP

- When did your household enrol in the PSNP?
- Did your household transition into the TDS? When?
- Do you receive your PSNP payments on time?
- Do you receive full amounts of benefits?
- What do you think are the main advantages of being enrolled into the PSNP for your household? Probe also specifically on TDS client status.
- Are there any drawbacks of being enrolled into the PSNP for you/your household? Probe also specifically on TDS client status.
- Did your household experience any challenges with the program implementation, since you enrolled in the PSNP? If so, what are they?
- Have you been informed about your rights as a PSNP client since your enrolment in the program?
- Is it possible to make a complaint about the PSNP? If so, to whom?
- Have you ever made a complaint? Please explain your experience.

5. Co-responsibilities

- As the PSNP client, are you required to perform any activities to receive the program benefits, such as health check-ups, child school enrolment/attendance, growth monitoring etc.
- Who in your household is responsible for fulfilling the co-responsibilities?
- Did you receive clear information about what exactly you are expected to do? Who delivers this information?
- Have there been any changes in your and your children's welfare status as a result of these co-responsibilities?
- What kind of changes? (Probe: changes in health seeking behaviour, school enrolment/attendance, knowledge on nutrition, and awareness about risks associated with early marriage, or increased work burdens).
- Have you experienced any challenges in fulfilling the co-responsibilities? Please provide example.

6. BCC sessions

- Have you attended any of the BCC sessions implemented by the PSNP?
- Are you required to attend these sessions to receive the program benefits?
- What is discussed during the BCC sessions? Who facilitates these sessions?
- Who in the household usually participates in the BCC sessions?
- Did you face any constraints in attending the BCC sessions?
- Think about the last time you attended the BCC event, how did it affect you personally?
- Have your attitudes and behaviour towards a specific issue changed, as a result of attending these sessions?
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7. Complimentary services and linkages

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- When did case management support start? Do you still receive support from social worker?
- Has the support from social workers helped you? How? Has the case management addressed your needs? If not, why not?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from social worker? If so, what are they?
- Can the support from Social Workers be improved? If so, how?

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- What services do HEW(s) provide in your community?
- What services and support do/have you and your household receive(d) from HEW(s)?
- Has the support from HEW(s) helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from HEW(s)? If so, what are they?
- Can the support from HEW(s) be improved? If so, how?

7.3. Support from the CCCs

- What services do CCCs provide in your community?
- What services and support do/have you and your household receive (d) from the CCCs?
- Haw has the support from the CCCs helped you? How?
- Have there been any changes in the situation of you and your children as a result of these services? What kind of changes?
- Did you experience any challenges or problems with the support that you receive from the CCCs? If so, what are they?

Appendix E: Informed consent form

Good morning/afternoon. I am _____ from FRONTIERI. On behalf of UNICEF Ethiopia, I am conducting a baseline survey that will provide UNICEF Ethiopia with initial empirical data that can be applied to measure change and midline survey attributable to the implementation of Integrated Safety Net Program. The study aims to examine the impacts of PSNP and CBHI linkages on the well-being of client households, across a range of dimensions, with a key focus on enrolment in CBHI, health seeking, and child health. Results will inform future advocacy work and Programme design related to integrated and child-sensitive social protection in Amhara region.

Your participation in this study is voluntary. You may decide not to participate or you may leave the study at any time. Your decision will not result in any penalty or loss of benefits to which you are entitled. If you have any questions, please feel free to ask the interviewer at any time during the interview.

CONSENT

I willingly agree to participate. I may withdraw my consent at any time and stop participation without penalty. All my questions about the study and my participation in it have been answered.

Given Consent

Consent given Consent not given

Statement of the Interviewer: I am the interviewer of the above-mentioned survey. I read this consent form, which is known by the respondent. After detailed understanding of the material given above, the respondent willingly marked (√).

Signature of Enumerator: Date : _____/_____/_____

Appendix F: Ethical clearance

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Amhara National Regional Sate
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Amhara Public Health Institute (APHI)

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Ref. NoH/R/T/T/D/07/40
ቀን፡- 04/04/2015
Date:-13/12/2022GC

Amhara Public Health Institute Research Ethics Review Committee Response Form
To - UNICEF
Addis Ababa

Subject: Health Ethical Clearance

You have requested the ethical clearance entitled on a project entitled with "**IMPACT EVALUATION OF THE INTEGRATED SAFETY NET PROGRAM IN AMHARA REGION**" to Amhara public health institute for renewal. The Regional public Health Research Ethics Review Committee /RERC/ has renewed the submitted project proposal for a **period of one year December 15/ 2022 to December 15/2023**.All your more recently submitted documents have been approved for use in this study. The study should comply with the standard international and national scientific and ethical guideline. Any change to the approved protocol or consent material must be reviewed and approved through the amendment process prior to its implementation. In addition, any adverse or unanticipated events should be reported within 24-48 hours to RERC. Please insure that you submit progressive report prior the expiry date of project.

We, therefore, request your esteemed organization to ensure the commencement and conduct of the study accordingly and wish for the successful completion of the project.

With regards

Taye Zeru
IRB Chair

Cc

To Tia Plermo

☎ 0582221493 P.O. Box: 477 ✉ admin@aphi.gov.et Bahir Dar| Ethiopia

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About us

UNICEF works in the world's toughest places to reach the most disadvantaged children and adolescents — and to protect the rights of every child, everywhere. Across 190 countries and territories, we do whatever it takes to help children survive, thrive and fulfill their potential, from early childhood through adolescence. And we never give up.

UNICEF Innocenti – Global Office of Research and Foresight tackles the questions of greatest importance for children, both current and emerging. It drives change through research and foresight on a wide range of child rights issues, sparking global discourse and actively engaging young people in its work.

UNICEF Innocenti equips thought leaders and decision-makers with the evidence they need to build a better, safer world for children. The office undertakes research on unresolved and emerging issues, using primary and secondary data that represents the voices of children and families themselves. It uses foresight to set the agenda for children, including horizon scanning, trends analysis and scenario development. The office produces a diverse and dynamic library of high-level reports, analyses and policy papers, and provides a platform for debate and advocacy on a wide range of child rights issues.

UNICEF Innocenti provides, for every child, answers to their most pressing concerns.

for every child, answers