A study of the socio-economic conditions of Productive Safety Net Programme (PSNP) Households in Addis Ababa, Ethiopia

Endline Study

Inception Report

UNICEF Innocenti - Global Office of Research and Foresight

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Study Team

Note: Names in alphabetical order by surname and not indicative of contribution

UNICEF Innocenti Global Office of Research and Foresight: Kaku Attah Damoah (co-Principal Investigator), Essa Chanie Mussa, Frank Otchere (co-Principal Investigator)

UNICEF Ethiopia: Getachew Berhanu Kebede, Kibur Martha, Mathew Tasker, Valentina Prosperi

DAB Development Research and Training: Nuru Hussen and Samuel Tekalign

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List of Acronyms

BCC	Behaviour Change Communication
BoWSA	Bureau of Women and Social Affairs
CBHI	Community Based Health Insurance
FGDs	Focus Group Discussions
HEW	Health Extension worker
IDIs	In-Depth Interviews
ISNP	Integrated Safety Net Programme
KIIs	Key Informant Interviews
MIS	Management Information System
MoWSA	Ministry of Women and Social Affairs
MUDC	Ministry of Urban Development and Construction
PDS	Permanent Direct Support
PLW	Pregnant and Lactating Women
PSNP	Productive Safety Net Programme
PW	Public Works
SIDA	Swedish International Development Agency
SRH	Sexual and Reproductive Health
SW	Social Worker
TDS	Temporary Direct Support
UNICEF	United Nations Children's Fund
UPSNP	Urban Productive Safety Net Programme

1. Background

The Government of Ethiopia is establishing a comprehensive integrated social protection system that brings together several fragmented interventions and sectors with a goal of improving poverty reduction, health, and nutrition outcomes. The existing social protection system in Ethiopia is constituted of many diverse interventions. A nationwide rural Productive Safety Net Programme (PSNP) and the Humanitarian Food Aid (HFA) account for the largest share of spending on social protection. In addition, there is an urban Productive Safety Net Program (UPSNP) currently being implemented in 11 major urban centres including Addis Ababa, a formal social security scheme for civil servants and private sector organization employees, a Community Based Health Insurance (CBHI) scheme, and health and education fee waiver schemes. These programs are not always efficient at reaching the most vulnerable parts of society, and the fragmentation undermines the potential synergies that could be realized by integrating the different schemes. At the same time, evidence shows that when social protection systems are well designed and effectively integrated, they have been effective in reducing the depth of monetary poverty and addressing children's multiple deprivations in a systematic way and during humanitarian response.[1]

Until 2016, when the UPSNP was introduced, most of the social protection interventions focused on addressing vulnerability in rural areas. This was mostly because Ethiopia is predominantly rural (about 77 per cent of population lived in rural areas in 2022)[2] and rural poverty rates have been much higher. However, Ethiopia's urban population is rapidly increasing (from 16.6 per cent in 2011 to 19.1 per cent in 2016 and projected to 28 per cent by 2030) due to natural population growth as well as rural-urban migration. The surge in urban population growth has been accompanied by increased urban poverty, street dwellers and slum conditions. As more of the poor live in large urban centres, expanding development programmes to address key challenges to urban poverty reduction is critical. An economically productive urban transformation is necessary for Ethiopia to reach middle-income status, end extreme poverty, and improve shared prosperity. If not managed proactively, rapid urban population growth may pose a demographic challenge as cities struggle to provide citizens with jobs, infrastructure and services, and housing.[3]

Socio-economic vulnerabilities in urban contexts are different compared to those typically experienced in rural areas. While extreme poverty rates are lower in urban contexts, food insecurity remains a severe problem. Urban poverty and food insecurity are mostly due to lack of adequate employment opportunities; lack of integrated social protection for disadvantaged groups; underutilized potential of urban agriculture; lack of modern market exchange system; lack of efficient service delivery; lack of conducive working environment; poor solid and liquid waste management; and environmental, natural

[1] United Nations Children' Fund (2019). UNICEF's Global Social Protection Programme Framework. New York, US. UNICEF.

[2] World Bank (2023), World Development Indicators, https://databank.worldbank.org/source/world-development-indicators (accessed on 31 July 2023).

[3] World Bank (2015). Ethiopia Urbanization Review. Ozlu, M. O., Alemayehu, A., Mukim, M., Lall, S. V., Kerr, O. T., Kaganova, O., ... & Ayane, B. L. (2015). *Ethiopia-Urbanization review: urban institutions for a middle-income Ethiopia* (No. 100238, pp. 1-168). The World Bank.

and man-made hazards. Some factors are also more prevalent in urban areas, and include human trafficking, sex work, drug abuse, and HIV/AIDS prevalence. There is also a geographical pattern, with clustering in low-income neighbourhoods.[4] Moreover, opportunities for relying on natural resources, including land, forest and river bodies for livelihood are limited in urban settings. In the past few years, COVID-19 also added another dimension to vulnerability for urban households with infection rates and restricted mobility disproportionately affecting urban than rural populations. The national urban social protection programme is therefore timely and a necessary strategy to address urban poverty and the health and social risks overburdening specific segments of the urban population.

Over the past few years, in the effort of developing an integrated social protection system, UNICEF, in collaboration with the government and partners, is implementing pilot programmes to inform policy, both in rural as well as urban areas, in Amhara region and Addis Ababa, respectively. One of the main objectives of the integrated safety net programme (ISNP) pilot in Addis Ababa is to integrate the UPSNP with the Community Based Health Insurance scheme (CBHI) and other social services. The CBHI is meant to improve health-seeking behaviour and utilization among poor households by reducing out-of-pocket expenditures for routine health care services which is a major barrier for equitable access to health care.

This study is a follow-up to a previous mixed-methods study conducted in 2021 and aimed to document changes in the welfare status of the UPSNP households in the two ISNP pilot sub-cities (Addis Ketema and Arada), beneficiaries' experience and perceptions of the UPSNP and challenges in accessing and utilisation of complementary services in order to inform program related measures. Unlike the first wave, the current study employs qualitative techniques to evaluate welfare changes among beneficiary households due to the change in the methodology from impact to summative evaluation. However, to support the household level analysis, the study also evaluates changes at the community and health facility levels in all the Ketenas from the four baseline sub-cities (Addis Ketema, Arada, Kirkos and Lideta). The study findings, along with the first wave results, will further be used for policy advocacy and to inform future and better programming aimed at integrating social protection systems and additional services in urban settings in Ethiopia.

The study will be led by UNICEF Innocenti – Global Office of Research and Foresight in close collaboration with UNICEF Ethiopia country office, the Ministry of Women and Social Affairs (MoWSA), the Ministry of Urban Development and Construction (MUDC), and other stakeholders. While the current study will be primarily qualitative, quantitative community and health facility studies will also be conducted to capture the overarching changes which influence the household level changes. The data collection will be conducted by DAB Research and Training Consult.

2. Urban PSNP Program

[4] Bundervoet, T., Nakamura, S., Paci, P., Beyene, B. M., Finn,, A. J. Turk, C., Mylenko, N. (2020). Ethiopia Poverty Assessment - Harnessing Continued Growth for Accelerated Poverty Reduction (English). Washington, D.C.: World Bank Group.

2.1. Integrated safety net programme in urban areas

Ethiopia's UPSNP is an essential element of the country's National Social Protection Program designed to enhance inclusive growth and development in urban areas. The first phase of UPSNP began in 2016 and lasted in 2020/1. The second phase was launched in early 2022[5]. The UPSNP has three major integrated components: 1) basic safety net support, including productive and predictable transfers through conditional and unconditional transfers; 2) livelihood services, including interventions that facilitate graduation from the program and promote moving out of poverty; and 3) capacity building (Institutional Strengthening, Project Management, and Coordination) for immediate safety net support for the urban poor. The UPSNP currently covers 11 major cities, including Addis Ababa, and about 600,000 beneficiaries. It is ultimately intended to support over 4.7 million urban poor in around 972 cities and towns[6].

Like the more established (rural) PSNP, the UPSNP has a public works (PW) component that employ poor households with able-bodied members in small-scale infrastructure and social services development and maintenance, urban beautification, watershed development, clean river basins and sewerage system, and urban agriculture projects. The UPSNP also has a permanent direct support (PDS) component that provides unconditional cash transfers to labour-constrained households. In addition, UPSNP puts forth a new component: financial and in-kind support (shelter, healthcare, counselling, reunification, education and vocational support) to the urban "destitute", which include people living on the street or working on the street in precarious conditions.

Despite meeting its ambitious objectives to develop a national social safety net, Ethiopia does not yet have a comprehensive and integrated social protection system that supports individuals throughout their lifecycle. Against this background, UNICEF has been supporting Ethiopia's social protection sector for over a decade. One of the ways in which it has done this is by working with the government to model specific programme design features in selected districts. Where they were found to be successful, the design features were then integrated into the programme implementation manuals of the PSNP and influenced the legal framework as well as broader institutional/programmatic arrangements for social protection.

The Integrated Safety Net Programme (ISNP) is a pilot programme financed by the Swedish International Development Agency (SIDA) and implemented by the Government of Ethiopia with UNICEF's support in 2018-2023. It represents the third generation of UNICEF-supported social protection pilot programmes in Ethiopia. While the ISNP started in rural areas (piloting in the Amhara region) to inform Phase 5 of the rural PSNP, an urban ISNP is more recently being envisioned. Ethiopia's efforts to implement social protection in urban areas is much more recent and thus the ISNP represents the first time a UNICEF-supported pilot targets an urban population.

The urban context is vastly different from that in which traditional social protection programmes operate in the region and it demands a tailored approach. The ISNP aims to contribute to fine-tuning social

[5] https://www.fanabc.com/english/addis-ababa-launches-second-phase-of-productive-urban-safety-net-programme-with-450mln/

[6] ILO (2021). Mapping of the National Social Protection System in Ethiopia, including Social Health Protection. Final Report. Geneva 22, Switzerland

protection programming in urban areas, basing it on a Cash Plus approach - which exploits the symbiotic and mutually reinforcing relationship between cash and social services to the advantage of programme participants - and focusing on making social protection child- and disability-sensitive.

The Urban ISNP will, first and foremost, seek to reinforce the planned design of the UPSNP. There are elements that are part of the UPSNP in theory but that have not been implemented yet or whose implementation modalities have not been detailed. The ISNP will support the Government of Ethiopia by testing the implementation of these elements for the first time and contributing to the elaboration of detailed and specific guidelines on how to implement them. In particular, the ISNP will pilot a "Cash Plus" approach to social protection, which will be delivered through the inter-sectoral case management of participating households.

To systematically document the progress of households under UPSNP, an impact evaluation study based on longitudinal data were designed due to uncertainty on the implementation design. As part of the study design, the first wave of the mixed-methods study was implemented between April to June 2021 which provided a snapshot of the socioeconomic conditions of the UPSNP households. The baseline study finds that, on average, households received transfers from UPSNP monthly. Ontime transition to temporary direct support among pregnant and lactating women in the past 2 years was very low – about 53% of the pregnant women have worked on PWs at any time during pregnancy. Insurance coverage was about 65% of PW and about 84% of PDS households at the time of the baseline study. It was also found that sample households have, on average, close to three meals per day; about 69% of households worried about that the household would not have enough food in the past four weeks, and about 51% reported that they were food insecure for at least one month in the 12 months prior to the study data collection. Regarding housing conditions, while 3 and 2 people in PW and PDS households respectively occupy a single room, all households had access to electricity, 95% have finished roof, and 17% have finished wall. Exposure to shock was high as 71% of households experienced at least one covariate or idiosyncratic shock in the last 12 months. The evidence also showed that while about 23% think that the shocks were entirely related to COVID-19, about 40% of households think that the shocks were partly related to COVID-19. Finally, regarding the nutrition and feeding knowledge by caregivers, 87% of caregivers reported that babies should be breastfeed immediately after birth, 75% report that colostrum should be given to babies soon after birth instead of throwing it away, and that 80% of households report that children be exclusively breastfeed in their first six months after birth.

An approximately a 24-month follow-up (wave 2) study is scheduled for May 2023 to December 2023, with data collection phase expected to take place in August 2023. This inception report outlines the overall approach, timelines as well as roles and responsibilities of partners.

The follow up study has two primary aims: 1) to examine the progress in the implementation of the ISNP components in Addis Ababa; and 2) to provide a 24-month follow-up evidence (qualitative) of early changes in core outcomes and pathways of change among UPSNP clients related to program objectives (with a focus on the intermediate, and mid-term, outcomes presented in the conceptual framework (Section 2.2).

The overarching objective of the research is to evaluate the effects of ISNP programming on institutional capacity of implementing partners and document the changes in the welfare of UPSNP beneficiary household in urban settings (Addis Ababa), particularly that of women, children, and other vulnerable groups, and examine their participation in the UPSNP and access to, and uptake of complementary services, UPSNP cash utilization and response to shocks and resilience. This will help to identify needs and the most critical programming gaps that could be addressed by the ISNP in order to improve the overall welfare of ISNP households. The study will also assess the availability and quality of existing services to be integrated with the UPSNP and knowledge and access to frontline service providers by clients.

2.2. ISNP conceptual framework

The conceptual framework guiding the overall ISNP impact evaluation is illustrated in Figure 1, which shows the pilot's various components, identifies relevant individual and household indicators, and suggests potential impact pathways. This framework draws from existing evaluations of the PSNP and related pilots, which suggest that cash transfers such as the PSNP have positive effects on food security, consumption and other aspects of wellbeing, but cash alone is often insufficient to achieve all health and nutrition-related outcomes of interest[7,8]. Thus, complementary programming such as linkage to existing services or additional, integral program components (information/BCC, additional benefits or psychosocial support) may help to boost the impacts of cash, which alleviates binding income constraints but may not overcome other barriers to accessing services[9,10].

The ISNP conceptual framework reflects a holistic approach, integrating services and program components across sectors to address income and other determinants of health and nutrition. It also draws on the UNICEF nutrition framework, which recognizes that malnutrition among children is only partially explained by inadequate access to food, and is additionally determined by factors such as inadequate care for children and women, insufficient health services, hygiene and environment, and caregivers' education[11,12]. In this way, the ISNP pilot aims to target additional, underlying determinants of child malnutrition beyond income constraints (poverty). The ISNP also focuses on supply-side moderators illustrated in the conceptual framework – namely availability and quality of public services – by reinforcing training, staffing and improving information channels about existing services. More details about the conceptual framework and pathways of change are described in the ISNP baseline report[13].

Figure 1: ISNP conceptual framework

[7] UNICEF, MOLSA, & IFPRI. (2020). *Impact evaluation of improved nutrition through Integrated Basic Social Services and Social Cash Transfer Pilot Program (IN-SCT) in Oromia and SNNP Regions, Ethiopia*.

[8] Berhane, G., Gilligan, D. O., Hoddinott, J., Kumar, N., & Taffesse, A. S. (2014). Can social protection work in Africa? The impact of Ethiopia's productive safety net programme. *Economic Development and Cultural Change*, *63*(1), 1-26.

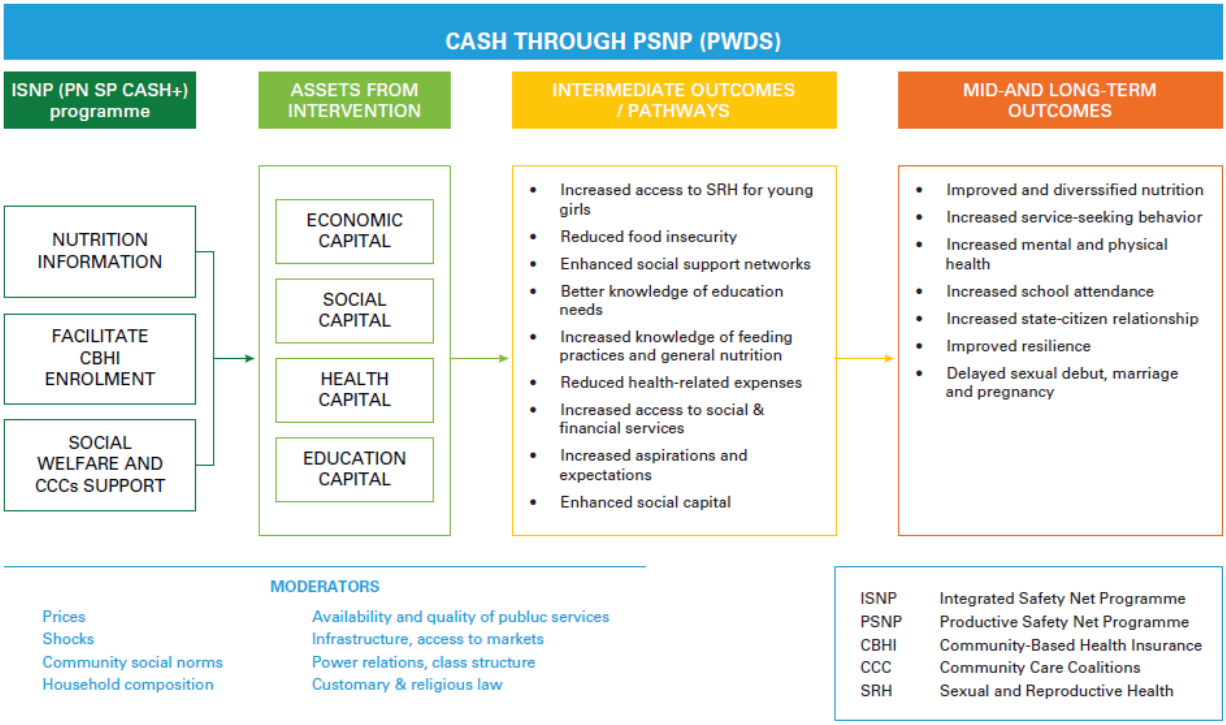
[9] UNICEF, MOLSA, & IFPRI. (2020). *Impact evaluation of improved nutrition through Integrated Basic Social Services and Social Cash Transfer Pilot Program (IN-SCT) in Oromia and SNNP Regions, Ethiopia*.

[10] Roelen, K., Devereux, S., Abdulai, A.-G., Martorano, B., Palermo, T., & Ragno, L. P. (2017). *How to make 'cash plus' work: Linking cash transfers to services and sectors*. UNICEF Office of Research.

[11] UNICEF. (2013). *Improving child nutrition: The achievable imperative for global progress*.

[12] UNICEF, MOLSA, & IFPRI. (2020). *Impact evaluation of improved nutrition through Integrated Basic Social Services and Social Cash Transfer Pilot Program (IN-SCT) in Oromia and SNNP Regions, Ethiopia*

[13] ISNP Evaluation Team. (2021). *Impact evaluation of the Integrated Safety Net Programme in the Amhara Region of Ethiopia: Baseline report*.



2.3. Evaluation questions

The study has the following general evaluation questions:

- How does UNICEF supported-ISNP strengthen the institutional capacity of Bureau of Women, Children and Social Affairs (BoWCSA) and Ministry of Women and Social Affairs (MoWSA) to support vulnerable UPSNP clients?
- How does the integration between the UPSNP and health and social support services affect the well-being of the UPSNP clients, including their enrollment into CBHI, utilization of basic services, and their health and nutrition outcomes?

The study will address the following primary and secondary research questions:

Primary research questions:

1. What is the **main demand- and supply-side barriers** to CBHI enrolment and access to other available services among UPSNP beneficiaries?
2. How does the **integrated programming mitigate barriers** to accessing and utilizing CBHI among UPSNP beneficiaries?
3. How does the integrated programming positively **impact the health and nutrition status** of UPSNP clients? What are the main determinants and pathways?

4. How does an integrated implementation of UPSNP and CBHI **affect the health-seeking behaviour** as well as the **ability and willingness-to-pay** for health insurance of UPSNP clients?
5. How does the UPSNP integrated programming **affect the use of the urban productive safety net and job programme monthly cash transfer** of client's households?
6. Do UPSNP linkages to CBHI **mitigate impacts of health shocks** for the PSNP beneficiaries?

Secondary questions of interest include:

1. Does the ISNP increase UPSNP clients' **knowledge of social worker (SW) activities** and services?
2. Does the ISNP increase **help seeking with social workers** among client households?
3. Does the ISNP increase UPSNP clients' **access to, and uptake of social support**?
4. Does the ISNP increase children's **school attendance**?
5. Does the ISNP improve **multi-sectoral collaboration and coordination** among social workers, health extension workers, and other relevant service providers?
6. Does the ISNP improve **linkages and coordination** between **PSNP and CBHI staff**?

3. Approach and Methodology

The qualitative endline evaluation (24 months after baseline study) does not measure impacts per se but rather it captures qualitatively the perceived changes experienced by the UPSNP households as a result of their participation in the pilot. As such, our sample for qualitative study focuses only on treatment communities (sub-cities) to understand what changes have occurred based on clients' perceptions, as well as identify pathways and reasons behind these changes (or lack thereof) that are attributable to the programme. As shown in Table 2, the methods used for endline data collection include key informant interviews (KIIs), in-depth interviews (IDIs) and focus group discussions (FGDs), which are described in detail in Section 3.1.2. The UPSNP beneficiary households are generally categorized as vulnerable to extreme poverty based on assessment of key socioeconomic indicators such as assets, income and access to social services. This study does not involve children as direct study participants or respondents.

The study will also conduct community and health facility surveys to document the overarching changes in all the baseline sub-cities which could explain or help to triangulate the outcome changes at the individual and household level.

As a result, the qualitative study will be conducted to the ISNP Pilot sub-cities, Addis Ketema and Arada. Within sub-cities, the qualitative sample will include three woredas, which will be decided in collaboration with UNICEF Ethiopia Country Office.

3.1 Qualitative study

3.1.1 Sampling and data collection instruments

A. In-depth interviews (IDIs)

A total of **45 in-depth interviews** will be conducted with primary caregivers to examine the changes in the wellbeing status of UPSNP clients, focusing on women and children aged 0-17, their experience of participation in the UPSNP program, and access and utilization of complementary services.

The key wellbeing indicators of interest will be grouped across three areas, as follows:

1) Women's and children's economic and livelihood security, health and nutrition outcomes, barriers to enrolment into and utilizing CBHI and access to other available services, and caretakers' health-seeking, dietary and feeding practices, resilience to income shocks, knowledge of social worker activities and services and help seeking with social workers, access to and uptake of social support;
2) Women's empowerment related to access to and control/ utilization of cash, agency and bargaining power, health and bodily integrity, psychosocial welfare, and mental health; and
3) Child protection and adolescent outcomes (eg. child labour, time use, sexual and reproductive health, drug and substance abuse, mental health etc.).

In addition to the above-mentioned topics, the IDIs will also explore whether and how the ISNP implementation influenced the utilization of cash received from the UPSNP and job programme and role of integration between UPSNP and CBHI in mitigating impacts of health shocks. Furthermore, IDIs with pregnant and lactating mothers will examine issues including nutrition and feeding practices, experience

of pregnancy, access to maternal healthcare services, co-responsibilities, and participation in Behavioral Change Communication (BCC) sessions.

B. Key informant interviews (KIIs)

The study will interview a total of **30 key informants** to learn about the UPSNP design and programme delivery, implementation bottlenecks and challenges with a focus on integrated programming and linkages to complementary services and benefits. KIIs will involve social workers, health extension workers (HEWs), Kabos (public work controllers) at the Ketena level and UPSNP and ISNP programme coordinators, CBHI coordinators, MIS, and BoWSA staff at the woreda level. In addition, interviews will be conducted with MoWSA Federal Health Insurance Agency, and staff from UNICEF Ethiopia to capture overarching issues related to integrated program design, implementation and sustainability. KIIs in general will elicit both the feedback and recommendations from the key stakeholders on the program-related processes and procedures, including success factors and challenges.

Specific topics with informants may include issues related to targeting, enrolment and payment process, co-responsibilities, BCC strategies, availability and quality of complementary programmes, services and linkages, referral mechanisms, MIS and transition protocols,[14] mandates and capacities of UPSNP staff, frontline workers and key service providers, and perceptions about how these contribute to changes in beneficiaries' wellbeing.

KIIs may also explore respondents' experiences and perceptions about the relevance and quality of the PSNP design and implementation in urban context, their awareness and understanding of their roles (including case management and cross-sectoral work), their commitment towards coordination, and opportunities and bottlenecks to effective multi-sectoral collaboration and coordination and linkages and coordination between UPSNP/ISNP and CBHI staff. Finally, KIIs with social and health extension workers will also explore beneficiaries' take-up of services offered as part of the ISNP.

C. Focus group discussions (FGDs)

One set of **6 focus group discussions**, with a total of about 48 participants, will be conducted with specific client groups including very vulnerable beneficiaries of the UPSNP to examine the multidimensional aspects of their wellbeing, including food security and nutrition, health, physical security and protection from abuse and violence, and psychosocial welfare and map their access to, and uptake of integrated services.

FGDs may involve discussions with extremely poor families, such as socially excluded female-headed households with children, and/or families with a disabled member of the household, or groups of adolescent boys and girls at risk. The FGDs will focus on beneficiaries' experiences, perceptions and awareness of the available integrated interventions offered to them, as well as the extent to which their

[14] These refer to protocols adopted to facilitate transition of clients from the public works scheme into temporary direct support.

specific needs and rights are met through the administrative and programme design features, such as case management and referral systems, targeting procedures in UPSNP, and rights and grievance mechanisms. Furthermore, the FGDs will also collect data on barriers to enrolment into and utilizing CBHI and access to other available services and response for and resilience to income shocks.

3.1.2 Data collection

The qualitative data collection will be led by DAB consulting. Th data collection will follow all the standard ethical requirements (e.g. seeking ethical clearance before training of field staff) and oral consent will be sought from interview participants. With consent from the interview participants, all of the interviews and FGDs will be audio recorded, transcribed verbatim and translated to English. Field teams will meet after each day of fieldwork to review key themes, address questions and concerns and identify any topics for further probing. Interviewers will write detailed field notes immediately following each interview using a structured template. Same-sex interviewers will conduct the qualitative interviews with UPSNP clients and female adolescents.

3.1.3 Qualitative data analysis plans

Qualitative analysis will be conducted in two phases: 1) rapid initial analysis to document observations during fieldwork and 2) in-depth analysis to increase overall understanding of changes in participants' lives. In the in-depth phase, the qualitative research team will develop analytic summaries for all participants, highlighting the changes from first visit, 24 months ago. These summaries will be organized around key themes and research questions, in order to simultaneously code the data to identify patterns in the key areas of interest to the program. The team will also identify illustrative quotes in the transcripts to reflect key themes. All interviews will be audio-recorded and transcribed in local language before being translated into English. The local research team will check the validity of the English translations to ensure local language nuances are captured. Transcripts will be analysed using Atlas.ti software. A codebook will be created using a priori themes from the interview guides and supplemented with themes that emerge during data analysis[15],[16]. Initial coding structures will be developed by the UNICEF Innocenti lead qualitative analyst and then shared with two other coders for recoding. In this way, the final coding structure will be validated, ensuring consistency in the application of codes.[17]

3.2. Health facility and community surveys

3.2.1 Data collection

[15] Denzin, N. K., & Lincoln, Y. (2000). Qualitative research. Thousand Oaks, CA, 413-427

[16] Weber, R. P. (1990). *Basic content analysis* (No. 49). Sage.

[17] MacQueen, K. M., McLellan, E., Kay, K., & Milstein, B. (1998). Codebook development for team-based qualitative analysis. *CAM Journal*, *10*(2), 31-36.

The community and health facility surveys will cover both the pilot and comparison sub-cities: Addis Ketema, Arada, Kirkos and Lideta. Within the study sub-cities, data will be collected in each ketena using the following instruments:

- Community questionnaire (to be administered to urban ketena leaders)
- Health facility questionnaire (to be administered to all health facility in the Ketenas included in the sample)

Health facility surveys will be administered to all baseline and newly constructed, if any, government dispensaries and primary health care facilities. Data will be collected from official logbooks and via face-to-face interviews with health care workers including information around child preventive and sick visits, nutrition-related services, barriers to health services provision using CBHI, and family planning.

Community surveys will be administered to a knowledgeable individual/group of individuals (e.g., a community leader, teacher, etc.) in each ketena to assess topics such as access to markets, and services, health facilities, schools, implementation of USNP, and shocks.

3.2.2 Data analysis plans

After data are collected, we will provide an in-depth analysis of the changes at health facility and ketena levels with respect to demographics and type of PSNP modality (i.e. PW, TDS and PDS). In addition, a supply-side analysis of social services will be conducted. This will help identifying the structural barriers in access to services and its linkage with PSNP. This analysis will help identifying the main gaps in services and will be used for producing policy recommendations in relation to the design and the implementation of the UPSNP as well as to the components of the UISNP. It also helps to triangulate the changes at the beneficiary level, or absence of change, with respect to main project outcomes. DAB consulting will also be responsible for the community and health facility data collection trainings and implementation of the data collection.

3.3 Training of field staff

DAB consulting will be responsible for all logistics and planning related to hiring and selection of enumerators, training, and fieldwork implementation. UNICEF Innocenti researchers will participate in training and observation of initial fieldwork. UNICEF Ethiopia will also provide technical support throughout the implementation of the evaluation.

Training of data collectors will occur over a 4-days period, including sessions on an overview of the study, refresher on research ethics, in-depth training on the survey instruments, field piloting of the instruments, and a debriefing session for the pilot. During the training, survey tools will be further adapted to the local context and changes/ major events through the feedback from local field staff and supervisors.

Qualitative and quantitative (health facility and community surveys) data collection will be implemented by two teams of field staffs comprised of qualitative researchers and one supervisor. Supervisors will be responsible for the data quality checks and the collection of community and health facility surveys. Community interviews are expected to last approximately 25-30 minutes per respondent.

4. Workplan and Timeline

The tentative timeline for the planned work is outlined below. Exact months may shift due to receipt of ethical review or other unforeseen events.

Table 3: Workplan and timeline

Facticity	**July 23**	**Aug 23**	**Sept 23**	**Oct 23**	**Nov 23**	**Dec 23**
Draft Inception report						
Revision of inception report						
Submission of final inception report						
Study preparatory activities						
Secure ethical clearance						
Training of qualitative researchers						
Piloting and debriefing						
Deployment for data collection						
Data collection						
Data analysis						
Transcription & translation of interviews						
Revision of Transcription & translation						
Cleaning and analysis of community and health facility data						
Draft report for review						
Report revision						
Submission of Final report						

Appendix 1. Analytical themes and target respondents for IDIs, KIIs and FGDs

A) Topics covered in IDIs

Type of respondent	Health status	Health-seeking behavior	Enrollment into CBHI	Access to education	Nutrition/ feeding practices	Experience of pregnancy	Access to maternal healthcare	Quality of PSNP implementation	Co-responsibilities	BCC sessions	Complementary services
PW clients	x	x	x	x				x		x	x
PDS clients	x	x	x	x				x	x	x	x
TDS clients – pregnant woman	x	x	x		x	x	x	x	x	x	x
TDS clients – lactating woman with infant child	x	x	x		x	x	x	x	x	x	x
TDS clients – caregiver with a malnourished child	x	x	x		x			x	x	x	x

B) Topics covered in KIIs and FGD

Type of informant	PSNP implementation	TDS	Co-responsibilities	Case management	BCC	Rights and grievance mechanisms	Multi-sectoral collaboration	MIS	Relevance of plus interventions	Impact and Sustainability
KII										
MoWSA staff	x	x		x		x	x		x	x
BoWSA staff	x	x	x	x		x	x		x	x
UNICEF Staff	x	x		x		x	x		x	x
PSNP/ISNP Coordinator	x	x	x	x	x	x	x	x	x	x
CBHI Coordinator	x	x		x		x	x		x	x
MIS focal person								x		
Social Worker	x	x	x	x	x	x	x	x	x	x
Health Extension Worker	x	x	x	x	x	x	x		x	x
Kabo	x	x	x	x	x	x	x		x	x
FGD										
Mixed PW & PDS	x				x	x			x	X
Pregnant women		x	x	x	x	x			x	
Lactating mothers		x	x	x	x	x			x	