



Understanding the Implementation and Perceived Outcomes of Integrated Social Protection in Addis Ababa

A mixed-method impact evaluation

UNICEF Ethiopia

June 2024

Contents

Contents	1
Synopsis.....	1
UPSNP in Ethiopia	1
Evaluation rationale and research questions	1
Methodology	2
Research findings	2
Recommendations	8
1 Introduction	10
1.1 Background	10
1.2 The ISNP	11
1.3 The ISNP conceptual framework	12
1.4 Evaluation rationale, objectives and research questions	13
2 Methodology	15
2.1 Evaluation design and setting.....	15
2.2 Evaluation population and sampling	15
2.3 Data collection.....	16
2.4 Analysis strategy	17
2.5 Community characteristics.....	17
2.6 Health facilities' characteristics	20
2.7 Ethical considerations	21
2.8 Limitations, mitigation strategies, and lessons learned	22
3 Implementation of the UPSNP.....	23
3.1 Targeting Process	23
3.2 Transfers' regularity and adequacy	25
3.3 Insights on usage of cash transfer	26
3.4 Participation and coverage among pregnant and lactating women	28
3.4 Summary	32
4 Demand- and supply-side barriers to CBHI enrolment.....	33
4.1 Availability of CBHI services	33
4.2 Barriers for PDS households	34
4.3 Barriers for PW households	35
4.4 Summary	38

5	Role of ISNP in facilitating CBHI enrolment.....	39
5.1	Enrolment of PDS households	39
5.2	Enrolment of PW households	39
5.3	Summary	40
6	Perceived impact of CBHI enrolment on health-related outcomes	41
6.1	Health service utilization	41
6.2	Health and well-being	42
6.3	Out-of-pocket health expenditure and financial protection	42
6.4	Satisfaction with health services	44
6.5	Summary	47
7	Linking UPSNP beneficiaries to social services through Integrated Programming	49
7.1	Beneficiaries' Responsibilities.....	49
7.2	Behavioural change communication sessions	51
7.3	Accessibility to and beneficiary interaction and satisfaction with service providers	55
7.4	Integrated Programming: Opportunities and barriers to intersectoral collaboration	58
7.5	Summary	60
8	Perceived impacts of ISNP on intermediate and mid-term outcomes.....	61
8.1	Food security	61
8.2	Infant and Young Child Feeding Practices.....	63
8.3	Care during pregnancy	64
8.4	Care for illness.....	66
8.5	Summary	68
9	Conclusions, Discussion and Policy Recommendations.....	69
9.1	Conclusions and discussion of key findings.....	69
9.2	Recommendations	71
	References and Endnotes	78
	Annex	81
	Annex 1: Characteristics of Qualitative Sample.....	81
	Annex 2: The number of clients that received care within a one-month time	82
	Annex 3: Availability of various supplies at the health facility on the day of the interview	83
	Acronyms	85
	Acknowledgements.....	87

Synopsis

UPSNP in Ethiopia

The Government of Ethiopia is implementing an Urban Productive Safety Net Project (UPSNP) in 83 urban cities, including Addis Ababa, to tackle vulnerability and poverty among urban households. The UPSNP is a multifaceted programme that involves a public works (PW) component and a permanent direct support (PDS) component that provides unconditional cash transfers to beneficiaries, such as the elderly, chronically ill individuals, and female-headed households that are labour-constrained. The programme also provides temporary direct support (TDS) to pregnant and lactating women in PW households until one year after childbirth.

In collaboration with the Government of Ethiopia, the United Nations Children's Fund (UNICEF) facilitates the linkages of services for UPSNP beneficiaries. In 2018/2019 UNICEF introduced the Integrated Safety Net Programme (ISNP) pilot in Addis Ababa as an addition to the UPSNP. One of the ISNP's objectives is to increase community-based health insurance (CBHI) enrolment and strengthen the linkages to social services. ISNP complementary features encompass CBHI enrolment facilitation, case management support, behavioural change communication sessions, and beneficiary co-responsibilities to increase access to and uptake of social services. The findings of the pilot will assist the Government of Ethiopia by evaluating the implementation of these elements for the first time and foster the development of a comprehensive and integrated social protection system.

Evaluation rationale and research questions

To assess and document the benefits of the complementary features to the UPSNP, a mixed-method evaluation was designed to assess the potential impacts of the intervention. A baseline assessment was conducted prior to the implementation of the ISNP in 2021, and a follow-up evaluation was necessary to evaluate the implementation. In answering this question, the evaluation findings could guide the design features of later phases of the UPSNP and broader social protection policy in Ethiopia.

The current evaluation is the follow-up of the ISNP after 24 months of implementation. It has three primary aims: 1) to examine the progress in the implementation of the ISNP components in Addis Ababa; 2) to provide 24-month follow-up evidence (qualitative) of the perceived changes by the UPSNP households and identify pathways and reasons behind these changes (or lack thereof) that are attributable to the ISNP pilot; and 3) to contextualize the implementation progress and perceived impact vis-à-vis supply-side constraints.

In fulfilling the aims stated above, the evaluation asks the following research questions:

1. What are the **factors that have influenced** the implementation of the **UPSNP**?
2. What are the **main demand- and supply-side barriers** to CBHI enrolment among UPSNP beneficiaries?

3. How does the **integrated programming mitigate barriers** to accessing and utilizing CBHI among UPSNP beneficiaries?
4. How does the CBHI **impact UPSNP beneficiaries including health service utilization, out-of-pocket expenditures, and health status**?
5. What are the **main determinants and pathways the integrated programming** influences the health and nutrition status of UPSNP beneficiaries?
6. What are the **perceived effects** of the integrated programming on food security, nutrition and health?

Methodology

This is a mixed-method evaluation with a qualitative research design to elicit stakeholders' views and experiences in the ISNP implementation to enhance access and uptake of social services and quantitative surveys at community and health facility levels to determine the supply-side constraints. The qualitative evaluation was conducted in the two sub-cities that piloted the ISNP-Addis Ketema and Arada, and two non-pilot sites- Kirkos and Lideta. The qualitative data includes 35 Key-Informant Interviews (KIIs), 20 In-depth interviews (IDIs), and 8 Focus Group Discussions (FGDs) with beneficiaries. The qualitative findings were triangulated with a community survey of 127 communities at baseline and 168 communities at follow-up, as well as a health facility survey with 19 and 20 health facility managers at baseline and follow-up, respectively.

Research findings

Overall, the evaluation demonstrates that cash transfers and complementary provisions (CBHI enrolment, BCC sessions, co-responsibilities, and interactions with service providers) are both instrumental in the uptake of social services. Strategies focusing on the demand-side, such as co-responsibilities and BCC sessions proved effective in raising awareness of practices and services previously unfamiliar to beneficiaries. The multisectoral collaboration facilitated by the programme enabled beneficiaries to enrol into the CBHI to access and utilize health services. However, external factors such as high inflation rates posed significant challenges to the adequacy of cash transfers for applying the acquired knowledge. Furthermore, internal challenges such as the shortage of social workers and budget constraints also affected the effectiveness of the complementary features.

UPSNP implementation

The qualitative findings show that the implementation of the core components of the UPSNP, such as targeting, cash transfers payment and TDS have improved through effective multi-sectoral collaboration, but gaps remain that need to be addressed.

Synopsis Box 1: Implementation

Targeting process

Facilitators

- Training of committee members involved in community-based targeting to ensure selection of beneficiaries is not based on personal relations.
- Retargeting to exclude ineligible beneficiaries.

Barriers

- Limited involvement of well-informed stakeholders in the targeting process.
- Limited budget to include all eligible households.

Cash transfers

Facilitators

- Collaboration with bank institutions to open bank accounts for beneficiaries.
- Home visits by social workers to monitor cash transfers payment and spending.

Barriers

- High inflation rates affecting the purchasing power of the transfer.

TDS participation during pregnancy and lactation

Facilitator

- Provision of TDS information immediately after entering the programme.

Barriers

- Lack of early pregnancy awareness among women.
- Women's unwillingness to disclose pregnancy status and provide proof of pregnancy to programme officials due to their fear of not finding other able-bodied household members to replace them.
- Major miscommunication and misinterpretation of the guidelines that pregnant and lactating women should be replaced by able-bodied household members in order to transition into TDS, which is not the case as stated by programme guidelines.

Demand- and supply-side barriers to CBHI enrolment

The findings show that the enrolment of PDS beneficiaries in CBHI is high. However, demand- and supply-side barriers hinder their universal insurance coverage. The primary supply-side barrier particularly for new PDS beneficiaries is misalignment between UPSNP targeting and CBHI enrolment periods. Many PW beneficiaries are not enrolled or have not renewed their membership due to several reasons, with affordability being the key barrier.

Synopsis Box 2: CBHI enrolment and barriers

PDS Households

The findings show that the CBHI enrolment of PDS beneficiaries is high. However, demand and supply side barriers hinder universal insurance coverage among PDS beneficiaries. The main barrier for PDS households after receiving the fee waiver is lack of support to activate CBHI cards. As many of these households are the elderly and may have reduced mobility, accessing CBHI offices to complete all the necessary requirements for CBHI is a major hurdle. Other demand-side issues include age-related challenges, such as forgetfulness about enrolment period and misconceptions from religious beliefs. The primary supply-side barrier, particularly for new PDS households, is misalignment between UPSNP targeting and CBHI enrolment periods. The targeting process for new PDS beneficiaries under UPSNP typically occurs periodically, whereas CBHI enrolment takes place annually, during the enrolment period between October and November. However, new beneficiaries joining UPSNP after the CBHI enrolment period often face delays in enrolment into the scheme due to administrative delays in transmitting their information to CBHI or delays by CBHI in activating their cards.

PW households

Many PW beneficiaries are not enrolled or not planning to renew their membership because of affordability of CBHI premiums. Amidst the high inflation, the cash transfers are insufficient for PW households to prioritize health insurance. Another demand-side barrier is limited understanding of CBHI benefits. Supply side barriers such as shortage of medicines at public health institutions and perceived limited benefit package also hinder CBHI enrolment and renewal among PW beneficiaries.

The role of ISNP in facilitating CBHI enrolment

ISNP has played a key role in CBHI enrolment of UPSNP beneficiaries, particularly PDS households. It shows how the programme has mitigated many of the challenges households face when enrolling in CBHI. Nevertheless, challenges remain to ensure all UPSNP beneficiaries are enrolled in the scheme.

Synopsis Box 3: ISNP and CBHI enrolment

Enrolment of PDS households

The findings suggest that coordination between the UPSNP staff, CBHI and health offices facilitated the provision of premium waivers to PDS beneficiaries. However, it is important to note that the fee waiver alone is insufficient for enrolment. Social workers play a crucial role in raising awareness about enrolment periods and assisting the elderly and those with reduced mobility in activating their CBHI cards. The inadequate number of social workers impedes the provision of this essential support to all beneficiaries who require it. In addition, the misalignment of PDS targeting and CBHI enrolment periods remains a challenge for new PDS beneficiaries to enrol immediately into the scheme.

Enrolment of PW households

The findings also show that PW beneficiaries are aware of CBHI and its benefits. They receive CBHI information from within and outside the programme. Some beneficiaries use their cash transfer for CBHI premiums, but many are unable to afford the premiums. Currently, the alternative strategy is by the CBHI and Health offices to use sponsorship from private entities to cover enrolment for some PW households.

Perceived impact of CBHI enrolment on health-related outcomes

The findings show that CBHI removal of the financial barrier to accessing health care has had many positive impacts on UPSNP beneficiaries. To boost further positive impacts, service delivery challenges such as shortage of medicines need to be addressed.

Synopsis Box 4: Impacts of CBHI

Health service utilization

The findings suggest that the scheme has increased service utilization by removing the key challenge to access care and affordability of health services. Previously, beneficiaries had to rely on other alternatives such as religious sites or forego care altogether, but with health insurance coverage most primary health care services, beneficiaries are now able to access essential services.

Health and well-being

The findings also suggest that health insurance has improved beneficiaries' health by enabling them to receive necessary health interventions. Furthermore, the CBHI has relieved the mental stress associated with healthcare costs.

Out-of-pocket health expenditure

The scheme covering most primary health care services has reduced out-of-pocket payments. However, frequent shortage of medicines threatens financial protection as beneficiaries' cash transfers are insufficient to cover medicines at private health institutions.

Satisfaction with health services

The findings suggest that beneficiaries are satisfied with the quality of care under CBHI, but there is room for improvement, particularly in the quality-of-service delivery. Shortages of medicines and perceived discrimination of CBHI members must be addressed to sustain service utilization and CBHI enrolment among PW beneficiaries.

Linking UPSNP to social services through integrated programming

The findings suggest that the effectiveness of BCC and co-responsibilities relies on several factors, including sufficient financial resources available to beneficiaries, effective multisectoral collaboration and an adequate number of social workers.

Synopsis Box 5: Integrating UPSNP and social services

Co-responsibilities

Participants' responses indicate that the impact of co-responsibilities depends on existing social practices and financial resources to fulfil these conditions. For instance, as women were already aware of maternal health services, the introduction of co-responsibility did not significantly influence their behaviour. However, life skills and financial literacy training sessions for PW households were better appreciated, as they were able to apply the acquired knowledge to improve their economic situation and social well-being.

BCC sessions

While BCC sessions are provided, resource constraints lead programme staff to prioritize community-based BCC sessions, which may not often suit PDS and TDS beneficiaries. However, the findings show that BCC attendance and engagement with frontline workers have positively influenced beneficiaries' utilization of cash transfers for food and increased their nutrition knowledge.

Interactions with service providers

Beneficiaries tend to interact more with health extension workers, and their interactions have influenced beneficiaries' hygiene practices and health literacy. Even though, their interactions with social workers were less frequent, they were able to engage with them to some extent. Having sufficient number of social workers is a key factor for interactions with beneficiaries. However, challenges in government financial constraints and poor working conditions impede social workers' recruitment and retainment.

Intersectoral collaboration

The findings suggest key partners are committed to intersectoral collaboration to ensure beneficiaries receive social services. However, collaboration efforts are constrained by resource scarcity, high staff turnover and restructuring of government administration.

Perceived impacts of ISNP on intermediate and mid-term outcomes

The analysis revealed the complex ways in which both the cash transfers and the complementary features of the ISNP influence the health and nutrition of beneficiaries. Both cash transfers and the complementary features are instrumental in the uptake of health services and nutrition practices. The findings shed light on different perceived impacts resulting from the programme efforts, as well as challenges that have affected programme implementation.

Synopsis Box 6: Perceived impacts of ISNP

Infant and young child feeding practices

Lactating women reported breastfeeding their infants exclusively until six months because of attending BCC sessions offered by the programme and counselling by health facilities.

However, despite this knowledge, mothers are unable to effectively utilize it to improve the nutrition of their young children due to the impact of high food prices on households' food spending.

Care during pregnancy

Antenatal and postnatal care visits appeared to be high, but this may not be attributed to the co-responsibility of pregnant women to attend checkups as women already had prior knowledge. Furthermore, these services are available free of charge so not having CBHI did not deter their use.

Care for illness

The findings underscored the significant role of CBHI in facilitating the use of health facilities by addressing the affordability barrier. By reducing the financial barriers, CBHI has effectively increased the use of health facilities for illnesses. However, the use of health facilities remains non-universal as lack of social support, geographical barriers, misconceptions from religious beliefs and issues with service delivery quality hinder access to care for certain beneficiaries, particularly the elderly.

Recommendations

The evaluation findings provide crucial recommendations for policymakers and researchers to advance social protection for vulnerable populations in urban areas. Specifically, the findings can inform policy on integrated programming and strategies to increase the uptake of social services among UPSNP beneficiaries. Drawing on the findings, several policy recommendations have been proposed to improve UPSNP implementation.

Recommendations

Invest in sufficient, trained and competent social workers to enable them to provide the necessary support to beneficiaries.

- Improve education training of social workers to ensure they have the necessary knowledge and competency to support beneficiaries.
- Increase employment and positive working conditions for social workers.
- Strengthen governance and management of social workers.

Address general CBHI enrolment and barriers to renewal that affect coverage.

- Deepen the understanding of health insurance and be transparent about entitlements.

- Ensure timely and efficient enrolment and renewal processes.
- Identify and support PDS beneficiaries likely to need assistance with the renewal process.
- Timely transfer of new PDS beneficiaries' information to CBHI authorities.
- Encourage PW beneficiaries to save monthly from their own income for CBHI .
- Leverage a framework for public-private partnership for PW enrolment.

Collaborate with health partners to address the supply-side barriers of CBHI.

- Timely payment of contributions on behalf of PDS beneficiaries.
- Reexamine CBHI purchasing arrangements.
- Invest in strengthening health systems.

Revisit the programme benefits in collaboration with key partners to ensure external challenges do not regress the progress made by the programme.

- Provide nutritional support to PDS and TDS beneficiaries.
- Increase transfer size to reflect inflation rates.

Strengthen implementation by undertaking assessments of programme provisions to increase uptake of services.

- Undertake qualitative analyses to investigate the reasons for variations in TDS implementation.
- Explore how to tailor BCC delivery mechanisms for UPSNP beneficiaries according to their social demographics.
- Identify and involve key partners in the targeting process to optimize its effectiveness

Strengthen institutional arrangements to ensure the sustainability of multisectoral collaboration

- Define roles and responsibilities for case management.
- Develop action plans and procedures for change in staff.

1 Introduction

1.1 Background

Ethiopia is the second most populous country in Africa and the largest land-locked economy on the continent. Ethiopia's per capita income in purchasing power parity is just under 1000 USD (The World Bank, 2021). Nearly 69 per cent of the country's population is classified as multidimensionally poor, with 42 per cent experiencing severe multidimensional poverty (UNDP, 2023). In Addis Ababa, a report (UNDP, 2022) shows that the poverty rate has been increasing, driven by domestic and global shocks, such as the COVID-19 pandemic, the conflict in northern Ethiopia and the Ukraine war, all of which have exacerbated food inflation reaching approximately 30 per cent. Furthermore, poverty indicators for Addis Ababa have also shown a stark increase in recent periods. For example, while headcount poverty increased from around 17 per cent in 2016 to 26 per cent in 2022, poverty gap and poverty severity indicators almost doubled (UNDP, 2022).

Following the Rural Productive Safety Net programme, Ethiopia has made tremendous progress toward expanding social protection to urban areas. As more of the poor live in large urban centres, expanding development programmes to address key challenges to urban poverty reduction is critical. Socio-economic vulnerabilities in urban contexts are different compared to those typically experienced in rural areas. Homelessness and streetism are more likely to occur among the urban poor, and risks of human trafficking, sex work, drug abuse, and HIV/AIDS exposure are also higher among the urban poor. Moreover, opportunities for relying on natural resources, including land, forest and river bodies for livelihood are limited in urban settings, and reliance on kinship and family ties for survival are usually more limited in urban settings.

In 2016, the government rolled out the Urban Productive Safety Net Project (UPSNP) to address poverty-related challenges among poor urban households initially in 11 cities including the capital city, Addis Ababa. In the second phase, the programme has expanded to 83 cities and has been renamed to Urban Productive Safety Net and Jobs Project (UPSNJP). The programme aims to boost food security, self-sufficiency, and economic empowerment of the poor and vulnerable through 1) safety net support through cash transfer, 2) livelihood services, including interventions that facilitate graduation from the programme, and 3) strengthening existing government institutions.

The UPSNP is a multifaceted programme that involves a public works (PW) component that employs poor individuals in urban beautification, small-scale infrastructure, and social services development and maintenance for two years. It also has a permanent direct support (PDS) component that provides unconditional cash transfers to beneficiaries, such as the elderly, chronically ill individuals, and female-headed households that are labour constrained. The programme also offers temporary direct support (TDS) to pregnant and lactating women in PW households.

Despite its national social safety net's expansion, Ethiopia does not have a comprehensive and integrated social protection system to address multidimensional poverty and vulnerability. In 2016, the Government finalized its National Social Protection Strategy with a cross-sectoral approach focusing on five strategies in the areas of social safety nets, livelihoods and employment schemes, social health insurance, access to social services addressing violence and abuse, and providing legal protection and support (Ethiopia Ministry of Labour and Social Affairs, 2016).

As part of the effort to address the fragmentation challenges, the United Nations Children’s Fund (UNICEF), one of the main stakeholders of the UPSNP, has been facilitating the integration of services to reach the most vulnerable. UNICEF’s strategies include working with the government to model specific programme design features in selected districts to inform the design features of the UPSNP and influence policy as well as broader institutional/programmatic arrangements for social protection. Recently, UNICEF supported the Government with a pilot initiative, the Integrated Safety Net Programme (ISNP) in Addis Ababa. The ISNP aims to increase community-based health insurance (CBHI) enrolment and access to other social services among UPSNP beneficiaries.

The UPSNP objectives aim to contribute to a handful of the Sustainable Development Goals (SDGs). Specifically, it directly contributes to SDG 1 (no poverty), SDG 2 (zero hunger), SDG 3 (good health and wellbeing), and SDG 5 (gender equality). These direct contributions come from the provision of unconditional cash transfers and health insurance to labour- and health-constrained poor households, such as the elderly and pregnant women. The provision of cash in exchange for labour in the PW arm also contributes to households’ wellbeing and lowers hunger and poverty. Moreover, it indirectly contributes to SDG 4 (quality education and SDG 6 (clean water and sanitation), mainly coming from the case management (monitoring) component and the BCC sessions that enhance households’ knowledge on the importance of sanitation and nutrition for overall health of household members, including children and infants.

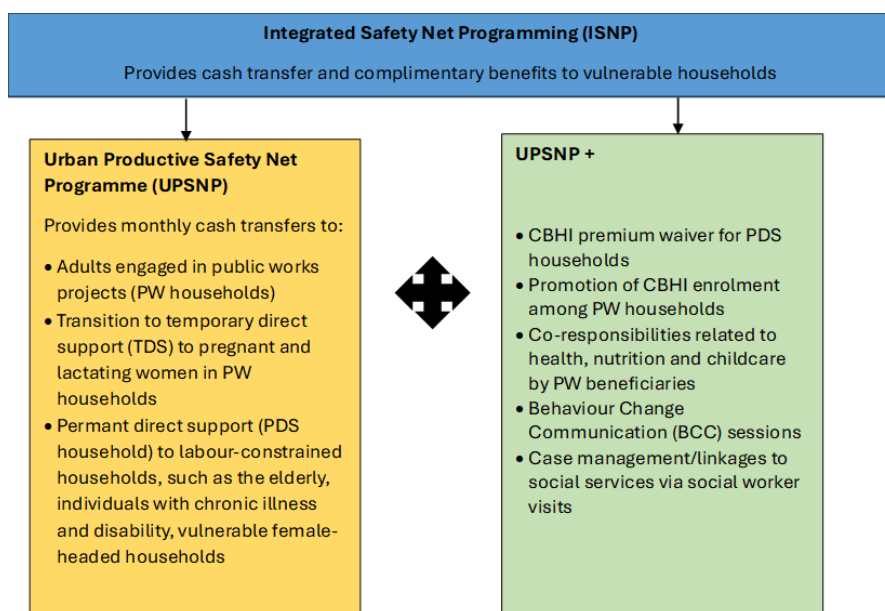
1.2 The ISNP

The ISNP has been piloted in two sub-cities, Addis Ketema and Arada in Addis Ababa from 2018 and is planned to continue until 2024. The ISNP builds on the UPSNP by providing integrated interventions in nutrition and health as well as CBHI enrolment of beneficiaries through a multi-sectoral collaboration approach (Figure 1). The provision of CBHI is central in the ISNP as it seeks to reduce out-of-pocket expenditures for health needs. Provision of health insurance schemes particularly, for poor and vulnerable populations is critical to access healthcare services with the overall aim of increasing universal health coverage as envisioned in target 3.8 of the SDG. In Ethiopia, CBHI is a voluntary scheme that only targets the informal sector. It began as a pilot between 2011 and 2013 in specific woredas (districts) and has since expanded coverage to 894 (7581%) of woredas nationwide as of 2021/22 (Ethiopian Public Health Institute (EPHI) et al., 2023). The design of CBHI which includes premiums and benefit packages, varies by region. Contributions are pooled at the woreda level, and the benefit package covers primary health services and curative care at public health institutions. The health insurance also covers referral hospitals, but only for those who receive referrals from primary healthcare providers. Financing of CBHI is through premiums from households and subsidies from the federal government.

Within the UPSNP, the programme increased the duration of the monthly transfers among PDS beneficiaries to 12 months a year, expanded the household programme responsibilities of public workers, and introduced co-responsibilities among pregnant and lactating women in public works who transitioned into TDS. The ISNP the programme is designed to facilitate CBHI premium exemptions for PDS beneficiaries, while PW beneficiaries receive information on CBHI enrolment and are required to pay their own CBHI premium. CBHI is a voluntary health insurance scheme established by the government to reduce out-of-pocket health spending among informal sector workers. Members pay an annual premium and caregivers’ memberships cover their dependents under 18 years. The provision of CBHI information to PW beneficiaries as well as CBHI premium exceptions for PDS beneficiaries is expected to increase health-seeking behaviour and utilization of services by reducing

out-of-pocket expenditures, a barrier to healthcare access among the poor and vulnerable population. Social workers in the programme also encourage and facilitate, if necessary, the enrolment of children in school and provide information and guidance to UPSNP households on nutrition, health-seeking behaviour and cash transfer expenditure. In addition, social workers deliver case management to support the links between UPSNP beneficiaries and health and social services.

Figure 1 description

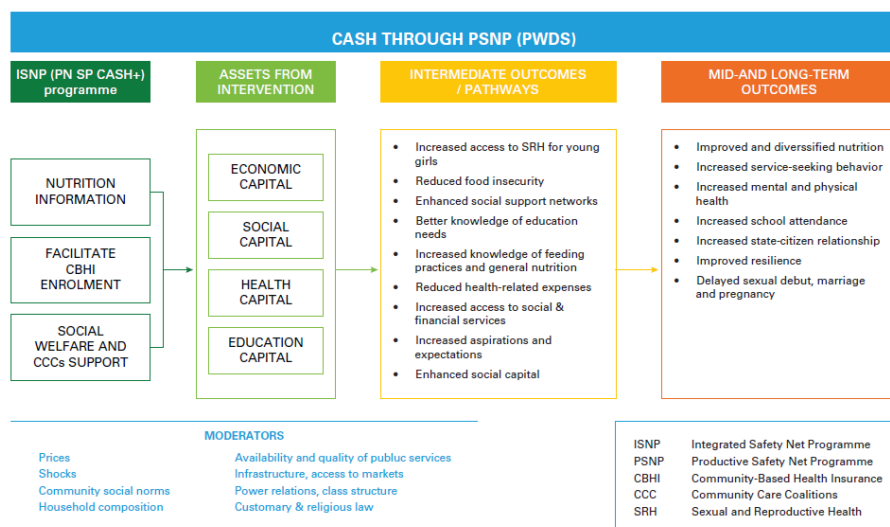


Source: The authors' own elaboration based on provisions detailed in UPSNP documents

1.3 The ISNP conceptual framework

The conceptual framework that guided the overall evaluation is shown in **Error! Reference source not found.**, which shows the various components of the ISNP and the suggested pathways of impact. The ISNP conceptual framework reflects a systems approach, integrating services and programme components across sectors to address income and other determinants of health and nutrition. It 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 caregivers' education (UNICEF, 2013). In this manner, 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. Further details about the conceptual framework and change pathways are described in the ISNP baseline report (INSP Evaluation Team, 2020).

Figure 2: ISNP Conceptual Framework



Note: Adopted from the Amhara Integrated Rural Safety Net programme evaluation

1.4 Evaluation rationale, objectives and research questions

To systematically document and examine the progress of households under UPSNP before ISNP implementation, quantitative and qualitative studies were conducted between April to June 2021 to provide a snapshot of the socioeconomic conditions of the UPSNP households and their experiences with CBHI enrolment and access to other social services (Otchere et al., 2022). The findings showed that the majority of PDS respondents were enrolled in CBHI through fee waivers, however, there were PDS households who continued to pay insurance premiums despite their eligibility for premium exemptions due to a lack of clear guidelines from the health bureau. On the other hand, more PW beneficiaries reported not having CBHI due to affordability and perceived drug shortages. Beneficiaries enrolled in CBHI had a positive perception of CBHI membership and considered it a valuable service. Negative perceptions of CBHI stemmed from frequent stock-out of medicines and the exclusion of some health services. The findings from the baseline evaluation also showed that the COVID-19 pandemic significantly affected the UPSNP implementation. Most households across all beneficiary groups reported an increase in food insecurity due to increasing food prices and inflation and coping with this shock by dietary changes and obtaining small loans.

The purpose of the current evaluation is a follow-up of the ISNP after 24 months of implementation. It has three primary objectives: 1) to examine the progress in the implementation of the ISNP components in Addis Ababa; 2) to provide a 24-month follow-up evidence (qualitative) of the perceived changes by the UPSNP households and identify pathways and reasons behind these changes (or lack thereof) that are attributable to the ISNP pilot; and 3) to contextualize the implementation progress and perceived impact vis-à-vis supply-side constraints.

In fulfilling the aims stated above, the evaluation asks the following research questions:

1. What are the **factors that have influenced** the implementation of the **UPSNP**?
2. What are the **main demand- and supply-side barriers** to CBHI enrolment among UPSNP beneficiaries?
3. How does the **integrated programming mitigate barriers** to accessing and utilizing CBHI among UPSNP beneficiaries?
4. How does the CBHI **impact UPSNP beneficiaries including health service utilization, out-of-pocket expenditures, and health status**?
5. What are the **main determinants of and pathways through which integrated programming** influences the health and nutrition status of UPSNP beneficiaries?
6. What are the **perceived effects** of the integrated programming on food security, nutrition, and health?

In answering these questions, the evaluation findings could guide the design features of later phases of the UPSNP and broader social protection policy in Ethiopia.

2 Methodology

2.1 Evaluation design and setting

This evaluation employed a mixed-methods approach using Key-Informant Interviews (KIIs), In-depth Interviews (IDIs), and Focus Group Discussions (FGDs), among programme beneficiaries and stakeholders, as well as community and health facility surveys. The community-level survey aims to understand the attitudes and perceptions of communities as well as obtain an overview of the availability of certain services, the extent of usage by community members, and their satisfaction with the services being provided. The main aim of the mixed-method approach is to triangulate the qualitative findings against the results from the quantitative community and health facility-level analyses. While the qualitative data collection was done between October and November 2023, the quantitative data collection took place in two time periods, the first wave in 2021 and a follow-up in 2023, to better capture the dynamics of service availability at both community and health facilities level.

The evaluation was conducted in Addis Ababa, the capital of Ethiopia and its largest city, where the adverse effects of rapid urbanization, including social vulnerability, homelessness, and unemployment, are most clearly magnified (Koroso et al., 2021). The qualitative evaluation was undertaken in the two sub-cities in Addis Ababa-Arada and Addis Ketema, which piloted the integration of UPSNP and CBHI. Addis Ketema was selected as it has a high proportion of destitute population, especially internally displaced persons (IDPs) arriving from its large bus station from the conflict-affected regions (mainly from Tigray, Oromia, and Amhara), whereas Arada was selected as it has many years of experience implementing the UPSNP since 2016). From each of the sub-cities, two woredas were randomly selected.¹ In addition to the two pilot sites, the community and health facilities surveys covered additional two sub-cities, Kirkos, and Lideta.

2.2 Evaluation population and sampling

Qualitative component

We employed purposive sampling for the participants for the KIIs. Policymakers and implementers at the federal, city, and lower levels were selected based on their roles and responsibilities in implementing the UPSNP and the integrated programme. KIIs were carried out with UPSNP coordinators, UNICEF UPSNP coordinators, CBHI coordinators, staff at the Ministry of Women and Social Affairs (MoWSA), and the city administration Bureau of Women and Social Affairs (BoWSA). At the woreda level, KIIs were conducted with social workers, public works coordinators, health extension workers, and health facility staff. In total, 35 KIIs were conducted.

To understand the lived experiences and the nature of UPSNP implementation and the integrated programme, interviews were undertaken with UPSNP beneficiaries based on specific household eligibility criteria. The sample included women caregivers from the following four categories:

- 1) PDS households with at least one child aged under 18,
- 2) PW households with at least one child aged under 18,
- 3) TDS pregnant women, and
- 4) TDS lactating women.

For each category of beneficiary, a random sample of at least three households was selected from the list of eligible households in each of the two woredas. One FGD was conducted for each category across the two woredas in the sub-cities. Overall, there were 30 IDIs and eight FGDs with UPSNP female beneficiaries in the different categories. Annex 1 provides detailed demographic and other characteristics of each respondent category.

Quantitative component

The community and health facilities surveys were conducted in four of the 11 sub-cities in Addis Ababa, namely Arada, Addis Ketema, Lideta, and Kirkos. Next, the field team attempted to reach all the communities and primary healthcare facilities in the four sub-cities for the survey, leading to a sample size of 127 communities at baseline and 168 communities at follow-up¹. The increase in the number of sample communities is due to the restructuring of administrative units by the Addis Ababa City Administration. The sample size for the health facilities survey was 19 at baseline and 20 at the follow-up. While the community survey was administered to community leaders and prominent personnel, the health facilities survey was administered to medical directors, in cases where specific information was required, pharmacists, data clerks, and other personnel also contributed to responding to certain questions.

2.3 Data collection

Qualitative component

Data were collected using semi-structured interview guides (Supplementary material, interview guides) informed by the ISNP's framework for developing interview questions. Interview guides were translated into Amharic and tested for quality during the training of research assistants. The interviews explored participants' views and experiences with the programme's operational and complementary features, such as transfer amount, payment delivery, case management systems, CBHI enrolment, access to social services, and awareness and support from social workers and health extension workers. The individual interviews lasted approximately 58 minutes, while the group interviews lasted approximately 90 minutes. Each interview guide was tailored for each target group. Questions were piloted in woredas in the two sub-cities that were not selected for the evaluation, and revisions were made to the interview guides before data collection. Trained research assistants conducted all the interviews in Amharic. The training sessions included an overview of the USPNP and the interview guides.

¹ Administrative re-organization lead to some communities being split, which increased the total number of communities at endline.

Quantitative component

The evaluation also conducted two rounds of quantitative surveys at the community and health facility levels, where the baseline was conducted in April-May 2021, and follow-up was conducted in November 2023. The survey also collected information on the expansion of infrastructures, job opportunities, and various shocks that affected the communities. Similarly, the health facility survey aims to explore the availability of various health facilities and infrastructures, the types of services provided by the healthcare facilities, the availability of services to CBHI clients, among others.

2.4 Analysis strategy

Qualitative component

All the interviews were audio-recorded and transcribed verbatim from Amharic to English. Data analysis was assisted using the qualitative software, Atlas.ti V.8.0. We analysed the data using a thematic analysis approach by adopting both deductive and inductive coding. We conducted deductive coding by adopting the ISNP conceptual framework as the analytical framework, while inductive coding explored themes that emerged from the data. We also followed the steps described by Braune and Clarke for conducting thematic analysis, which included familiarization, generation of initial codes, searching for themes, reviewing the themes, defining, and naming themes, and producing the report (Braun & Clarke, 2006).

To enhance credibility, we employed *crystallization*, a method involving using the synthesis of diverse perspectives from to develop a rich and nuanced understanding of the phenomenon under investigation (Larrinaga-González, 2011). In this evaluation, we acknowledged dissonances among the different data sources to capture the complexities in how the ISNP affects UPSNP beneficiaries.

Quantitative component

The quantitative data from the baseline and follow-up community surveys are analysed using descriptive statistics along with statistical tests (t-tests) for the significance of differences in means/averages at baseline and follow-up. More specifically, the quantitative analysis uses the following estimation framework adopted from (Wooldridge, 2010).

$$Y_i = \beta Time_i + \epsilon_i$$

where Y_i indicates the community level indicators; i indicates the community; $Time_i$ takes zero if baseline and one if follow-up; β are the parameters of interest showing the mean differences between baseline and follow-up; ϵ_i is the error term. On the other hand, given the small sample size for health facilities, which prevents the establishment of reliable inference, the analysis is primarily based on simple averages. Note that the results present the community level averages when using community level data and health facility level averages when using the health facility level data.

2.5 Community characteristics

Table 1 presents the characteristics of communities that are included in the community and health facilities survey at baseline and follow-up. The table shows that about 6 per cent of the communities reported Islam as the main religion in their communities. When it comes to the movement of people, about 30 per cent of the communities at baseline and 40 per cent at follow-up perceived that there are more people coming to their communities in the five years before the survey; about 61 per cent

of the communities at baseline and 83 per cent perceived that people temporarily leave their communities to look for work; and about 59 per cent of the communities at baseline and 79 per cent at follow-up perceived that people are coming to their communities looking for work. In all the three migration indicators, there is a statistically significant increase at follow-up compared to baseline. In terms of marriages, about 57 per cent of the communities at baseline and 67 per cent at follow-up believed that there is no polygamy and about 48 per cent at baseline and 45 per cent at follow-up believed that the most common type of marriage is through the municipality, meaning that more than half believed that other forms of marriages are more prevalent. The perceived number of homeless persons and the number of elderly persons that live alone appear to decline at follow-up.

Table 1: Community characteristics at baseline and follow-up

	(1)	(2)	(3)	(4)
Variable	Baseline	Follow-up	Difference	N
Islam is the main religion in ketena ⁱⁱ	5.51 (22.91)	5.95 (23.73)	0.44 (2.75)	295
More people moved in the ketena in the last 5 years	29.92 (45.97)	39.29 (48.98)	9.36* (5.61)	295
People temporarily leave this ketena to look for work	60.63 (49.05)	82.74 (37.90)	22.11*** (5.06)	295
People temporarily come to this ketena to look for work	59.06 (49.37)	79.17 (40.73)	20.11*** (5.25)	295
Average of homeless people (such as street children) live in this ketena	42.72 (269.53)	8.17 (13.75)	-34.55* (20.82)	295
Average of orphaned children in this ketena	14.30 (39.74)	9.43 (19.33)	-4.86 (3.51)	295
Average of elderlies live alone in this ketena	37.55 (70.89)	20.35 (32.09)	-17.21*** (6.16)	295

Observations	127	168	295
--------------	-----	-----	-----

Note: Difference in column 3 shows the difference between follow-up and baseline values in percentages. Significance *** p<0.01, ** p<0.05, * p<0.1.

Error! Reference source not found. presents the availability of various types of services in the sample communities at baseline and follow-up. Based on these results, the availability of some services, such as the availability of factories within 5 5-kilometer radius, the availability of piped communal water (Bono), and the availability of food banks, declined at follow-up. In contrast, the availability of roads, banks, consumer associations, urban agricultural extension offices, and agricultural cooperatives increased at follow-up.

Table 2 availability in the communities

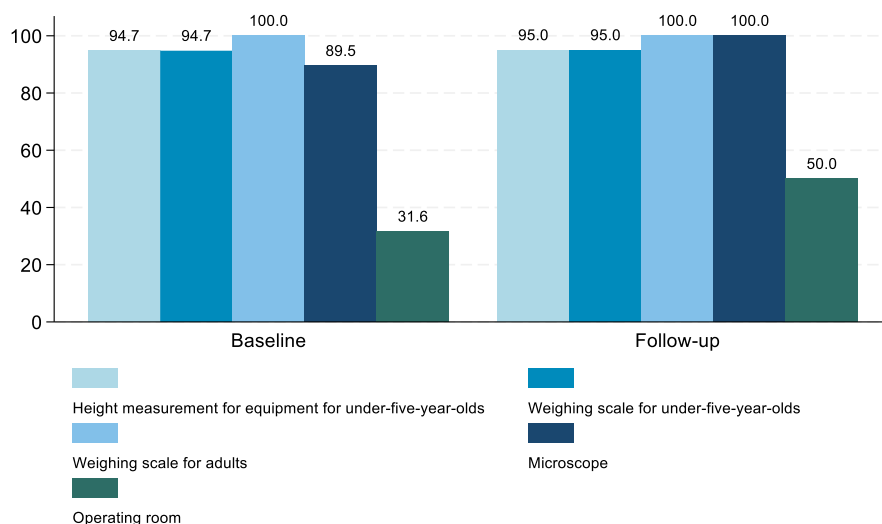
Variable	(1) Baseline	(2) Follow-up	(3) Difference	(4) N
Publicly accessible notice board present in this ketene	39.37 (49.05)	24.40 (43.08)	-14.97*** (5.38)	295
Factory within kebele-within 5KMs	33.86 (47.51)	20.83 (40.73)	-13.02** (5.15)	295
Main access road surface tar/asphalt	31.50 (46.63)	63.10 (48.40)	31.60*** (5.60)	295
There is a place in the ketena to purchase common medicines	77.17 (42.14)	69.05 (46.37)	-8.12 (5.24)	295
Mobile network in ketena is decent or fast	61.42 (48.87)	76.79 (42.35)	15.37*** (5.32)	295
Ketena has public piped water (Bono)	74.02 (44.03)	56.55 (49.72)	-17.47*** (5.57)	295
Bank is available in this ketena	56.35 (49.79)	76.19 (42.72)	19.84*** (5.41)	294
Daily open market is available in this ketena	85.60 (35.25)	94.05 (23.73)	8.45** (3.45)	293
Consumer Association is available in this ketena	63.20 (48.42)	83.33 (37.38)	20.13*** (5.01)	293
Food Bank is available in this ketena	17.46 (38.11)	1.19 (10.88)	-16.27*** (3.09)	294
Urban agricultural extension officer is available in this ketena	21.26 (41.08)	54.76 (49.92)	33.50*** (5.45)	295
Agricultural Cooperative is available in this ketena	17.46 (38.11)	39.88 (49.11)	22.42*** (5.27)	294
Observations	127	168	295	

Note: Difference in column 3 shows the difference between follow-up and baseline values in percentages. Significance *** p<0.01, ** p<0.05, * p<0.1.

2.6 Health facilities' characteristics

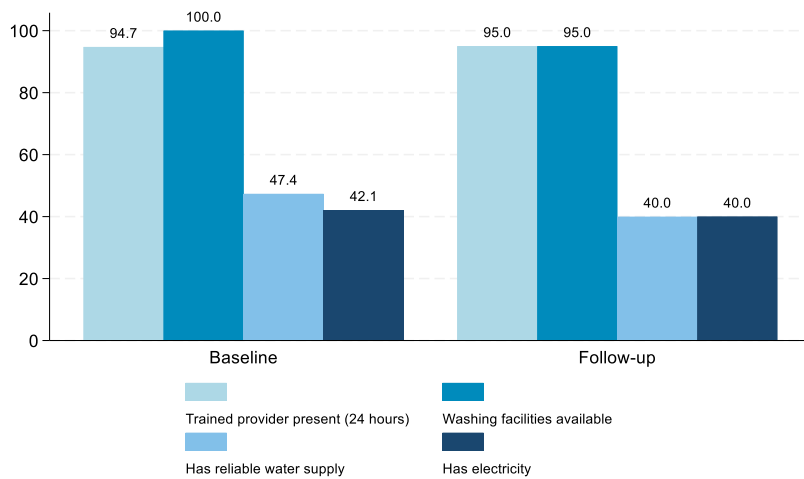
This section presents some statistics on health facilities' characteristics. **Error! Reference source not found.** presents the availability of basic tools and healthcare infrastructure at the facilities. Based on the figure, height and weight measurement scales are available in more than 95 per cent of the facilities. The availability of operating room infrastructure, unfortunately, appeared to be low, especially at baseline at about 31 per cent, and slightly increased at follow-up to 50 percent. Additionally, Annex 2 presents the number of clients that received various services at the health facilities and shows that while the number of clients that received certain services such as outpatient, ANC and PNC increased, the number of clients that received other services such as HIV treatment, malnourished treatment, and deliveries decreased at follow-up.

Figure 3: Availability of basic tools and healthcare infrastructure



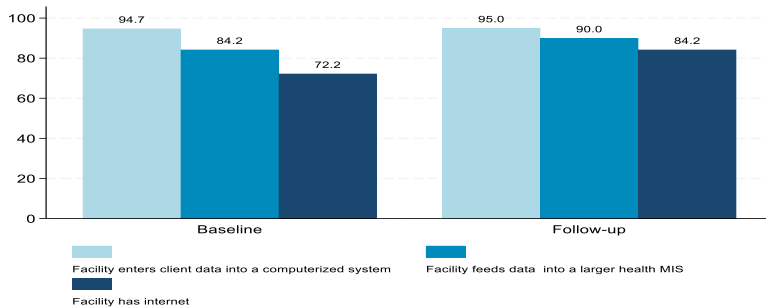
Error! Reference source not found. shows the health facilities' access to basic services such as water and electricity, as well as trained healthcare professionals. Both at baseline and follow-up, about 95 per cent of the facilities reported the availability of trained healthcare professionals for 24-hour services. Nearly all the facilities at baseline and 95 percent at follow-up also reported having washing facilities that can serve staff and clients with a detergent. On the other hand, less than half of the health facilities reported having reliable water and electricity in both rounds.

Figure 4: Health facilities' access to basic services



Error! Reference source not found. presents the extent of availability and usage of information system technologies. About 95 percent of the facilities reported that they enter client data into a computerized system. About 84 per cent at baseline and 90 per cent at follow-up reported that they feed client data into a larger management information system (MIS). About 72 per cent of the facilities at baseline and 84 per cent at follow-up reported to have Internet access.

Figure 5: Information technology availability and use



2.7 Ethical considerations

Interviewers received instructions on ethical interview practices and informed consent during training sessions. During training, it was emphasized to enumerators to respect the privacy and confidentiality of all information they are exposed to during the research. To safeguard research participants, informed consent was obtained from all individuals interviewed. Enumerators explained to research

participants that the decision to consent to the interview does not have any effect on any programme benefit and respondents are allowed to skip answering questions if that makes them uneasy or stop the participating in the interview all together. Other measures undertaken includes removal of all identifying information in the transcripts or the reports. Data that consisted of identifiable information was stored in a secure, safe location with access restricted to only the evaluation team. Details of the ethical procedures as well as the evaluation design, instruments and the composition of the research team were submitted to the Ethiopian Society of Sociologists, Social Workers, and Anthropologists (ESSSWA) Intitutional Review Board (IRB) for vetting and review before commencement of research activities. The ESSSWA's IRB granted ethical approval (IRB/ESSSWA/016/2023) for the evaluation.

2.8 Limitations, mitigation strategies, and lessons learned

This sub-section summarizes key limitations of the evaluation, mitigation strategies employed during data collection as well as lessons learned during the research implementation. The main limitation of the quantitative evaluation with respect to the community survey is the likelihood of a change in the composition of respondents between survey, whilst the survey unit remains the same community. This is because some of the respondents might be unavailable for various reasons (such as change of responsibility, relocation, death, etc.) at follow-up, leading to a variation in the composition of community leaders.

In anticipation of such risk, a mitigation strategy was to ensure that at least half of the composition of the community leaders who responded to the baseline questionnaire are present at the follow-up survey. This ensures consistency is maintain between waves. This was achieved by recording contact information – with their informed consent - of the community leaders for the purpose of the follow-up. Regarding the health facilities survey, even though the data are likely to be more objective as some of the questions were answered by looking at their records, the sample size is too small to conduct statistical analyses that could lead to a strong conclusion.

One of the key lessons from the data collection shows the need for flexible and adaptable approaches in constituting the respondents composition of the communities surveys as well as sampling of households to be interviewed. This is necessary to address the often dynamic and unpredictable field conditions. Another key lesson is to ensure effective communication and continuos partnership between all stakeholders. This reduces over-reliances on individuals and places the community as an organized body at the centre of relations with relevant national stakeholders. This also ensures the loss of informations is greatly minimized when an inividual move from the community and ensures continuity with programme delivery.

Commented [GBK1]: Good mention the change of phases from UPSNP to UPSNJP.

3 Implementation of the UPSNP

This chapter presents the results for research question 1: *What are the factors that have influenced the implementation of the UPSNP?* From stakeholders' perspectives, it shows the extent to which UPSNP components—targeting, cash transfers, and TDS participation—have been implemented, highlighting the gaps and challenges. Understanding the factors influencing the implementation of these components is crucial, as they can also influence the effectiveness of the complementary features (Roelen et al., 2017).

3.1 Targeting Process

The effectiveness of UPSNP in reaching the poorest and most vulnerable households is highly dependent on the targeting process (Schnitzer & Stoeffler, 2023). Targeting beneficiaries includes community targeting comprising of community members responsible for identifying eligible programme beneficiaries. Key informants expressed that targeting has improved to include only eligible beneficiaries, but gaps remain.

Facilitators

Key-informant participants communicated that **the targeting process has improved by retargeting to exclude ineligible households from the programme.**

“Before this time, many rich people were entering...majority were coming with their cars to the health centre, holding keys, and with golds on hands and their necks are coming. They said that they were safety net beneficiaries and we felt ashamed, but since I came to this position, I have been minimum of three years, the people coming are mainly very poor once, who have sugar [problems] and hypertension, mainly are in need.”

– KII with CBHI coordinator, Arada, Woreda 6.

“There was a quality problem in identifying the right people for the program. People were included based on their connections. These problems were cleared over time through retargeting by excluding the illegible ones. Even car owners were participating in the program and now the information is clear.” – KII with Social Worker, Addis Ketema, Woreda 10

Stakeholders explained that the **improvements in the retargeting and screening process were facilitated by training committee members responsible for community-based targeting** and removing those deemed unsuitable for the task.

“Committee members took training on how they can recruit. Based on that criterion, unfit committee members were removed and replaced with others. In addition, committee members who were obstacles to the recruitment process were also excluded from recruitment activity.” –KII with Social Worker, Arada Woreda 2.

Barriers

Nevertheless, some respondents highlighted that there are still **ongoing challenges with community-based targeting due to some committee members recruiting beneficiaries** based on kinship and personal relations, which conflict between social workers and these members.

“There are committees assigned at the ketena level to identify beneficiaries. However, some of the committee members work to recruit their relatives. Because of that, there is conflict between social workers and committee members.” –KII with a social worker, Arada, Woreda 2

“There have been some committees that mismanaged the project. They registered households based on kinship, corruption, or personal relations. Based on the information we gained, we tried to clarify the registration process wherever we reached.”–KII with Public Works coordinator, Addis Ketema.

Some participants also indicated **limited involvement of stakeholders well-informed about communities’ welfare**. For instance, stakeholders within the Bureau of Women and Social Affairs communicated that although they are responsible for PDS households, they are not involved in the targeting, which leads to inclusion of households that should not be in the programme.

“We found those who should not be selected, based on the targeting criteria for PDS, registered on the beneficiary selection criteria list when we went to check the targeting ketena. It should have been done in such a way that the public works would target beneficiaries for the public works and the PDS team targets beneficiaries for the PDS separately.” –KII with BoWSA safety team lead, Arada, Woreda 6.

Some health stakeholders also reported their limited role in the targeting process, suggesting that it could improve the targeting accuracy.

“The issue lies in the fact that the Woreda safety net office does not coordinate with our family health team members during the beneficiary recruitment process. Given that the family health team members offer door-to-door services; they possess a wealth of information about individuals living in extreme poverty. I cannot speak to the effectiveness of their selection criteria, but there are individuals within the community who deserve the opportunity but are not considered. It is a situation where collaboration and information could make a real difference.” –KII with Health Provider, Addis Ketema, Woreda 10.

Finally, key informants highlighted that not all vulnerable populations who meet the program’s eligibility criteria are selected due to quota restrictions. Due to budget constraints, each sub-city and woredas have quotas which limit the inclusion of all needy households can participate in the program to receive its benefits.

“There are restrictions on the number of beneficiaries targeted at the woreda level. Due to budget limitations, it is only possible to give some needy people access to free health insurance. Many want to be enrolled to be in the health insurance for free, yet they cannot.” –KII with Social Worker, Addis Ketema, Woreda 2.

3.2 Transfers' regularity and adequacy

The effectiveness of the UPSNP in increasing access to social services and smoothing consumption partly relies on the regularity and predictability of the transfer (Davis et al., 2016). According to the programme implementation manual, PDS clients are entitled to 12 months of transfers at the beginning of the Ethiopian budget year, and transfers should be disbursed every month. Similarly, PW households are expected to receive transfer monthly with a maximum of one-month lag after the beginning of public works implementation.

Facilitators

In the IDIs and FGDs, most of the PDS and PW households **confirmed receiving timely monthly transfers**. Timely monthly transfers were facilitated by social workers collaborating with banking institutions and vital event registration offices to assist beneficiaries in opening bank accounts or delegate others to receive bank deposits on behalf of physically disabled beneficiaries.

However, some beneficiaries reported **delays of a couple of days to a month occurring sporadically**. **Despite these delays, they expressed confidence in borrowing cash or buying household items on credit due to the predictability of the transfers.**

“Yes, if you set a programme to do or buy something, it is left behind [delayed due to the delay in the payment] but you can borrow and use it if you have confidence in getting payment. Yes, when there is a delay in payment, you can borrow instead and do what you want. You can replace [repay] later.” –IDI with PW beneficiary, Arada Woreda 2.

“Sometimes, when the holiday comes, I expect it (the safety net), as it has come every month, to be used to fill the existing gap. I will wait with hope when I face difficulties, as they come every month uninterrupted. Having hope in it, I will borrow money from other people too.” –IDI with PDS beneficiary, Arada, Woreda 6.

A few of those who stated experiencing transfer delays did not have other coping mechanisms for the delays, and therefore suffered.

“Unfortunately, I did not receive this month's allowance from the program, and as a result, I am suffering from hunger. I feel ill due to hunger.” –IDI with PDS beneficiary, Addis Ketema, Woreda 2.

“I expect the payment to make shopping of monthly food items. As I told you, my husband has no regularly paid job. He covers house rent from irregular works. Our expenses for food consumption are covered by me and I have nothing else other than the safety net. So, the delay causes a lack of food to eat.” –IDI with pregnant woman, Addis Ketema, Woreda 2.

In relation to predictability of cash transfers is the inconsistency in transfer size. Few beneficiaries especially PW households in Arada, Woreda 2 recounted a significant reduction during their time in the program.

“At the beginning it was around 1,000 ETB [Ethiopian Birr] and something, then it went down and down eventually it reached around 300 ETB then we left the program. When it was getting less and lesser it reached 300 ETB. Lastly, it was decreased, but we did not have room to argue with them. Finally, we took the deposited money.”-IDI with PW beneficiary, Arada, Woreda 2.

“As the first 1,200 ETB gradually decreased and sometimes reached only 300 ETB. Lastly, we get some Birr that I didn’t remember.”-IDI with PW beneficiary, Arada, Woreda 2.

Barriers

Both beneficiaries and key informants expressed concern regarding the effectiveness of cash payments in smoothing consumption and improving food security. **Amidst high inflation and rising cost of living, the transfer size was perceived as inadequate to smooth consumption.**

“ Currently we transfer 435 ETB [Ethiopian Birr] for each person [in a PDS household]. Hence, on behalf of four family members, they could earn 1700 ETB. This amount of money is nothing to do with these problems. They may raise many more questions about financial constraints. Even this cash transfer cannot cover utility payments. I recommend improving the amount of cash.” -KII with Social worker, Arada, Woreda 2

“The payment made to beneficiaries; it is not as per the situation. Now one [kilogram] of pepper is sold for 300, but a family works for four days and gets 600 per month. I don’t believe this can fill in the food gap. It is not right to [pay] based on the assessment made a year or two years back. It would be good if this could be revised. Because if it is to ensure their food security, I believe the payment has to be taken into consideration.” -KII with Public works coordinator, Addis Ketema Woreda, 10.

3.3 Insights on usage of cash transfer

On the usage of the cash transfer, participants reported using the cash for various purposes particularly for food and household necessities. The cash transfer allowed them to meet their basic needs as captured below:

“ May God bless them with his abundance grace...we are able to eat this much because of them. I am very grateful for that. They are the only ones that offer us a helping hand when we are in a dire situation. I pay for electric and water utility bills as well as for IDIR [a social institution in Ethiopia used for mutual aid mainly for funeral ceremony] monthly fee.” -IDI with PDS beneficiary, Addis Ketema, Woreda 2

“The good part of UPSNP is that we are sure that we get a monthly payment. We plan what to buy for our children with the money. Though it is not enough we can at least fulfil half of the monthly requirements for our children. For what they eat...even if it does not cover everything they need, it is used to support our children. We were beneficial in that regard.” -Respondent 2, FGD with PW beneficiaries, Addis Ketema, Woreda 10.

PW beneficiaries reported using the cash to pay rent, pay medical expenses, expand business, and pay premiums to enrol in the CBHI.

"Health insurance premium was paid from this salary. Initially, we had enrolled in health insurance through payment from the salary, and subsequently, renewal was made by this payment." – Respondent 4, FGD with PW beneficiaries, Arada, Woreda 6.

"I use the money to save and for my household expenses. I use it to cover my medical expenses, rent, and food expenses." –IDI with pregnant woman, Arada, Woreda 6.

The cash transfers play a crucial role among the most vulnerable beneficiaries, such as female-headed households with children who often face perilous conditions and lack alternative sources of support.

"It is helping me with my living. Because I cannot go out and work due to my health problem, with the payment I receive, even though I cannot say I am fulfilling, I allocate it to the needs of my children. Thus, it has helped me." –IDI with PDS beneficiary, Arada, Woreda 6

"Before, these individuals didn't have anything, but now, they can at least pay for food. They are given financial support to cover monthly expenses, but at least they use that to eat for some days; it is a good thing for them. Through the support, they can send their children to school; they can cover the food expenses by themselves. If such kind of support were not there, harsh things would happen to them." – IDI with BoWSA staff, Addis Ketema, Woreda 2

Furthermore, some beneficiaries expressed that the **ongoing economic situation has increased the stress of poverty, which may disrupt the caregiver's physical and mental state.**

"When I think of it [my house i.e., her life] I feel stress, it significantly affects my ability to sleep, leaving me wide awake throughout the night. The source of my stress primarily stems from financial limitations, as I struggle to meet my financial obligations. Failing to make ends meet causes me great worry, leading to severe headaches and blurred vision." – IDI with PDS beneficiary, Addis Ketema, Woreda 6

"I am stressed out a lot especially when I am at home. I feel better when I go out. I am better now compared to the past. Being unable to fulfil your children's basic needs has another source of pain and stress. When your children ask something that they saw from their neighbour or school and when I cannot afford to make them the lunchbox of their choice that is another stress." – IDI with PW beneficiary, Addis Ketema, Woreda 10

Finally, participants raised concern about the limited role of the UPSNP in nurturing the economic empowerment of PW beneficiaries and enabling them to graduate from poverty.

"In the program, the graduated person will not get any service from any safety net program. He will not be retargeted either in the PDS or in the public work. What happened now is that people who graduated three years ago came and asked us either to let them enrol in public work or to target them in the PDS as the poorest of all other poor; they heard saying the safety net support changed their lives. This means the program is not effective." –KII with BoWSA safety team lead, Arada, Woreda 6

"At that time [being in PNSP], it greatly helped me and supplemented my expenditure but now in addition to my children's needs, I am suffering." –IDI with PW beneficiary, Arada, Woreda 2

Some key informants also suggested that participation in the UPSNP enables dependency on external aid and decrease the urgency to work.

“What’s surprising is that there are so many people who don’t want to follow the advice given to them. They did not implement it. Now, even though training was provided, most of the people are not motivated to work. A few years ago, they were given training and money but instead of starting a business, they bought a sofa and television. But today, the money that is supposed to be given to us does not even buy one television. So, what people should do now is to go to work with the money they have been given and save money to buy the bed and television they want.” -KII with Public Works Team leader, Arada, Woreda 2.

“My concern about the safety net is that, instead of accessing the available job opportunities, they will see the safety net as the means to their end. This makes them not look for another opportunity, and it creates dependency among some individual who has the potential to be engaged in other productive activities. This is idleness” -KII with Public works coordinator, Arada, Woreda 2.

Respondents highlighted the necessity for more proactive efforts to link PW beneficiaries with livelihood support, such as securing workspaces, facilitating access to credit and employment opportunities.

“For those who cannot be engaged in the mobile business, there should be government support to give them access to the labour market. Investment has been made in them. Ignoring after investing in them will be a problem for them and even for the country.” -KII Public Works coordinator, Addis Ketema Sub-City.

“We have graduated after three years of public works. Currently, there are many elderly people working in public works and living in a very low economic status. If possible, I would like to recommend PSNP to capacitate those people in terms of health, lifestyle and others. It is better to say worked and changed than worked and graduated.” -Respondent 3, FGD with PW beneficiaries, Addis Ketema, Woreda 10.

3.4 Participation and coverage among pregnant and lactating women

A subcomponent of the UPSNP is improving the links to social services for pregnant women and lactating mothers who transition to TDS status from the time of pregnancy until the child turns one year old while keeping their eligibility for the PW scheme. In the TDS period, they are bound with soft conditionalities, including attendance of training and antenatal and postnatal care visits, which are expected to improve their children’s health and nutrition.

Facilitators

The IDIs with PW and pregnant and lactating women explored their awareness of and experience with the transition into TDS. In addition, stakeholders engaged in TDS implementation were asked about their experiences and knowledge of the component. Overall, the KIIs revealed that **PW beneficiaries are knowledgeable about the TDS process for lactating mothers and pregnant women**.

“They [female beneficiaries] will take a rest for 18 months, especially if they are women. It could also be due to sickness or holy water, and leave is provided. Other than that, those who are pregnant, six

months during pregnancy and 12 months after they give birth, a total of 18 months. We record that. If they bring the sick leave form, based on that, we make follow-up and support so that they won't be on duty. If they are found, since we are responsible for taking action, they won't be there. All of them have an awareness of this issue: how long would they rest, when they would be back.” –KII with Public works coordinator, Addis Ketema, Woreda 10.

Interviews with pregnant and lactating women confirmed that these groups are aware of TDS provisions and are benefiting from it. They were given information about TDS immediately upon entering the program and the requirements to receive the entitlement.

“They told us you cannot work after three months. They said the support will continue until the child is one year old.” –Respondent 2, FGD with pregnant women, Addis Ketema, Woreda 2.

“We were informed when we initially joined the program that a pregnant mother should get leave at the third month. She cannot clean after that. She should take leave and take rest. Her salary will be directly deposited. They gave us this information” –IDI with pregnant woman, Addis Ketema, Woreda 2.

Barriers

However, **the timing and duration of the transition were not implemented in practice**. According to the UPSNP rules, pregnant women should be exempted from public works activities from the third month of the pregnancy, and this rule was also confirmed through KIIs with public works coordinators, social workers and IDIs, and FGDs with the women. **Meanwhile, most women only transitioned into TDS in the fifth month of their pregnancy**. Some women explained that their delayed transition was due to being aware of their pregnancy later, while others mentioned continuing working because they enjoyed it and felt healthy enough to do so. However, it is unclear whether these reasons fully explain women's failure to transition promptly after the three-month period. Another possibility is that the expectation of receiving full salary required their work had to be substituted by other members of the household, the husband or children over 18 years, influencing their decision to delay the transition.

“Challenges...some of them hide [their pregnancy] and work up to four months, and they like not to engage their husband or other person in the work. There may be a situation where you may not know the pregnancy just by looking. Some of them have a tendency to hide and pass the time.” –KII with Public Works coordinator, Addis Ketema, Woreda 10

Additionally, there appears to be either a **miscommunication or misinterpretation of TDS guidelines regarding substitution by able-bodied household members leading to inconsistent implementation among discretion by public works administrators and woreda officials**. In some instances, women who were unable to find a substitution reported to losing their full salary, therefore they had to continue working.

“I am glad to get a break. In the past, maternal leave pay was not cut. My husband is a security guard, and we were told that our salary would not be cut, so we submitted a leave of absence. We were on leave, but my boss called me and forced me to come in before my time. As a result, I am worried about who I would give my child to.” – Respondent 3, FGD with lactating women, Addis Ketema, Woreda 10

“I used to be paid a full salary, but lately, I am being cut because I am on leave, and my husband is not able to take my place.” – Respondent 8, FGD with lactating women, Addis Ketema, Woreda 10

Among the participants who were able to transition, they were asked about the benefits of the leave. Most of the women who were pregnant at that time reported that the leave allowed them to rest and reduced exposure to hazards at the workplace.

“I could have been affected by the dust if I worked when pregnant. There could be a foetal impact. I’m better able to take care of the foetus and myself thanks to this transition.” –IDI with lactating woman, Arada, Woreda 2.

“As I told you before, there is exhaustion. So, you need to get rest. It is nice to get enough sleep in the morning (laughing). So, since I am not cleaning in the morning; he cleans in the morning. That helps me to get rest.” –IDI with Pregnant woman, Addis Ketema, Woreda 2.

Furthermore, women with older children expressed that being on leave has also allowed them to take care of their school-aged children in the morning.

“It is good because they cry during night-time, and they also cry when you leave them and go. No one will care like a mother, so the break is very nice.” – Respondent 5, FGD with lactating women, Arada, Woreda 2.

“Yes, because we get up early in the morning, the first thing we do is take care of the children at home and be with them. Secondly, we protect ourselves from the cold and smell.” –Respondent 1, FGD with pregnant women, Addis Ketema, Woreda 2.

This section concludes by presenting a summary of the availability of UPSNP and its coverage based on data from the community survey. **Error! Reference source not found.** presents the results showing the availability of UPSNP services in the sample communities. While the perception of coverage appears to reach 100 per cent at follow-up, the results show a striking decline in the number of beneficiaries at follow-up compared to baseline: the number of PW households declined by more than half (about 64 per cent), the number of PDS decreased by about 40 persons (a 44 per cent decline), and the number of TDS decreased by 14 persons (a 64 per cent decline). Relatedly, the share of communities that perceived that yearly re-targeting was conducted for PDS and PW at the same time increased from about 16 per cent to 52 per cent, an increase by 36 percentage points and significant at 1 per cent. Despite the decline in the number of clients, the share of communities that reported the availability of daycare services for PW clients increased from about 5 per cent at baseline to 12 per cent at follow-up.

Table 3: UPSNP services

Variable	(1) Baseline	(2) Follow-up	(3) Difference	(4) % change	(5) N
UPSNP ever operated since 2016 in the ketena	77.17	100.00	22.83***	29.58	295
	(42.14)	(0.00)	(3.25)		

Number of PW households in the ketena	202.81	73.59	-129.22***	63.71	295
	(506.35)	(44.21)	(39.24)		
Number of PDS households in the ketena	87.30	48.74	-38.56***	44.16	295
	(171.41)	(43.60)	(13.77)		
Number of TDS households in the ketena	22.52	8.07	-14.45***	64.16	295
	(63.29)	(10.32)	(4.97)		
Yearly re-targeting conducted for PW and PDS at the same time	15.75	51.79	36.04***		295
	(36.57)	(50.12)	(5.27)		
Childcare centre available at workplace for PW clients	4.72	12.50	7.78**		295
	(21.30)	(33.17)	(3.37)		
Observations	127	168	295		

Note: Difference in column 3 shows the difference between follow-up and baseline values. Column 4 presents the percentage changes for indicators that are expressed in numbers, whereas column 3 presents the percentage changes for the last two indicators. Significance *** p<0.01, ** p<0.05, * p<0.1.

3.4 Summary

In summary, there has been progress in implementing the various components of the UPSNP, facilitated through multisectoral collaboration with different stakeholders. However, based on the community survey, the number of PW, PDS and TDS clients decreased at follow-up compared to the baseline. Moreover, the program has also been affected by internal and external barriers. The overview of these facilitators and barriers are presented in Box 1.

Box 1: Summary of findings factors affecting UPSNP implementation
Targeting process
<i>Facilitators</i>
<ul style="list-style-type: none">a. Training committee members involved in community-based targeting to ensure adherence to selection criteria.b. Retargeting to exclude ineligible beneficiaries from the programme.
<i>Barriers</i>
<ul style="list-style-type: none">a. Limited involvement of well-informed stakeholders in the targeting processb. Limited budget to include all eligible households
Cash transfers
<i>Facilitators</i>
<ul style="list-style-type: none">a. Collaboration with bank institutions to open bank accounts for beneficiariesb. Home visits by social workers to monitor payment of cash transfers and spending.
<i>Barriers</i>
<ul style="list-style-type: none">a. High inflation rates reduce the adequacy of the cash transfer amount.
TDS participation during pregnancy and lactation
<i>Facilitator</i>
<ul style="list-style-type: none">a. TDS entitlements shared with women upon entering the programme.
<i>Barriers</i>
<ul style="list-style-type: none">a. Failure of women to disclose pregnancy status.b. Inconsistency in guideline for other able-bodied household members to replace women in TDS.

4 Demand- and supply-side barriers to CBHI enrolment

The ISNP aims to increase CBHI enrolment by facilitating fee waivers for PDS households and by increasing awareness for PW households who are not exempt from the payment of CBHI premiums. This chapter addresses research question 2: *What is the main demand- and supply-side barriers to CBHI enrolment among UPSNP beneficiaries?* It describes the availability of CBHI services and examines CBHI enrolment barriers separately for PDS and PW households, given their distinct enrolment pathways.

4.1 Availability of CBHI services

This section provides background information on the availability of CBHI services in the communities and the availability of healthcare for CBHI clients and presents the results in **Error! Reference source not found.** Both at baseline and follow-up, 100 per cent of the communities reported that there is an office where they can register for CBHI. Similarly, about 97 per cent at baseline and 98 per cent at follow-up stated that the nearest healthcare facility admits CBHI clients.

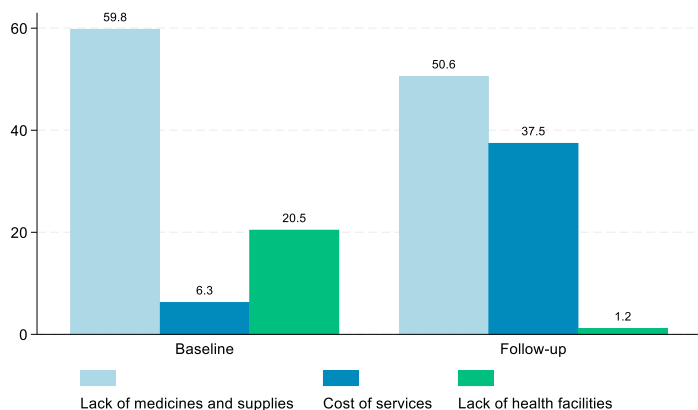
Table 4: Healthcare availability

Variable	(1) Baseline	(2) Follow-up	(3) Difference	(4) N
Office available to register for CBHI	100.00 (0.00)	100.00 (0.00)	0.00 (0.00)	209
There is CBHI in this ketena	97.62 (15.31)	97.02 (17.04)	-0.60 (1.92)	294
Nearest health facility admits people covered with CBHI	96.85 (17.53)	98.21 (13.28)	1.36 (1.79)	295
Observations	127	168	295	

Note: Difference in column 3 shows the difference between follow-up and baseline values in percentages. Significance *** p<0.01, ** p<0.05, * p<0.1.

Error! Reference source not found. presents the major problems associated with healthcare service delivery based on the community survey data. The most cited problem in both baseline and follow-up is a lack of medicine and supplies (for availability of supplies in the health facilities, please see Annex 3**Error! Reference source not found.**). While lack of health facilities appears to be the second most cited problem, in the follow-up, cost of services becomes the second most widely cited problem.

Figure 6: Problems associated with healthcare services delivery



4.2 Barriers for PDS households

All the PDS beneficiaries that were interviewed confirmed their CBHI enrolment, and programme staff also confirmed high enrolment among these beneficiaries. However, key informants noted that there might not be universal insurance coverage among PDS households due to both demand- and supply-side barriers. Respondents reported that the primary supply-side barrier was the **misalignment in the timing of retargeting of new PDS households and CBHI enrolment**. PDS retargeting occurs quarterly to enrol new PDS beneficiaries, while CBHI enrolment takes places on an annual basis from October to November. Typically, UPSNP staff submits PDS beneficiaries' enrolment applications during CBHI enrolment period, so new PDS beneficiaries may not be enrolled immediately due to underreporting by UPSNP staff and delays by the CBHI office.

"Some new members remain unregistered due to data inaccuracies and underreporting to health centres. This issue is particularly prevalent among new clients, where the likelihood of underreporting is high. Since we recruit beneficiaries at various times, they may be overlooked" – KII with social worker, Arada, Woreda 2

"The other is that after we have identified and listed the names of the newly enrolled beneficiaries and sent them to the health institution [CBHI office], the health institution [CBHI office] delays facilitating giving them the health insurance card. It should not be delayed for 2 or 3 months. Such problem has been noted at the health facility. I think it will be good if the newly enrolled beneficiaries are given the health insurance on time." –KII with social worker, Addis Ketema, Woreda 10.

Many of the **demand-side barriers among PDS beneficiaries are associated with age-related problems**. Most are elderly and chronically ill, and they need social support to activate CBHI cards. Following the receipt of the fee waiver, PDS households are required to activate their CBHI cards by visiting CBHI offices to fulfil necessary procedures, such as submitting identification cards and passport photos. Some beneficiaries have difficulties in submitting these documents or physically accessing CBHI offices. Additionally, key informants cited forgetting the CBHI enrolment window (October to November) as another barrier for the elderly.

Participants also highlighted additional demand-side barriers, such as reliance on religious beliefs and, misconceptions about healthcare needs, making some PDS beneficiaries not value the CBHI.

"Some people are careless and feel as if they have no problems. Some people have abandoned it, feeling it doesn't have any benefit. This is mainly due to their lack of awareness. Some of them lean toward their religion and see it as a panacea, and there are others, especially older people, who forget the registration date. When we ask them, they will say, 'When did you say the registration date was?' These are some reasons why some people do not renew their cards to access the CBHI." –KII with Social worker, Arada, Woreda 6.

4.3 Barriers for PW households

Many PW households mentioned not being currently enrolled in CBHI, due to unaffordability of the annual premium, which must be paid in one instalment during the enrolment period. Many of them were willing to enrol in the scheme, but the annual CBHI membership fee, which had increased from the previous year, was seen as too high to pay.

"Every year, the payment is increased. It rises in comparison to the initial payment rate. The current rate is unaffordable." –IDI with lactating woman, Arada, Woreda 2.

"Most of them will be registered. Yet, some have not been enrolled because of payment issues, as they face a shortage of cash to pay for health insurance." –KII with Public Works Coordinator, Addis Ketema, Woreda 10.

Another financial barrier for those who are inactive CBHI members is the payment of arrears from previous years. Since membership requires annual renewal, any lapse in renewal results in the accumulation of renewal fees. Consequently, for each year a household fails to renew, their outstanding fees increase, leading to a situation where the accumulation fees become a barrier preventing some households from reinstating their membership.

"I have a three-year back payment that I have not paid if they pay it to me. If it is one time, it is not difficult, but if it is three times, it will be very difficult. When I think about signing up, it worries me." –Respondent 3, FGD with pregnant women, Addis Ketema, Woreda 2.

Furthermore, the renewal fee had increased to 1000 ETB per household head in 2023, so when asked whether they planned to renew their membership, as the evaluation period also coincided with the CBHI renewal window, **many of the current CBHI members contemplated not renewing because of their inability to cope with the high inflation.** Additionally, because the cash transfers are insufficient, they prioritize food expenses rather than CBHI enrolment.

"Currently, I don't expect to enrol in the CBHI program through payment. The UPSNP payment is not enough for extra expenses other than food consumption. You know that about rising inflation, so the UPSNP money doesn't buy anything; it just helps for some food consumption expenses." –IDI with Pregnant woman, Addis Ketema, Woreda 10.

"I have paid 500 ETB for health insurance so far. But it has increased to 1000 ETB so I do not think that we will renew it." –Respondent 3, FGD with PW beneficiaries, Addis Ketema, Woreda 10.

Key informants explained that the increase in CBHI membership and renewal fees was also due to the high inflation, even though the government already subsidizes a sizeable portion of membership fees. Furthermore, the cost of services utilized by CBHI members tremendously outweighed the current CBHI premium.

“The income from beneficiaries is not sufficient, and government subsidies highly support their services. If we couldn’t get different subsidies from different bodies, we couldn’t sustain providing healthcare services with 1000 ETB.” –KII with CBHI coordinator, Addis Ketema Sub-city.

The main barrier on the supply side **PW beneficiaries cited is the perceived poor quality of care**. Both beneficiaries and key informants highlighted that the shortage of medicines and unavailability of laboratory services at health facilities discourage individuals from seeing the benefits of the scheme.

“We also heard that the medication used by CBHI users is not available at the health centre.”–IDI with lactating woman, Arada, Woreda 2.

Others also **perceived that the shortage of medicines was part of the discrimination against CBHI members, as those paying out-of-pocket do not face these challenges**.

“Even if you have the money, there isn’t much of a benefit. Getting a bed could be helpful in cases of serious illnesses. I do not see any advantages. For example, even though medication is available, they might claim it doesn’t exist. But in the case of a serious illness, finding a bed might be useful. It benefits bedridden people. Simply put, I don’t think it’s worth it. I have no interest in it.”–IDI with pregnant woman, Arada, Woreda 6.

Several respondents, particularly PW households, were not satisfied with the activation and renewal process of CBHI cards. Beneficiaries pointed out the tedious administration processes and physical accessibility challenges to CBHI offices.

“The health insurance office is on the fourth floor. And it is difficult for aged people. There are people who are moving with walking sticks. These people will beg the youngsters. The health centre lacks an elevator. Hence, if you are not able-bodied or have a family member that can support, it is impossible to renew. Even if you reach there with support, they will send you back without bringing a payment voucher. I am not against the payment. However, the service should be on the ground, and one banker should be assigned there with his computer to collect the money.” Respondent 4, FGD with PW beneficiaries, Arada, Woreda 6.

“The first time they registered me at home and then you have to go to the health centre and take it on your own after you are registered. And last year, they gave papers from here, meaning a filled form. And when they give, you cannot deposit through Commercial Bank, it is exclusive, you have to go to Ras Desta (hospital) to pay and get a paper. It had lots of back and forth.” Respondent 5, FGD with Lactating women, Arada, Woreda 2.

The community survey also collected information from community leaders on their perceived factors that hinder CBHI membership. Table 5 summarises these results. Firstly, about 35 per cent of communities at baseline and 83 per cent at follow-up consider expensive premiums to be one of the problems that discourage CBHI membership. Travel time and/or costs to the CBHI registration office was mentioned by under one per cent of the communities at baseline but it jumped to 22 per cent at follow-up period. Again, while only about 5 per cent at baseline mentioned long waiting lines at the registration sites at baseline, it jumped to 21 per cent at follow-up. As also noted from the qualitative interviews, one of the challenges facing enrolment to CBHI is the perceived quality of care for CBHI users. The community survey also reveals that this perception has dramatically increased at follow-up:

from about 14 per cent at baseline to 58 per cent at follow-up. Service coverage also affects enrolment in CBHI as about 27 per cent at baseline and 65 per cent at follow-up mention it as one of the factors that discourage membership. Interestingly, the share of communities that mentioned a lack of understanding of CBHI increased at follow-up, from about 9 per cent at baseline to 43 per cent at follow-up. This decline could be arising from either an updated belief of the community leader that CBHI knowledge is low or could be due to a possible change in the community leaders interviewed at baseline and follow-up.

Table 5: Reasons that discourage CBHI membership

Variable	(1) Baseline	(2) Follow-up	(3) Difference	(4) N
Premium too expensive	34.65 (47.77)	82.74 (37.90)	48.09*** (4.99)	295
Travel time/cost too high	0.79 (8.87)	22.02 (41.56)	21.24*** (3.75)	295
Waiting time at enrolment too long	4.72 (21.30)	20.83 (40.73)	16.11*** (3.97)	295
Poor quality care for those with CBHI	14.17 (35.02)	57.74 (49.55)	43.56*** (5.16)	295
Preferred services not covered	26.77 (44.45)	64.88 (47.88)	38.11*** (5.46)	295
Use clinics or traditional healers	3.94 (19.52)	8.33 (27.72)	4.40 (2.88)	295
Don't understand CBHI	9.45 (29.37)	42.86 (49.64)	33.41*** (4.95)	295
Observations	127	168	295	

Note: Difference in column 3 shows the difference between follow-up and baseline values in percentages. Significance *** p<0.01, ** p<0.05, * p<0.1.

4.4 Summary

This chapter has shed light on the barriers that impede UPSNP beneficiaries from enrolling in CBHI. Currently, CBHI services are available at ketenas for registration, and nearly all health facilities accept CBHI for health services. However, demand and supply-side barriers hinder CBHI enrolment for PDS and PW households. Box 2 presents an overview of these barriers.

Box 2: Summary of demand and-side supply side barriers to CBHI enrolment

PDS households

- Misalignment of PDS retargeting period and CBHI enrolment window
- Limited support of social workers to assist in CBHI activation process
- Age-related problems, such as forgetfulness of CBHI enrolment window
- Reliance on religious sources for healing
- Misconceptions about healthcare needs rendering CBHI enrolment valueless/useless

PW households

- Unaffordability of premiums
- Accumulated CBHI debts prevent former CBHI members from enrolling
- Lack of understanding of CBHI benefits
- Poor perceived quality of care, particularly due to shortage of medicines
- Perceived discrimination against CBHI members in accessing medicines

5 Role of ISNP in facilitating CBHI enrolment

This previous chapter revealed various barriers that hinder CBHI enrolment among UPSNP beneficiaries. This chapter seeks to answer research question 3: *How does the integrated programming mitigate barriers to accessing and utilizing CBHI among UPSNP beneficiaries?* It explores which of the barriers the ISNP addresses and the progress of its mitigation strategies.

5.1 Enrolment of PDS households

Key informants highlighted the **critical role of effective coordination among the various partners in providing the fee waiver for PDS beneficiaries**. During the CBHI enrolment period, UPSNP staff compiles the list of current PDS beneficiaries, sends it to the CBHI office, and submits a request to the health office to pay on behalf of beneficiaries. CBHI coordinators reported occasional payment delays from the health office, but currently, it seems not to affect the timely enrolment of PDS beneficiaries.

After the fee waiver, **social workers and health extension workers are crucial for PDS beneficiaries to activate their CBHI cards**. Social workers inform PDS beneficiaries about their CBHI entitlements and remind them to visit CBHI offices for card activations. Additionally, they facilitate the enrolment of those with reduced mobility.

“One of our office’s main tasks is awareness creation. If they are not aware, they will not know about the program. Thus, either calling them by phone or reaching out to their house to inform them to enrol in the CBHI is one of our roles. We are working on awareness creation. We do this if they do not come to register by themselves, possibly because they are disabled or elderly. We inform them to enrol by delegating to other able people.” –KII with Social worker, Arada, Woreda 6.

Beneficiaries confirmed the assistance by social workers and health extension workers in the renewal process.

“It was a simple process as they visited my residence and enrolled me without any charge. Every year during the renewal, they would come to my house and exchange the old book for a new one. There was no hassle.” –IDI with PDS beneficiary, Addis Ketema, Woreda 2.

However, programme staff expressed that due to the ratio of social workers to the number of beneficiaries they support, not all PDS beneficiaries are able to receive assistance from social workers to enrol in the health insurance.

5.2 Enrolment of PW households

The ISNP is designed to increase awareness and understanding of CBHI, and both key informants and PW participants confirmed the promotion of CBHI enrolment among PW households. During CBHI enrolment period, public works coordinators remind PW beneficiaries about CBHI enrolment. In

addition, at the ketena levels, the health insurance and the health office conduct awareness campaigns for community members so that PW beneficiaries receive CBHI information through these channels.

The cash transfer to PW beneficiaries is the main mechanism by the ISNP for these beneficiaries enrol into the CBHI. As mentioned in section 3.3, some PW participants do use their UPSNP salary to enrol in CBHI. However, as also described in section 3.3, the high inflation rates have made the transfer size insufficient to cover all their necessities. CBHI and health stakeholders mentioned assisting some beneficiaries to enrol in the scheme. They explained enrolling PW beneficiaries through sponsorships from private contributions and non-governmental organizations (NGOs).

“Sponsorship will be searched for by the various sectors, faith-based institutions, other humanitarian sectors, and even individuals who are working in humanitarian service. By this, some safety net beneficiaries from public work and TDS are enrolled in health insurance. Their health insurance fee will be covered for one or two years by this mechanism.”—KII with CBHI coordinator, Arada, Woreda 2.

“One of the health workers came to my home and asked me to get enrolled. I told her I have no money. She paid for me and helped me enrol into CBHI.”—Respondent 3, FGD with PW beneficiaries, Addis Ketema, Woreda 10.

5.3 Summary

This chapter discusses the role of the ISNP in facilitating CBHI enrolment among UPSNP beneficiaries. The findings suggested that the ISNP has been crucial in PDS beneficiaries’ enrolment into CBHI. The findings are summarized in Box 3.

Box 3: Summary findings of the role of the ISNP in CBHI enrolment

Enrolment of PDS households

The findings suggest that coordination between the UPSNP staff, CBHI, and health offices facilitated the provision of premium waivers to PDS beneficiaries. However, it is important to note that the fee waiver alone is insufficient for enrolment. Social workers play a crucial role in raising awareness about enrolment periods and assisting the elderly and those with reduced mobility in activating their CBHI cards. The inadequate number of social workers impedes the provision of this essential support to all beneficiaries who require it.

Enrolment of PW households

The findings also show that PW beneficiaries are aware of CBHI and its benefits. They receive CBHI information from beneficiaries within and outside the programme. Some beneficiaries are able to use their cash transfer for CBHI premiums, but many reported not being able to afford the premiums, especially over the last couple of years due to the spiking inflation. Currently, the alternative strategy is by the CBHI and health offices to use sponsorship from private and other entities to cover PW households.

6 Perceived impact of CBHI enrolment on health-related outcomes

This section examines the perceived impacts of CBHI on UPSNP beneficiaries after they enrol in the scheme. It presents the results on research question 4: *How does the CBHI impact UPSNP beneficiaries including health service utilization, out-of-pocket expenditures and health status?*

6.1 Health service utilization

When asked how the insurance has changed their care-seeking, several respondents reported that CBHI has increased care-seeking at health facilities. Previously, beneficiaries had to pay all the costs associated with accessing healthcare such as consultation fees, medicines and diagnostics thereby leading them to forego healthcare or seeking care from other sources.

“Aha! The first thing, you may not have money at hand. If you have health insurance you go, just taking your insurance. If you don't have health insurance, what do you do if you don't have money? You will stay sick or even die, how can you go?” –IDI with lactating woman, Addis Ketema, Woreda 10.

“I could not have managed to lead a life as the current cost of living has skyrocketed. If I am not enrolled in health insurance for free, I may go to Tsebel (religious site for spiritual cleansing) because I cannot afford the cost of the health service. I need help getting the health service through cash. Many people, like me, could have passed away if the CBHI had not come to the community.” –IDI with PDS beneficiary, Arada, Woreda 6.

Additionally, respondents also reported that CBHI has contributed to reducing the delay in seeking health care. Previously, they would have to wait until they had adequate financial resources to visit the health facility, but with CBHI removing this financial barrier, they are able to go immediately.

“I used to get sick before, and when I get sick, it is treated with money. I will not go to the doctor's house until I get the money. The disease will stay with me. I used to trouble my children. But now, after the introduction of health insurance, I am treated for free.” –Respondent 3, FGD with PDS beneficiaries, Addis Ketema, Woreda 2.

Key informants at health facilities also confirmed this finding and stressed the importance of beneficiaries receiving timely care.

“As I told you I want to emphasize the importance of seeking care at our health centre early on, as it allows for easier treatment at our facility. If individuals delay seeking care, their condition may worsen and require referral to larger health institutions. Additionally, they may incur extra costs for investigations such as ECG [electrocardiogram] and X-ray, which are not covered by CBHI.” –KII with Health Provider, Addis Ketema, Woreda 10.

While CBHI has improved health-seeking behaviour, some health actors raised concerns regarding more frequent healthcare visits than necessary to seek treatments for illness that can be managed at

home with over-the-counter medicine as they aware they no longer bear the costs. This can lead to strain on services in healthcare facilities.

"As a correction, some CBHI members visit our health facility daily, even for illnesses that can be treated at home. They insist on receiving medical treatment [for minor illnesses] here [at the health facility] simply because they are CBHI members. Since they are CBHI members, some members have thought of going to the health facility in the morning and evening. This needs to be resolved. Even for them, coming back is not beneficial." –KII with Health Provider, Arada, Woreda 2.

"Sometimes they repeatedly come without finishing the drugs they were given due to the health insurance. If they get the prescription and medication today and if they don't get relief by next day, they tend to come to the health centre before taking the required dose as prescribed." –KII with CBHI coordinator, Arada, Woreda 2.

6.2 Health and well-being

Several respondents suggested that the health insurance has contributed to improving their general health status, particularly, among vulnerable group such as children, the elderly, and those with chronic illness.

"It's great for me. It means that. It means that I got my life because of health insurance. I am with you today because I was at the point where I thought I would die, and I have health insurance. It was because of health insurance that I had an operation." –Respondent 4, FGD with PDS beneficiaries, Addis Ketema, Woreda 2.

"It saved us from serious damage. The physician knows how cerebral malaria is fatal. Free of charge, we are saved from deadly diseases because of the health insurance book." –Respondent 7. FGD with PW beneficiaries, Arada, Woreda 6.

6.3 Out-of-pocket health expenditure and financial protection

Respondents were also asked about their perceptions of using CBHI to access health services. The majority reported benefits such as reduced household medical expenditures, particularly for those with chronic diseases and severe illnesses and reduced negative coping strategies such as borrowing.

"Thanks to Allah, it is better to think about others. It is greatly helpful for those diabetes patients and those who suffer from comorbidities. It is also helpful for my daughter's medical expenses." –IDI with PW beneficiary, Arada, Woreda 2.

"The amount of cash they receive is known for its inadequacy (hand to mouth), and it cannot cover their expense for a month. Had they used their transfer on health services, they could not cope with the living costs. Thus, they get many benefits from the health insurance." –KII with Social Worker, Addis Ketema, Woreda 2.

Furthermore, respondents expressed that the reduced financial burden from CBHI membership has also reduced the stress and anxiety associated with healthcare costs.

“The first indicator is they come immediately whenever they feel sick. They are not worried about the medical expenses because of CBHI.” –KII with Health Provider, Addis Ketema, Woreda 2.

“It helped me to take my child to the health centre without [getting] concerned about money.” – IDI with Pregnant woman, Addis Ketema, Woreda 2.

Finally, some respondents indicated that the decreased out-of-pocket medical expenditures have enabled them to allocate funds towards other essential household needs.

“We spend the money on necessities and various social activities, as our medical expenses are covered.” –Respondent 2, FGD with PDS beneficiaries.” Addis Ketema, Woreda 2.

This finding is also confirmed by KIIs with social workers.

“The programme enables them to reduce the financial expenditure they would otherwise spend for the services and makes them worry only about their daily food consumption. Now, for example, some households have enrolled up to seven or eight members in CBHI. If one or two of their household members got a disease, they would spend all their food consumption on health services. So, the programme reduces their financial burden.” –KII with Social Worker, Addis Ketema, Woreda 2.

Although out-of-pocket health expenditure have decreased, participants expressed that frequent shortage of medicines at health facilities and public pharmacies jeopardizes adequate financial protection for beneficiaries. Adequate financial protection through CBHI is crucial for beneficiaries as their cash transfers are not sufficient to cover expensive medications at private health institutions.

The overall positive impacts found from the qualitative analysis are also corroborated by the quantitative results that come from the community leaders. **Error! Reference source not found.** presents the perceived benefits of CBHI in the sample communities. The results show that while about 80 per cent of the communities at baseline believed that CBHI provides financial protection against the cost of illness, the share dropped to about 67 per cent at follow-up. In contrast, the share of communities that believe that CBHI improves affordability of healthcare and those that believe that it improves health-seeking behaviour remain similar at baseline and follow-up. Additionally, the share of communities that perceive that CBHI improves the quality of healthcare showed an increase of about 12 percentage points at follow-up from the baseline average of 80 per cent.

Table 6: CBHI service availability and perceived benefits

Variable	(1) Baseline	(2) Follow-up	(3) Difference	(4) N
Financial protection by CBHI against the cost of illness is medium or high	80.31 (39.92)	66.67 (47.28)	-13.65*** (5.21)	295
Access to affordable healthcare due to CBHI is medium or high	85.83 (35.02)	89.88 (30.25)	4.05 (3.81)	295
Health consumption patterns improvement due to CBHI is medium or high	83.46 (37.30)	88.69 (31.77)	5.23 (4.03)	295

Observations	127	168	295
--------------	-----	-----	-----

Note: Difference in column 3 shows the difference between follow-up and baseline values in percentages. Significance *** p<0.01, ** p<0.05, * p<0.1.

6.4 Satisfaction with health services

Many respondents were highly satisfied with the services under CBHI in terms of waiting times and treatment from health staff.

“So far, I faced nothing. The service is good. It is good when I use the card. I use the card both for myself and my daughter.” –IDI with Pregnant woman, Addis Ketema, Woreda 2.

“The change is good. Previously, we were required to pay for all the services provided at the health facility, including the prescribed medication. However, now we have access to medical services and prescribed medications free of charge. In cases where the necessary medications are not available at the health facility, they inform us and provide a written recommendation to purchase them from Kenema pharmacy [public community pharmacy] at a discounted price.” – IDI with PDS beneficiary, Addis Ketema, Woreda 2.ⁱⁱⁱ

A key area of discontentment among beneficiaries pertained to the service quality from using CBHI. The major concern was the shortage of medical supplies at public health facilities, particularly drugs. Participants reported that even with the Kenema public community pharmacies as a supplementary to mitigate the drug availability issue at public health facilities, challenges remain.

“My other concern is about the supply of essential drugs. A certain medicine may not be available at Kenema (public) pharmacy but available in private pharmacies. It can be unavailable at the health centres, but the basic drugs should be available at the Kenema.” –IDI with PW beneficiary, Addis Ketema, Woreda 10.

“There is no medicine at all even if you go with health fund [CBHI]. Even amoxicillin is not there. They tell you to buy from Kenema Pharmacy. You become a member of the health insurance to take rest and not to spend money.” –IDI with pregnant woman, Addis Ketema, Woreda 10.

Additionally, respondents pointed out that the Kenema may not be situated close to health facilities. This poses a tremendous challenge for beneficiaries with mobility issues or those unable to cover transportation costs, making it difficult to access health services.

“Most of our beneficiaries are very old people and chronic patients. They do not get health services to meet their needs. When they lack the service, they suffer more, and they will even further debilitate their health when they lack the medicine for their ill health. If they get the medicine that they demand in time, I think they will be free from their problems.” –KII with Social worker, Addis Ketema, Woreda 2.

Some respondents perceived that their CBHI membership was the reason for their inability to receive drugs at health facilities.

"I have only ever had medicine once. It was fever syrup, but they said that the medication was not available. After giving me the medication one day, I seem to recall that they took it again and said it was not available. When they are aware that you use CBHI, they do not provide you with medication." –IDI with pregnant woman, Arada, Woreda 6.

"Some CBHI members are not happy when they are told that drugs are not available [at the health facility]. They think that the reason for the unavailability of drugs is that they are CBHI members. They may also say that non-CBHI members got it here [at the health facility] yesterday. They may believe that because they are CBHI members, they are being told the medication is not available but there is no such thing that drugs to be available for non-CBHI service seekers and unavailable for CBHI members. They have a lack awareness." –KII with Health Provider, Arada Woreda 2.

The findings suggest that there is limitation on the prices and diagnostics covered by CBHI benefits, but some members are unaware of these restrictions and assume all health services to be free under the insurance, which contributes to their dissatisfaction.

"Interviewer: How well do you think CBHI members understand their rights?"

"Respondent: Hmm... This requires education meaning... Or it poses a limitation on CBHI, for example, Kenema or pharmacy or laboratory... there is no limitation as long as they paid since there are no limits. However, there may be certain limits related to some kinds of laboratory tests or diagnosis. With an exception to this, there are no limits." –KII with CBHI coordinator, Addis Ketema, Woreda 2.

"We are usually told to buy from outside; laboratories, ultrasounds and drugs are outside. Even if we have health insurance and we expect to get drugs and other services for free, it is not available. For instance, I have a three-year-old baby. He had a common cold and fever. I took him to the health centre. They conducted blood test and sent me outside for another test. I paid 500 ETB at Ethio Tebib hospital." –Respondent 3, FGD with PW beneficiaries, Addis Ketema, Woreda 10.

Participants explained that the shortage of drugs and other services at public health facilities presents two main challenges for both beneficiaries and the scheme. For beneficiaries turning to private institutions for services or medicines not available at public health facilities leads to higher out-of-pocket expenditure or entirely forgoing necessary care altogether.

"I often get requests to perform ultrasounds. I'm told to head outside because they claim there are no ultrasound reagents. You have to pay 500 and 600 ETB. Where would we consistently bring these sums of money? Living expenses these days are very high. We are paying over 100 ETB per kilogram of teff. Our mothers did not live like this." –IDI with pregnant woman, Arada, Woreda 6.

"Last time I was told to get medical test outside. That test is very expensive; I cannot afford it. So, I still don't know the health problem on my baby and myself as well ... because of shortage of money." –IDI with pregnant woman, Addis Ketema, Woreda 2.

From the insurance perspective, the shortage of drugs and the perceived unfair treatment of CBHI members creates scepticism about the value of renewing their insurance.

"After admission you are required to visit laboratory, ultrasound, and pharmacy but they send us to seek those services from outside? So where is the contribution of CBHI if I buy drugs from

outside, conduct a laboratory test outside and use ultrasound outside? So, what is the importance of CBHI?” –Respondent, 3, FGD with PW beneficiaries, Addis Ketema, Woreda 10.

“Due to these inconveniences, other people develop negative attitudes. If I didn’t get the service I wanted, why should I renew my health insurance membership card and refuse to renew their health insurance membership card. These kinds of complaints are common.” –KII with ISNP coordinator, Addis Ababa City.

Respondents also expressed dissatisfaction with the limited-service coverage. Some beneficiaries complained about the restriction to accessing only health centres within their respective woredas. The restrictions do not allow them to visit health facilities that they perceive to have higher-quality care.

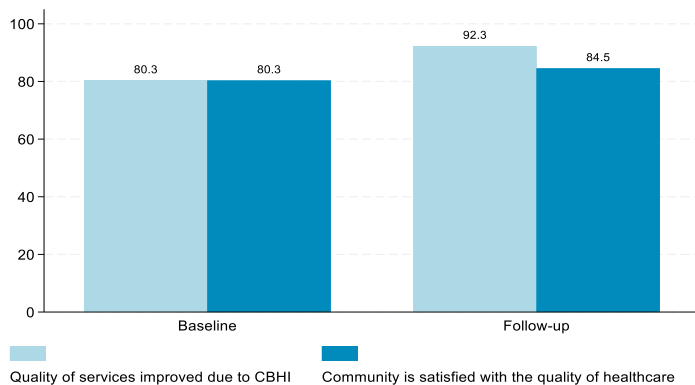
“Although we live in Arada sub city, I visit the Yeka sub city health centre because the Arada health centres’ waiting list is too much. What would be the issue if you seek medical treatment everywhere since all the health centres by the government? The government is the source of the CBHI. What would be the issue, then, if we looked for medical care everywhere?” –IDI with pregnant woman, Arada, Woreda 6.

Additionally, participants were dissatisfied with the exclusion of specific medical products, such as eyeglasses which can be costly but are often necessary for beneficiaries.

“So, it is not helpful to cover the whole healthcare costs, so many individuals are vulnerable to sickness. And the other is related to the package of the insurance. For instance, if eyeglasses cost is not included in the package and if one beneficiary needs to buy eyeglasses and the eyeglasses costs 6000 ETB, he or she will use an alternative of selling of the assets he or she has. So, there is a problem of adequacy. It is not adequate.” –KII with MoWSA Social Protection Advisor.

The community survey also collected data on the perceived satisfaction with CBHI as well as the quality of healthcare services. **Error! Reference source not found.** Error! Reference source not found. presents the results that show the share of communities that perceived that the quality of healthcare services improved due to CBHI at baseline and follow-up. The figure shows that, compared to the baseline, more communities in the follow-up perceived improvements in the quality of healthcare due to CBHI. Similarly, the share of communities that reported being satisfied with the quality of healthcare services provided by the nearest facilities increased from 80 per cent at baseline to about 85 per cent at follow-up. The divergence of these findings from the qualitative analyses could be attributed to the fact that the community survey is collected from prominent personalities who either might not be members of CBHI and hence may not have as accurate information as the members or they may receive better care as they are likely to be well-known by healthcare providers.

Figure 7: Satisfaction with CBHI and healthcare facilities



6.5 Summary

To summarize, from the perspectives of key informants and beneficiaries, CBHI has had a positive impact on beneficiaries. By reducing the costs associated with health services, CBHI has increased health service utilization, improved the health status, reduced out-of-pocket health expenditures, and increased satisfaction with health care services. However, to further boost the impacts of CBHI, challenges in service delivery need to be addressed. The findings are summarized in Box 4.

Box 4: Summary findings of perceived impacts of CBHI

Health service utilization

The findings suggest that the scheme has increased service utilization by removing the key challenge to access care and affordability of health services. Previously, beneficiaries had to rely on other alternatives such as religious sites or forego care altogether, but with health insurance covering most primary health care services, beneficiaries are now able to access essential services.

1) Health status

The findings also suggest that the health insurance has improved beneficiaries' health status by enabling them to receive necessary health interventions in a timely manner. Furthermore, the CBHI has relieved the mental stress associated with healthcare costs.

2) Out-of-pocket health expenditure

The scheme covering most primary health care services has reduced out-of-pocket payments. However, frequent shortage of medicine threatens financial protection as beneficiaries' cash transfer are insufficient to cover medicines at private health institutions and pharmacies.

3) Satisfaction with health services

Generally, the findings suggest that beneficiaries are satisfied with the quality of care under CBHI, but there is room for improvement, particularly surrounding service delivery quality. Shortages of

medicines and perceived discrimination of CBHI members must be addressed to sustain service utilization and CBHI enrolment particularly among PW beneficiaries.

7 Linking UPSNP beneficiaries to social services through Integrated Programming

This chapter focuses on the other complementary features of the ISNP to improve the demand and access to basic services. To improve health and nutrition status, demand-side strategies involve 1) co-responsibilities to attend BCC sessions and health check-ups and 2) interacting with social workers and health extension workers. It seeks to address questions 5: *What are the main determinants and pathways through which the integrated programming influences the health and nutrition status of UPSNP beneficiaries?* The first section presents beneficiaries' co-responsibilities, and the second section presents findings on BCC sessions. The third section focuses on accessibility, interaction and satisfaction with service providers. The final section discusses the opportunities and barriers to integrated programming.

7.1 Beneficiaries' Responsibilities

According to the programme design, TDS beneficiaries with infants and young children are required to attend nutrition counselling sessions, antenatal care visits for pregnant women, post-natal care, nutrition counselling for lactating women and child vaccinations. PDS beneficiaries are accountable for ensuring their dependants are enrolled in school and attend regularly. This section explores how the additional responsibilities are implemented practically as well as the level of understanding among beneficiaries of their responsibilities and the perceived impact on access and uptake of social services.

Types of extra responsibilities and compliance

Most of the beneficiaries, specifically PW and TDS beneficiaries, were aware of the co-responsibilities required to receive their benefits and understood these obligations. The most cited in interviews with key informants include requirements for caregivers to send children to school regularly and for pregnant and lactating women to receive essential services for themselves and their infants. Others mentioned requirements for PW beneficiaries to attend various trainings on life skills, financial literacy, and nutrition.

“A pregnant mother should be monitored during pregnancy, and a woman who has given birth should be monitored after delivery, she should be vaccinated and that when she is sick, she should go to the health centre, if there are dropouts or who have not gone to school, she should send them and related things.” – KII with Social Worker, Addis Ketema, Woreda 10.

“So, they have these co-responsibilities. As PDS what we call co-responsibilities or soft conditionality are showing evidence or supporting documents whenever they seek free services, attending and listening awareness.” –KII with ISNP coordinator, Addis Ababa.

When asked about whether the programme encouraged pregnant women to seek ANC advice, IDIs and FGDs, beneficiaries provided conflicting responses even among women in the same Woreda. The

reason for this discrepancy, whether it stems from differences in implementation across ketenas, remains unclear and warrants further investigation.

“Interviewer: As a safety net beneficiary, are you advised to get the checkup services?”

Respondent: Not given.”–IDI with Pregnant woman, Addis Ketema, Woreda 2.

When the first safety net program came, a pregnant woman could not work after three months, [XXX] explained to us very well before we started working in the first youth centre.”–Respondent 2, FGD with Pregnant women, Addis Ketema, Woreda 2.

“Interviewer: Are you advised to have these checkups as a safety net beneficiary? Do they advise you from the safety net on pre-natal care, and about health, overall, on what you should do?”

All: Yes.”–FGD with Lactating women, Arada, Woreda 2.

Perceived impact of co-responsibilities on behaviour

Participants' responses suggest that that the impact of co-responsibilities depended on the behaviour. For instance, for the co-responsibilities regarding uptake of antenatal care or healthcare-seeking behaviour, participants explained that as most of the women were aware of these services, the program did not have an influence.

“I have not noticed any change. Already they are well informed about antenatal care and postnatal care visits. Before we provided the information.”–KII with Social Worker, Arada, Woreda 2.

“I was using the health centre before the safety net, and I also use it now. There is nothing new I know due to the safety net.”–IDI with Pregnant woman, Addis Ketema, Woreda 2.

For other areas, such as education, and financial literacy, many PW beneficiaries had positive attitudes towards the co-responsibility, and it appears it has been effective in influencing positive behavioural changes.

“We say no school-aged children should be left behind from school. In doing this, many children have been sent to school because their parents have accepted it. For example, some families have children with disabilities or mental impairments. After our awareness-raising activities, many of them could send their disabled children to school.”–KII with Social Worker, Arada, Woreda 6.

“It poses no challenge. Instead, they offered us training to run our own business. We had selected our preferred jobs. However, due to current living conditions, we cannot proceed further.”–Respondent 4, FGD with PW beneficiaries, Arada, Woreda 6.

However, others reported not observing any positive changes in behaviour. Co-responsibilities were perceived to be insufficient to prompt behavioural change and bring substantive improvements in the broader social welfare due to the lack of resources.

“The problem is after we completed the training, we faced shortage of money to start business with what we learned. It will be good if they give us that [financial] support.”–IDI with lactating woman, Addis Ketema, Woreda 10.

Challenges to implementation

Both beneficiaries and key informants reported several challenges related to the fulfilment of co-responsibilities and the monitoring of compliance. First, staff responsible for monitoring compliance highlighted the shortage of staff.

“Last time, basically what we do is, there are social workers; there are more than 550 social workers in Addis Ababa at all the 11 sub cities. The distribution of social workers is not equal in all sub cities. For example, we have the largest size of beneficiaries in Addis Ketema and when we do the ratio of social workers, Addis Ketema has the least number of social workers. So, as a city, we have discussed it with the Civil Service, but we could not solve it. At least, allocating social workers as per the size of beneficiaries; we are dealing to make the allocation that way but as said, recruitment has been suspended and transfer is not possible. It has been nearly a year since new employment got suspended not specific to social workers but to any positions.”—KII with BoWSA safety team lead, Arada, Woreda 6

Second, for TDS beneficiaries, limited coordination between Food Security Office and BoWSA hinders monitoring of their co-responsibilities. After women transition to TDS, Food Security Office must send their information to BoWSA in order for social workers to monitor their compliance for health checkups, but this does not always occur.

I believe it is good to work in collaboration with the Job Creation and Enterprise Bureau. They may not transfer her [TDS beneficiary] to our office, even though she is pregnant, and she is due to give birth. They have to take the lion's share. If awareness is created for the Job and Enterprise Officers, the implementation will be fruitful. – KII with Social Worker, Arada, Woreda 2.

Finally, beneficiaries elaborated on the financial constraints in fulfilling responsibilities, particularly for school attendance. Although school materials, such as exercise books and uniforms are supplied by the government, delays in distributing them put a strain on families.

“Of course, it is difficult. Exercise books are not an issue. They [government/ school] provide exercise books slowly, but they are not timely. Unless we had kept reserve exercise books, they didn't provide it completely. They [children] get worried and suffer. They request us to buy exercise books which are difficult to get for two or three children. It is better if you either provide it on time or tell us to buy exercise books on time. There is a gap in this regard.”— IDI with PW beneficiary, Arada, Woreda 2.

“For example, this year, there were more expenses needed for the youngest sons for school materials. Because of that, he dropped out of school but thanks to my neighbours and community people who contributed two or three exercise books and pencils to have him stay in school. Then he went back to school.” – IDI with PW beneficiary, Addis Ketema, Woreda 2.

7.2 Behavioural change communication sessions.

One of the additional components of the UPSNP is the behaviour change communication sessions on nutrition, health, gender equality, early marriage, and sexual and reproductive health. These

trainings are typically provided by social workers and health extension workers in their areas of expertise in their designated woredas and ketenas.

Table 8 presents the results that show the share of communities that took part in the BCC sessions. The share of communities that mentioned that BCC sessions have been conducted as part of the UPSNP reached almost 99 per cent at follow-up from 64 per cent at baseline. The share of communities that took part in the various sessions increased at follow-up. For example, the share of communities that took part in BCC session on livelihoods increased from 55 to 95 per cent; those that took part in BCC session on nutrition increased from 35 to 76 per cent; those that took part in BCC on child feeding increased from 35 to 60 per cent; the share of communities that took part in the BCC session on CBHI enrolment increased from 49 to 70 per cent; the share of communities that took part in BCC session on early marriage increased from 7 to 49 per cent; and the share of communities that took part in BCC session on harmful traditional practices increased from 11 to 43 per cent.

Table 7: Behaviour change communication for UPSNP

Variable	(1) Baseline	(2) Follow-up	(3) Difference	(4) N
BCC has been conducted as part of UPSNP	63.78 (48.25)	98.81 (10.88)	35.03*** (3.84)	295
PSNP BCC sessions: Livelihoods (agriculture, livestock, etc.)	55.12 (49.93)	95.18 (21.48)	40.06*** (4.32)	293
PSNP BCC sessions: Nutrition	35.43 (48.02)	75.90 (42.90)	40.47*** (5.33)	293
PSNP BCC sessions: Child feeding	35.43 (48.02)	59.64 (49.21)	24.21*** (5.74)	293
PSNP BCC sessions: CBHI enrolment	48.82 (50.18)	69.88 (46.02)	21.06*** (5.64)	293
PSNP BCC sessions: Cooking demonstration	18.11 (38.66)	53.01 (50.06)	34.90*** (5.36)	293
PSNP BCC sessions: Early marriage	7.09 (25.76)	49.40 (50.15)	42.31*** (4.88)	293
PSNP BCC sessions: Harmful traditional practices (i.e., FGM)	11.02 (31.44)	42.77 (49.62)	31.75*** (5.04)	293
Observations	127	168	295	

Note: Difference in column 3 shows the difference between follow-up and baseline values. Significance *** p<0.01, ** p<0.05, * p<0.1.

Table 9 presents the prevalence of early marriage in Addis Ababa city and the most influential enablers. Based on the table, two trends stand out: the perception of the prevalence of early marriage, where it decreases from about 53 per cent at baseline to around 30 per cent at follow-up and the perception that the respondent's religion is against early marriage, which also increased from

about 78 per cent at baseline to 98 per cent at follow-up. The former is striking, given the fact that the sample comes from the country's capital city, where better awareness and knowledge are expected to prevail. A larger share of community leaders perceive that parents are the most influential decision makers pertaining to early marriages followed by elders at baseline and religious leaders at follow-up.

Table 8: Early marriage

Variable	(1) Baseline	(2) Follow-up	(3) Difference	(4) N
Girls under 18 never marry in the ketena	47.06 (50.28)	69.49 (46.44)	22.43** (8.64)	127
My religion is against early marriage	77.94 (41.77)	98.31 (13.02)	20.36*** (5.67)	127
Religious leaders in my ketena do not support early marriage and advise against	92.65 (26.29)	86.44 (34.53)	-6.21 (5.41)	127
Elders are most influential in determining marriage under the age of 18	26.47 (44.45)	18.64 (39.28)	-7.83 (7.50)	127
Religious leaders are most influential in determining marriage under the age of 18	16.18 (37.10)	23.73 (42.91)	7.55 (7.10)	127
Parents are most influential in determining marriage under the age of 18	36.76 (48.57)	33.90 (47.74)	-2.87 (8.57)	127
Observations	68	59	127	

Note: Difference in column 3 shows the difference between follow-up and baseline values.

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

Delivery Mechanisms for BCC sessions

BCC sessions are delivered through various channels, such as community training for PW beneficiaries and informally during home visits for PDS beneficiaries. Staff responsible for conducting BCC suggested the need for utilizing suitable delivery mechanisms that are based on beneficiary needs and program feasibility.

“BCC is mainly in public work. I think they also have an officer; SBCC while they are at work, after work, what is expected from them about safety, safeguarding and the like. As I told you, SBCC is challenging for us [PDS]. As the concept of PDS, most of our beneficiaries are bedridden, they have mobility issues. SBCC is [provided] mostly in groups. So that was challenging. Now, we have broken that challenge, and we are implementing SBCC using community sensitization approach. That made us very successful.”—KII with BoWSA Safety Team lead Addis Ababa

“Look, from the beneficiary's side, as the training is given at the house-to-house level, it may not be effective. Yet, suppose the awareness is given by collecting the beneficiaries at a place and given by well-versed professionals instead of individually through the house-to-house level visits, for one or two days. In that case, it will be more effective as reaching all of them at once is possible. Our awareness activities

through house-to-house visits are tedious and cannot be more effective than using groups to reach everyone.”–KII with Social Worker, Arada, Woreda 6.

Perceived changes as a result of BCC attendance

The findings show that BCC sessions played a role in numerous ways. First, they increased awareness of different topics such as health, hygiene, and financial literacy. In addition, when resources were available in the households, the BCC contributed to changing their behaviour related to nutrition and hygiene practices and saving habits.

“The nutrition education we were given was really helpful. The diet I used to follow is not the same as the one I follow now. Fruit was something I never ate, but now I do. Even though I didn’t drink milk before, I do now. The training has provided me with a lot of knowledge.”–Respondent 1, FGD with Pregnant woman, Arada, Woreda 6.

“Some people thought their children could not be cured. For example, some parents believed there was no treatment for their children with mental development impairments. However, through our awareness activities, we changed their thinking and brought their children to medical services. Many of them are now receiving their treatment.”–KII with Social Worker, Arada, Woreda 6.

Others mentioned that the BCC sessions have contributed to improving their emotional well-being, and greater social interaction with peers.

“This training helps all of us to calm down. We are happy with that. When we behave inappropriately, our friends say to us, “How can you be like this? You got training, so our behaviour is corrected I swear to Allah.” Another very good thing is being ethical. Thus, behaviour plays the biggest part in our work, family and our religion. Our disciplined behaviour is critical to raising our children with good behaviour. We have received good training on ethical and trust. We come to understand that we have to trust each other when we work as a team.”–KII with PW team leader, Arada, Woreda 2.

Challenges to implementation and uptake

Beneficiaries typically had a positive attitude towards BCC sessions, but frontline providers mentioned that some beneficiaries do not value the trainings or have different expectations from the program.

“Many people are linked to their social life. For example, when there is training, there are people who say it is better to worry about their business rather than attending the training, feeling it will waste the time that they will spend to cope with their living. Yet, the training is beneficial for those who understand the importance of the training and can convert the knowledge gained from the training into practice.” –KII with PW team leader, Addis Ketema, Woreda 10.

“Yes, I am saying that when we go home-to-home...a change in behaviour...it is from the point of view of their expectations; they expect something better from us. Because they think we are there to give them something, this may be due to a lack of awareness or sickness. Some of them are not willing to give information. They may be annoyed at us when they do not get what they expect from us.” –KII with Social worker, Arada, Woreda 6.

Additionally, lactating women, mentioned that the caring for newborns and infants made it difficult to attend trainings

“My complaint is with the training. I just gave birth to my son, who is only 2 months and 15 days old and has not started eating. When I say I cannot let my child in the neighbour’s house, they tell me to take him and attend the meeting and how did I do it? After I went to the meeting hall, how could I stay at a meeting, which is starting at 8:00 AM in the morning up to 5:00 AM with this new baby, and how could I gather for 5 hours in this hot weather? When we say we will not come, they say that there is money to be released at the end, which will not be given for absence.”—Respondent 7, FGD with Lactating women, Addis Ketema, Woreda 10.

“We did not encounter any problem, but what may concern me is, because they said there will be a practical training in the future, I only have a concern for where I will keep my baby. But there is no problem I have faced till now.”—Respondent 1, FGD with Lactating women, Arada, Woreda 2.

However, one staff member insisted that child support is provided by the programme during BCC sessions to circumvent this issue.

“For those who can go out of their home, we make them come to the training place, and for this, we prepare a specific place for their children to stay. Yet, here are some people who are in TDS who refuse to come to the training place because of concern for their children, though we prepare a place for their children to stay. We see it as a challenge.”—KII with PW coordinator, Addis Ketema, Woreda 2.

However, it is unclear whether these child centres are suitable for infants and may not address the worries of mothers and caregivers. On the supply side, staff responsible for conducting BCC sessions indicated they do not have the expertise in providing these services to beneficiaries and there are no structured guidelines to conduct the sessions.

“In the implementation of behavioural change, you need a psychologist. As I told you... To implement this service, with whom you are coordinated. You should identify this first. For example, to work on psychological work, to refresh the person’s mind... To go to the person and do this and that, first, you need to get the gifted person—I mean, not the gifted person but the professional. From where do you get that professional? Which stakeholder are you working with? To tell the truth, there are no clear things. Usually, it has been done simply by us.”—KII with BoWSA Safety Net team lead, Arada, Woreda 6.

“It is not supported by training, when we go door-to-door visit, we inform them informally.”—KII with Social worker, Arada, Woreda 6.

7.3 Accessibility to and beneficiary interaction and satisfaction with service providers

A key factor that enables beneficiaries to access and receive social services is their interaction with service providers, particularly social workers, and health extension workers. Below are the findings from beneficiaries and key informants about beneficiaries’ interactions with these providers.

Experiences and interactions with social workers

UPSNP beneficiaries in the sub-cities and respective woredas had various levels of awareness of social workers. Some respondents mentioned they were aware of the social workers in their communities and had interacted with them in their homes. However, there were some beneficiaries, including PDS and TDS beneficiaries, who were unfamiliar with social workers nor interacted with any 'safety net officials.'

Key informants emphasized the importance of having a proportional number of social workers to beneficiaries as it is crucial for meaningful interactions. However, they highlighted an insufficient number of social workers hinder this interaction. They elaborated that the shortage of social workers is due to numerous challenges, such as a high turnover, low salaries, and poor working conditions.

"Though most of the budget is covered by UNICEF, our salary is based on the government scale. The level for the position is level 8, and the salary assigned to this position is from 3500 to 4000 birr per month. You can assume how much money is left after the salary tax. In short, this all creates alienation from work."—KII with BoWSA safety team lead, Arada, Woreda 6.

In addition, key informants highlighted that reaching beneficiaries poses a significant challenge due to the considerable distances between woreda offices and ketenes as well as safety concerns in neighbourhoods. Moreover, beneficiaries are frequently unavailable at home during visits, further complicating the implementation process.

Nevertheless, beneficiaries who were able to interact with social workers viewed them in a positive light and were appreciative of their support.

"Advise...since I have health insurance, they told me to get my children treatment on time when they get sick and make health follow-ups for myself, too. Secondly, they also ask whether the monthly cash transfer is being made on time. I then replied to them that it was being transferred monthly."—IDI with PDS beneficiary, Arada, Woreda 6

"For instance, even though I don't usually, I might give my kids avocado. I didn't feed them avocados in the past since I couldn't afford to. Thus, I am getting good support from the social worker."—IDI with lactating woman, Arada, Woreda 2

Few respondents' responses suggested their only interaction with social workers is during monitoring of their living conditions.

"They ask us how many rooms the house has, whether there is a television, whether there is a sofa or whether there is a table, and they go and record it. No other advice."—Respondent 2, FGD with PDS beneficiaries, Addis Ketema, Woreda 2.

Experiences and interactions with health extension workers

Unlike social workers, most beneficiaries were aware of health extension workers in their communities and interacted with them on a regular basis. Beneficiaries were able to articulate the benefits received from health extension workers clearly.

“Yes! It is very helpful to me, is it not a joke to measure diabetes? If I went to some private (Hospital), it would cost me a lot. Is it not, right?”—IDI with PDS beneficiary, Arada, Woreda 2.

“Yes, even yesterday, they came to me. They asked me about how many times I feed my child, what he replies with when talk to him. They tell me that if he is a healthy baby he should support his head during tummy time, to open music for him and that he has to listen. They tell me to talk to him loudly, that he should not be quiet. They teach me how to follow up his mental development, that he should answer by saying, uh, uh, when I talk to him, that he should match his age.”—Respondent 1, FGD with lactating women, Arada, Woreda 2.

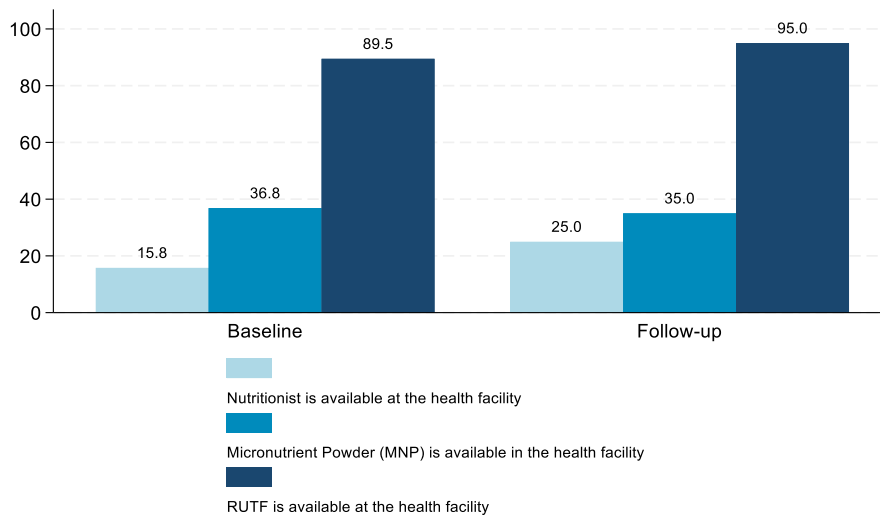
Some beneficiaries also suggested for health extension workers to increase their visits and expand the scope of issues they counsel.

“Hmmm...the service offered by the health extension workers is highly commendable. I recommend that they visit regularly to monitor the community’s progress towards cleanliness and overall health.”—IDI with PDS beneficiary, Addis Ketema, Woreda 10

“Hmmm well, it is better if they provide health education about various issues that may have an impact on the community’s health once a month. They also can disseminate health information like on ante natal and post-natal care simultaneously with vaccination. They just arrive suddenly. That is all.”—IDI with PW beneficiary, Addis Ketema, Woreda 10.

Error! Reference source not found. presents nutrition-related services provided by the healthcare facilities in the evaluation communities. About 15 per cent of the facilities at baseline and 25 per cent at follow-up reported having a nutritionist. About 37 per cent at baseline and 35 per cent at follow-up reported having micronutrient powder. The most widely available nutrition supplement appears to be ready-to-use therapeutic food (RUTF), as it is available in more than 90 per cent of the facilities at both baseline and follow-up.

Figure 8: Nutrition related services provided by health facilities



7.4 Integrated Programming: Opportunities and barriers to intersectoral collaboration

To increase integrated service delivery on the access and uptake of services, multisectoral collaboration and coordination of activities among actors involved in the UPSNP implementation. This section discusses the programme staff 's understanding and commitment towards integrated programming and the challenges hampering intersectoral collaboration.

Staff understanding and commitment towards integrated programming

All the key informants, from service providers to policy leaders, displayed a good awareness of the integrated programming, except for health extension workers. Staff were aware of the various components, such as the linkage of PDS beneficiaries to CBHI premium waivers, conditions of PW beneficiaries to TDS, and co-responsibilities for PDS and TDS beneficiaries.

Additionally, key informants perceived the collaboration between UPSNP and CBHI, and the coordination of targeting and awareness activities to be highly crucial for programme beneficiaries to enrol in CBHI and access health services.

‘I mean, it is good that we work together to make CBHI accessible. We would reach house-to-house and they would also, we get information from them, what kind of person should be involved, when to renew, and how much the payment is, we hear from them mostly. We take that and work accordingly.’ –KII with HEW, Arada, Woreda 2.

Operational and institutional modalities for integrated programming

To increase access and uptake of social services, multisectoral collaboration and integrated planning of the UPSNP is critical. At the community level, collaboration between social workers and health

extension workers is essential to enrol programme beneficiaries into CBHI and uptake of other social services.

"Before we identify safety net program beneficiaries, we make home visits. We do screening with health extension workers. We do screening with Labour and Social [Affairs]. We work in collaboration. Labour and Social [Affairs] is concerned with direct support; health extension workers are concerned about health condition. We do screening with them in all the five ketenas, but we do not work [with them] after screening." –KII with Public Works Coordinator, Addis Ketema, Woreda 10.

At the woreda level, intersectoral collaboration is fostered through the technical coordination committee (TCC), which comprises focal persons from different government sectors, including education, health, and vital events registration. The committee is responsible for improving accessibility and service linkage, planning, and monitoring of the UPSNP.

Challenges hampering intersectoral collaboration and integrated programming

Key informants were asked about the challenges hindering multisectoral collaboration and coordination to foster integrated service delivery. Several challenges were identified across different levels of implementation.

First, the findings show that restructuring of government administration and high staff turnover of woreda implementers hinder program efficiency and intersectoral collaboration. For instance, in the past year, Addis Ababa merged Women and Children Affairs with Social Affairs, which was previously under the Ministry of Labour.

"There are problems related to merging the existing structure and turnover of staff. When a well-trained person leaves and is replaced by a new one, there will be a loss of investment as well as time. Even now, there is a rumour that a new structural arrangement will be made."–KII with Public Works Coordinator, Addis Ketema Sub-City.

Second, key informants mentioned frontline agencies lacked clear guidelines to support them in fulfilling their responsibilities as a significant concern. Consequently, implementation heavily relies on the efforts of frontline workers, thereby affecting the overall quality of implementation. These concerns were raised by social workers and their supervisors in relation to case management, where there are no measures of how to ensure cases are resolved. It was not clear from the interviews whether guidelines existed but may have not been cascaded down to frontline workers through training.

"We are facilitating for them [beneficiaries] to renew their ID card at the vital event registration office through our own will. The person there is doing so by his will, as there is no guide from the higher level for us to lead by. In general, our activities are not uniform, as there is no guideline by which we are led. Nevertheless, it is by our will that we are doing this to solve the problem."–KII with Social Worker, Addis Ketema, Woreda 2.

"No, I do not believe that it is fully implemented. We are solving only those within our reach. Despite transferring the case, we know that the problem cannot be solved by the next level. We

are addressing minor problems. We say that most of the problems are not solved.”–KII with Social Worker, Addis Ketema, Woreda 2.

Policymakers highlighted that the fundamental challenge underlying all the issues affecting collaboration and integrated programming is the absence of a legal framework for a national social protection system. The current structure, where various agencies manage different programme components, results in fragmented data and resource allocation disputes.

7.5 Summary

This chapter discussed the implementation of the complementary features of the ISNP and their perceived impacts and challenges. The findings suggest that the effectiveness of BCC sessions and co-responsibilities depend on several factors, such as sufficient financial resources available to beneficiaries, effective multisectoral collaboration, and an adequate number of social workers. The detailed findings are summarized in Box 5.

Box 5: Summary findings of linkages to social services
<p>Co-responsibilities</p> <p>Participants’ responses indicate that the impact of co-responsibilities depended on prevailing social norms and financial resources to fulfil these conditions. For instance, as women were already aware of maternal health services, the co-responsibility did not influence their behaviour, but life skills and financial literacy training for PWV households seemed to be more appreciated as they were able to use the acquired knowledge to improve their finances and social life.</p>
<p>BCC sessions</p> <p>While BCC sessions are provided, resource constraints lead program staff to prioritize community-based BCC sessions, which may not often suit PDS and TDS beneficiaries. However, the findings show that BCC attendance and engagement with frontline providers have positively influenced beneficiaries’ utilization of cash transfers for food and increased their nutrition knowledge.</p>
<p>Interaction with service providers</p> <p>Beneficiaries tend to interact more with health extension workers, and their interactions have influenced beneficiaries’ hygiene practices and health literacy. Even though their interactions with social workers were more limited, they were able to engage with them to some extent. Challenges in recruiting and retaining social workers stemming from government financial constraints and poor working conditions hinder their engagement with beneficiaries.</p>
<p>Intersectoral collaboration</p> <p>The findings suggest key partners are committed to intersectoral collaboration to ensure beneficiaries receive social services. However, collaboration efforts are constrained by a lack of clear guidelines and responsibilities for frontline workers, resource scarcity, high staff turnover, and restructuring of government administration.</p>

8 Perceived impacts of ISNP on intermediate and mid-term outcomes

This chapter presents stakeholders' perspectives on the impact of the integrated programming on key intermediate and mid-term outcomes of the ISNP framework namely reduced food insecurity, increased knowledge of feeding practices and general nutrition, and increased service-seeking behaviour. It builds on the previous chapters to understand how various components of the program have influenced outcomes. It presents the results of research question 6: *What are the perceived effects of the integrated programming on food security, nutrition, and health?*

The chapter consists of five sections covering perceptions on the programme's impact on food security, nutrition knowledge, infant and young child feed practices, care during pregnancy and care for illnesses. It builds on section 3.2 about transfers' regularity and adequacy and chapter 7, which focuses on linking UPSNP beneficiaries to basic services through integrated programming.

8.1 Food security

As shown in section 3.2, on cash transfers' regularity and adequacy, the amount of the cash transfer is insufficient for beneficiaries to cope with the rising inflation. Participants were asked how the program has impacted their food intake and they reported that the **cash transfer size is insufficient to reduce food insecurity, but it appears to have helped participants avoid extreme hunger.**

"Yes, it is really helpful. Even small helps are supportive and thanks to Alhamdulillah [Thanks to God], after my husband died, I had a hard time and then I got registered for this [safety net] at the Kebele and they told me what is, and they gave me."—IDI with PDS beneficiary, Arada, Woreda 2.

"Despite the cash not being sufficient to afford a very nutritious diet due to inflation, at least they can have bread with the cash transferred. Thus, the program transferred beneficiaries from nothing to something. To the best of my understanding, it has a positive impact."—KII with UPSNP coordinator, Addis Ababa

Few beneficiaries explained that **through home visits, social workers influenced their allocation of transfer to food expenditures.**

"For instance, when I first started, because they did not visit back then, I used to spend the money on different stuff like soap and some things like that, that is also important but not as important as the food. But then after they started to come and give advice; they told me to buy them food (for her children) [I also buy food and take it] as an obligation with the payment I get from them. Thus, their advice, they are right. Because I have convinced myself on purchasing my children's food and needs with the money I get from the safety net, even if it gets late, I will buy them food stuffs in the morning because the thought of buying some other things only reminds me of them, while I win this on my own."—IDI with PDS beneficiary, Arada, Woreda 6

Interviewer: "What has safety brought to your children's nutrition? Is there an understanding of how nutrition is made, eaten, and worked?"

Respondent 1: "They often come and ask how much we spend on what we eat." –FGD with PDS beneficiaries, Addis Ketema, Woreda 2.

Nevertheless, responses from **frontline providers and beneficiaries indicated that food insecurity was a challenge, especially with the high inflation.**

"It is less effective in relation to food security. In relation to health insurance, it is better because they live in the city, and their knowledge is better." – KII with Social Worker, Addis Ketema, Woreda 10

"Hmmm I experience persistent hunger throughout the day. I can get [food] when I want. No one gives me. As you can see, the children quickly go back to their homes and don't stay with me. I am left with the necessity to buy INJERA [basic staple food in Ethiopia made from Teff] but consuming it upsets my stomach. Unfortunately, I lack the funds to purchase other food items. My sole source of income is 1000 ETB from the safety net program, which falls short when considering various expenses, such as utility bills for electricity and water, as well as the need to buy ingredients for meals. It is simply not enough to cover all these costs." –IDI with PDS beneficiary, Addis Ketema, Woreda 2.

It appears from interviews with beneficiaries that the **school feeding program in public schools has been imperative for households that struggle to provide food for children.**

"Interviewer: So, you received support to keep your children at school?"

Respondent: I sincerely thank them for feeding our children. It is a great support for us. Although my grandchild has his own parents, he is living together with me and is growing up with me. I am the one who provides everything." –IDI with PDS beneficiary, Addis Ketema, Woreda 2.

"Thanks to God, currently the government has also started school feeding. So, if we were to give them tea or some other thing for breakfast, they will be able to eat their lunch at school. Of course, there is breakfast there too, so that's how it is. Thanks to God, things are much better now than before." –Respondent 2, FGD with PW beneficiaries, Addis Ketema, Woreda 10.

Key-informants mentioned that UPSNP previously supported beneficiaries with food items, but this support has stopped and the reason for ceasing is unclear from the interviews. Stakeholders suggested for the UPSNP to **provide in-kind support, such as food items to pregnant and lactating women to cope with the rising inflation.**

Likewise, the community questionnaire elicited information on food security and food inflation from community leaders. Table 11 summarizes the food related challenges faced by the communities. The table shows that the number of years the communities have been facing inflation significantly increased between baseline and follow-up, a trend likely driven by the national and global shocks, such as the civil war, COVID-19 and the Russia-Ukraine conflict. While 91 per cent of the communities at baseline stated that they faced food price increases following the first case of COVID-19 pandemic, at follow-up, the share declined to about 84 per cent. This decline could be either due to actual decline in inflation or perceived lower inflation due to a lower rate of price increase in 2023 compared to 2021. Unsurprisingly, the share of communities that receive food distribution following the

pandemic also declined at follow-up by about 26 percentage points. The decline in food distribution has also been found in the qualitative analysis.

Table 9: Food availability and inflation

Variable	(1) Baseline	(2) Follow-up	(3) Difference	(4) % change	(5) N
Number of years with sharp increase in price in the ketena since 2019/20	3.07 (1.45)	3.45 (1.27)	0.38** (0.16)	12.37	294
Food price increased in the ketena after the first case of COVID	91.34 (28.24)	83.93 (36.84)	-7.41* (3.93)		295
Food items were distributed in the ketena during COVID	81.10 (39.30)	55.36 (49.86)	-25.75*** (5.36)		295
Observations	127	168	295		

Note: Difference in column 3 shows the difference between follow-up and baseline values in percentages except for the first indicator where the percentage change is reported in column 4. Significance *** p<0.01, ** p<0.05, * p<0.1.

8.2 Infant and Young Child Feeding Practices

Caregivers of infants reported receiving counselling about breastfeeding and feeding for young children. They also mentioned that they breastfeed their infants according to the advice provided by health professionals and described their breastfeeding practices.

“No, until six months, we didn’t give any food as the doctors and health professionals advised us. It is now we started giving supplementary food.”—IDI with lactating woman of an 8-month-old baby, Addis Ketema, Woreda 10

“Yes, for the first six months of her life, she was only breastfed. She struggled to begin eating when she was six months old. I refused to give it, but I breastfed her until she was six months old, despite the advice of many that she should start eating more at four months.”—IDI with lactating woman of a 10-month-old baby, Arada, Woreda 2

Few women reported having difficulties with breastfeeding due to their inability to have sufficient fluids.

“She must be fed breast milk. Yet sometimes my breast may not have milk due to my feeding. There may not be milk in my breasts if I do not take sufficient fluids. By then, I will feed her other available food. I started supplementary food after she became six months of age, and yet I feed her my breast milk as far as I can. Yet, no sufficient milk is available.”— IDI with Lactating woman of a 7-month-old-baby, Addis Ketema, Woreda 10.

Regarding feeding practices of young children, beneficiaries reported that they struggled to feed them diversified meals due to financial constraints and therefore children ate the same foods as the rest of household members.

“I wish I could prepare and give her special food and make her stronger. My child frequently suffers from common cold, and I speculate that this could be due to a lack of a balanced diet. But the others are well, they do not get sick.”—IDI with PW beneficiary with a 2-year-old baby, Addis Ketema, Woreda 10.

Key-informants also mentioned that the UPSNP is focused on improving the nutrition of young children and supporting those with malnutrition.

“In the past year, we found one or two children and ensured they got what they needed. We contributed to providing nutrient-rich foods for children with malnutrition through the children’s support department available at the children’s office.”—KII with Social Worker, Arada, Woreda 6.

“From the dimension of the amount of money you transfer, you cannot say eat, do this type of physical exercise, it is very difficult to them to lead a healthy lifestyle because there are priorities other than that. But as far as we can, attention is given to the children. At least, if they are very far from affording it, they will be selected by our bureau from Woredas and they will be able to get nutritious food so they will not be stunted.”—KII with BoWSA Safety Team Lead, Addis Ababa.

8.3 Care during pregnancy

Pregnant and lactating women were asked about their experiences during pregnancy, regarding nutrition, antenatal care, delivery, and postnatal care. One of the main co-responsibilities for pregnant women is antenatal care visits. According to the UPSNP, social workers and health extension workers should also encourage and support pregnant women to receive ANC. Interviews with social workers and other UPSNP officials also confirmed that social workers do provide advice during pregnancy. However, others explained that although they found the information useful, they have been unable to put their awareness into action due to the economic hardship.

“I just can’t afford to buy some food. For instance, while fruits are essential, I am unable to buy oranges. Even though it is available in the market, I am unable to buy it; I will return without buying it after only seeing it there.” – IDI with Pregnant woman, Arada, Woreda 6.

“The state of the economy and your finances have an impact on your diet. For example, even though I am aware that eating fruits and other foods is beneficial to my health, I only eat them for my foetus because life is hard. After training, I feel better. I’ve benefited from it. You learn things, but you apply them when you can since it all depends on your financial situation at the time.”—Respondent 2, FGD with Pregnant women, Arada, Woreda 2.

Social workers reported that previously, nutritious meals were distributed to pregnant women, but this practice has stopped.

Most of the pregnant and lactating women in IDIs and FGDs answered positively, when asked whether they had received ANC check-up since becoming pregnant or when they were pregnant.

“It is mandatory to go every month to listen to the advice they give you and to know your child’s condition to protect your health because they get angry if the month is skipped.”—Respondent 2, FGD with Pregnant women, Addis Ketema, Woreda 2

“Interviewer: How many of you have had antenatal care? Did you go checkups during pregnancies?”

All: Yes.

Interviewer: Everyone?”

Participants: Yes” –FGD with Lactating women, Arada, Woreda 2

Most women reported positive and satisfactory experiences during their ANC at public health centres in terms of waiting time, affordability, and care provision. According to the Ministry of Health guidelines, ANC services are free of charge.

“It is good. I say it is good because you get treatment as you reach there, if you are pregnant, you get priority to get card. Plus, there are offices you get in if you are there for medication [for other illnesses]. But if it is pregnancy, you don’t need to wait in those lines. You get your card and go to the place where you get treatment. I think I got that service at an appropriate time.”–IDI with Pregnant woman, Addis Ketema, Woreda 2.

“Pregnant women receive all services at no cost. There, all the vitamins and essential services are provided at no cost.”–Respondent 5, FGD with Pregnant woman, Arada, Woreda 6.

However, a few respondents also recounted negative experiences such as perceived medical negligence, disrespect by providers and high out-of-pocket expenditures from services not available at public health facilities.

“I’m not going to the health centre to get ANC. I went to the health centre last year when I was one month pregnant, but I was given an appointment for three months and fifteen days. However, a miscarriage occurred in between. The baby was not doing well when I returned in the sixth month, and a caesarean section was performed to spare the foetus. I’m currently seeking ANC at a private health facility.”–Respondent 4, FGD with Pregnant woman, Arada, Woreda 6.

Lactating women were also asked about their delivery and postnatal care experiences, and similarly, all the women responded receiving these services at health facilities and having positive experiences. Birth delivery and postnatal services are also free of charge. Nevertheless, few women reported negative experiences, mostly due to disrespect by health workers and perceived negligence.

The qualitative results have shown that pregnant clients are mostly satisfied with the facilities. Table 12 presents the average number of women that received care at the health facilities in the evaluation areas. The average number of women that received their first ante-natal care (ANC) is 587 at baseline and 676 at follow-up, an increase of 15 per cent. The number of women that received their fourth ANC visit is lower than that for the first visit (from 587 to 382 at baseline and from 676 to 583 at follow-up). Furthermore, the average number of women that delivered at the health facilities is even lower than the number that received their 4th ANC, with just 260 at baseline and 310 at follow-up.

Table 10: Average number of pregnant women that received healthcare service at the health facilities within 12 months

Variable	(1) Baseline	(2) Follow-up	(3) % change	(4) N
----------	-----------------	------------------	-----------------	----------

Average number of pregnant mothers that received 1st ANC visit	587.11	675.90	15.12	39
Average number of pregnant mothers that received 4th ANC visit	382.21	583.10	52.57	39
Average number of pregnant mothers that delivered in the reporting facility	259.89	310.25	19.37	39
Observations	19	20		

Note: this table does not include statistical tests due to small sample size.

8.4 Care for illness

Additionally, respondents noted that although the CBHI has increased healthcare accessibility, challenges remain in the other dimensions of care accessibility. One of the main barriers for care-seeking for beneficiaries is the ability to reach health facilities. Some beneficiaries, particularly from the PDS component are elderly with mobility constraints who do not have social support to seek care.

“There are older people and bedridden patients; these groups cannot go to the hospital by themselves, and there are also many mothers who take care of children, and they don’t go to the hospital, leaving the children behind.” –KII with Social worker, Arada, Woreda 6.

Preconceptions that are informed by religious beliefs are also a barrier to treatment seeking for illness. When asked what they often did when they were sick and some respondents, particularly elderly beneficiaries, reported preferring religious institutions over medical care with medical care being an alternative after religious sources have failed.

“Medical treatment will not alleviate my pain, but the Tsebel does a better job.” –PDS beneficiary, IDI with PDS beneficiary, Addis Ketema, Woreda 2.

“Since I am Orthodox [Christian], I use holy water. Drugs have side effects, so it is better to use holy water initially and then go to the health centre if the holy water could not help.” –IDI with PW beneficiary, Addis Ketema, Woreda 10.

Finally, participants reported that previous experiences of inappropriate care such as disrespect by health care workers, and the perceived poor quality of care, deter some respondents from seeking care again. Participants perceived quality of care to be poor because of frequent drug stock-outs and not receiving appropriate treatment.

“Because they talk bad to me, I just stopped going. Now I use traditional medicines and it has been so long since I have brought any medications. That is, it. Those [previous health professionals at health centre] whom I looked up to for my health conditions were not there, I think they have been replaced.” –IDI with PDS beneficiary, Arada, Woreda 6.

“As for us, maybe the challenge is, the preference, they may say “Holy Water is better for me and terminate it” we cannot say this is because of lack of awareness. Because some people try two or three times and if they are not getting relief by medication, they will go to Holy Water. As a result, there is a tendency to be exposed to serious health problems. There is a tendency to go back to their traditional beliefs. So, as far as

we can, our social workers on the ground are trying to convince them to follow up their medication in parallel without terminating the Holy Water. But what I consider as one challenge is a kind of immediate feeling of hopelessness. You go today and if you are not getting appropriate treatment at the health centre, they decide not to go there again. Since they are sensitive, they become immediately hopeless. Sometimes, if it is not solved after trying it two or three times, they tend to prefer the Holy Water.”—KII with BoWSA Safety Net team lead, Addis Ababa

All the participants reporting seeking care for their ill children at the health facilities.

“I take him to the health centre. I have health insurance.”—IDI with Pregnant woman with a 2-year-old baby, Arada, Woreda 6.

“We simply keep an eye on the baby’s condition at home to see if it improves. If not, we will take it to the medical facility. You will follow their instructions and they will take care of it.”—IDI with lactating woman, Arada, Woreda 2.

Even caregivers who mentioned not often utilizing health facilities for themselves reported using health facilities for their ill children.

“I do not visit the health centre unless it gets serious. But if my children are sick, I do not waste time. I immediately take them to the health centre, even if at midnight. We seek care at the health centre mostly. For myself, I may use garlic, ‘Feto’ [local herbs] and etc. Children have poor resistance to diseases, but we can resist.”—Respondent 3. FGD with PW beneficiaries, Addis Ketema, Woreda 10.

“Respondent: I take him to the health centre.

Interviewer: Who takes him there?

Respondent: Either neighbours or I if I am feeling well enough. I will personally take my child to the health centre in our Woreda. However, if I am not in a condition to do so, I rely on the assistance of my neighbours to bring my child to the health facility. I rely on the assistance of my neighbours to bring my child. I refrain from asking them to take me because I do not want to burden them. Unfortunately, I do not have any relatives nearby to rely on for help.”—IDI with PDS beneficiary, Addis Ketema, Woreda 2.

As can be observed from the qualitative results, households are more likely to seek treatment from health facilities for their children than for themselves. Table 13 presents the average number of children that received different types of health care at the health facilities. Firstly, the number of children that received health care was similar at baseline and follow-up, with the exception for vitamin A supplements where the number of recipient children almost doubled at follow-up. On average, about 525 children per facility received Penta 3 vaccinations, about 561 at baseline and 265 at follow-up received pneumonia treatment, and about 382 children at baseline and 583 at follow-up have received deworming treatment.

Table 11: Average number of children that received healthcare at the health facilities within 12 months

Variable	(1) Baseline	(2) Follow-up	(3) % change	(4) N
Average number of eligible children vaccinated for Penta 3	525.58	523.95	0.31	39

Average number of under-five sick children of diarrhoea and treated with ORS and	264.84	381.20	43.93	39
Average number of under-five sick children of pneumonia and treated with appropriate antibiotics	561.58	264.95	52.82	39
Average number of children aged 6-59 months who received vitamin A supplements	1765.84	3529.20	99.89	39
Average number of children aged 2-5 years de-wormed	382.21	583.10	52.56	39
Observations	19	20		

Note: this table does not include statistical tests due to small sample size.

8.5 Summary

This chapter has discussed the complex ways in which the ISNP affect beneficiaries' health and nutrition. It has shed light on various perceived outcomes resulting from the program efforts, as well as challenges that have influenced program implementation. The summary of the findings is in Box 6.

Box 6: Summary of the perceived effects of the ISNP

Food security

The findings highlight that social workers have influenced beneficiaries use of the cash transfer for food consumption. However, despite the cash transfer mitigating extreme hunger amidst high inflation rates, food insecurity is a key challenge.

Infant and young child feeding practices

Lactating women reported breastfeeding their infants exclusively until six months as a result of attending BCC sessions offered by the program and counselling by health facilities. However, despite this knowledge, mothers are unable to effectively utilize it to improve the nutrition of their young children due to the impact of high food prices on household food spending, rendering many important food items unaffordable.

Care during pregnancy

Antenatal and postnatal care visits appeared to be high, but this may not be attributed to the co-responsibility for pregnant women to attend check-ups as women already had prior knowledge on their importance. Furthermore, these services are available free of charge and so not having CBHI did not deter their use.

Care for illness

The findings underscored the significant role of CBHI in facilitating use of health facilities by addressing the affordability barrier. By reducing the financial barriers, CBHI, has effectively increased using health facilities for illness. However, use of health facilities remains non-universal as lack of social support, geographical barriers, misconceptions from religious beliefs and service delivery quality hinder access to care for certain beneficiaries, particularly the elderly.

9 Conclusions, Discussion and Policy Recommendations

This evaluation aimed to understand the implementation of the Integrated Safety Net Programme in Addis Ababa and its perceived impact on UPSNP beneficiaries. The main goals of the ISNP are –1) Promoting CBHI enrolment and premium waivers for PDS beneficiaries, 2) Transitioning of pregnant and lactating women in Public Works into Temporary Direct Support (TDS) and 3) Strengthening the links to social services for beneficiaries. The overall primary question was ‘*To what extent has the integrated programming influenced CBHI enrolment among UPSNP beneficiaries and how does the programme affect access and uptake of social services?*’

9.1 Conclusions and discussion of key findings

UPSNP implementation

The qualitative findings show that the implementation of the core components of the UPSNP, such as targeting, cash transfers and TDS have improved through multi-sectoral collaboration, but gaps remain that need to be addressed.

Targeting of vulnerable populations has improved to ensure the program only include eligible households, but challenges remain in the community-based targeting due to some committee members selecting beneficiaries based on personal relations. This is consistent with the literature on the weaknesses of community-based targeting in the social protection sector (Arif, 2006; Levy, 2003; Yusuf, 2010). In a review of 30 programmes using community-based targeting, Yusuf reported that these challenges, such as corruption and elite capture are negatively correlated with targeting performance (Yusuf, 2010). Additionally, he finds that programmes that include in its design monitoring, accountability and transparency are more likely to improve targeting performance.

In relation to the cash transfers, the analysis revealed that although the cash transfers are regular, they are inadequate for households to cope with inflation and rising cost of living. The finding aligns with current literature on the negative effects of the COVID-19 crisis and the Russia-Ukraine conflict in both low- and high-income countries (OECD, 2023; World Bank, 2022). In Ethiopia, a study analysing inflation using price indices from 2016 to 2022 reported that high inflation is primarily driven by the high rate of inflation in food prices (Ali, 2023). Consequently, poor households which typically allocate a larger portion of their income to food expenses are affected disproportionately than rich households. This underlines the need for the government and development partners to develop strategies to assist UPSNP beneficiaries cope effectively with the spiking inflation rates.

Finally, the findings also reveal that TDS participation during pregnancy and lactation is high, and it is attributed to early information provided to women upon their enrolment into the UPSNP. However, the timing of women’s transitioning into TDS and the requirement of other household members to work on behalf of women in TDS are inconsistently implemented in woredas. It is important to ensure that pregnant women transition on time to prevent potential adverse consequences associated with heavy physical work (Corchero-Falcon et al., 2023).

CBHI enrolment, role of the ISNP and perceived impacts of CBHI

On the key question of CBHI enrolment, the findings show that enrolment of PDS beneficiaries is high, thanks to the collaborative efforts among various actors to provide premium waivers and support the renewal process. However, universal insurance coverage among PDS beneficiaries has yet to be achieved due to demand-side barriers. The finding underscores the importance of addressing all the barriers, besides affordability, that hinder CBHI enrolment among the elderly and those with reduced mobility. Providing fee waivers is not enough to ensure equitable enrolment of vulnerable populations into health insurance schemes.

Meanwhile many of the PW beneficiaries indicated not being enrolled and not having intentions to renew their CBHI membership. The main reason was unaffordability of the increased CBHI annual premium. With inflation decreasing the transfer value, households have shifted their priorities to other essential needs such as food rather than paying CBHI premiums. This finding is also consistent with those other studies across Ethiopia (G. D. Demissie & Atnafu, 2021; Fite et al., 2021; Hussien & Azage, 2021). The finding highlights that beyond awareness and information, PW beneficiaries require additional support to enrol in the scheme.

Participants explained that CBHI enrolment has increased health service utilization by removing the affordability barrier and has reduced out-of-pocket health expenditure. Similar findings have been reported by other qualitative and quantitative studies from various parts of Ethiopia (Alemayehu et al., 2023; B. Demissie & Gutema Negeri, 2020; Mebratie et al., 2019). Generally, beneficiaries were satisfied with health services under the CBHI, but many were disappointed with the activation process, limited access of the health insurance to many health care services and medicine, and shortage of medical supplies at health facilities as they lead to unexpected out-of-pocket expenses or beneficiaries foregoing care. Quantitative findings have shown that household's healthcare utilization is positively associated with continuous availability of essential medicines (Anselmi et al., 2015; Kuwawenaruwa et al., 2020). On the other hand, health facility survey showed that most essential medicines were available/in stock at the day of the interview, and the shortages beneficiaries may have been referring to could have been medicines excluded from the benefit package or that even though supplies were in stock, they might not be available in sufficient quantities to satisfy the demand of all clients. The findings suggest that beneficiaries' expectation of 'free' health services under the CBHI also contributes to their dissatisfaction and termination of their membership. Beneficiaries should be provided with clear and comprehensive information on CBHI entitlements, especially the limit of its benefit package to manage their expectations. Having a clear understanding of their entitlements is critical for renewal (Kaso et al., 2022).

Linking UPSNP to basic services through integrated programming

Beneficiaries' responses suggest they are motivated to fulfil their co-responsibilities, but financial constraints hinder them. This emphasizes the importance of ensuring that transfer size is not adequate to enable beneficiaries to fulfil their co-responsibilities.

Due to limited resources, particularly a shortage of social workers, programme staff prefer using community training, but this mechanism is often not suitable for PDS and TDS beneficiaries. Frontline workers, specifically social workers and health extension workers are crucial in supporting

beneficiaries with fulfilling their co-responsibilities, BCC, and case management. Beneficiaries had more experiences interacting and were satisfied with services from health extension workers than social workers. Recruitment and retention of social workers, which stem from poor working conditions, hinder their engagement with beneficiaries.

Finally, the findings show that stakeholders are committed to integrated programming, and multisectoral collaboration has improved but sustainable collaboration is impeded by high staff turnover and restructuring of government administration.

Perceived impacts of ISNP on intermediate and mid-term outcomes

Interviews with participants reveal that food price shocks from the high inflation have affected food security. Nonetheless, the findings also suggest that the cash transfer is at least preventing beneficiaries from experiencing extreme hunger.

All the pregnant and lactating women interviewed reported receiving maternal health services such as ANC, skilled birth delivery and postnatal care, but they reported it was due to their own knowledge and not from the ISNP. The health facility survey also showed that ANC and skilled birth delivery have increased generally. Similarly, other beneficiaries also reported seeking care at health facilities, with a few also using spiritual healing in combination. However, most beneficiaries mentioned health facilities as the main source of care for children. The findings indicate the programme impacted health-seeking behaviour through CBHI and the cash transfer, but not necessarily their attitudes towards care-seeking at health facilities as it was already their preferred choice. A cross-sectional study also reported a moderate proportion of caregivers (70%) seeking care for childhood illnesses (Bellete et al., 2021).

9.2 Recommendations

The evaluation's findings provide crucial insights for policymakers and researchers to advance social protection for vulnerable populations in urban areas. A validation workshop was held in Addis Ababa on 29th July 2024 with policymakers and national stakeholders to present the research and its findings. A first set of policy options based on the research findings were first proposed and presented. Policymakers and national stakeholders deliberated on these policy options in small working groups. A plenary discussion session followed where each working group presented the conclusions of their deliberations as well as suggesting other policy options that may not have been initially considered. This sub-section presents the summary of the policy recommendations in two parts. The first part presents policy recommendations for increasing uptake of social services, CBHI enrolment, and enhancing multisectoral collaboration, and the second part proposes recommendations for further research.

Policy recommendations

1) Invest in adequate numbers of social workers that are well trained and competent.

Trained and competent social workers, as the findings show, are crucial to mitigating some of the challenges beneficiaries face regarding CBHI renewal, access to services and behaviour change. However, the current ratio of social workers to beneficiaries is not conducive to regular engagement

Commented [GBK2]: There were comments from workshop participants about whether the recommendation would be feasible? There were suggestions to divide into short-term, mid-term, and long-term recommendations.

with beneficiaries. The underlying factors for this inadequacy are related to the recruitment and retention of social workers. As social workers in Addis Ababa are part of the public service, several specific actions can be taken in collaboration with the Government of Ethiopia to address their issues.

a) Improve education training of social workers.

One of the main concerns raised by social workers is adequate training to effectively manage cases and conduct BCC sessions. Therefore, it is critical for pre-service training to have high standards in social work. Quality pre-service training ensures that social workers begin their careers equipped with the necessary knowledge and competency to support vulnerable populations effectively. Furthermore, continuous educational training should be accessible to all social workers. Although the programme has offered numerous pieces of training, some workers perceived the training not to be adequate and hence continuous training opportunities could ensure sustainability.

b) Increase employment and positive working conditions for social workers.

A fundamental challenge lies in the shortage of trained social workers, exacerbated by the current ban on public sector recruitment. Upon lifting the ban, it is critical not only to increase the number of social workers, but also to prioritize the recruitment of qualified professionals for the role of social workers.

To improve the retention of social workers, their working conditions also need enhancement. During home visits, provisions, such as transportation and protective gear for varying weather conditions, should be made available. Additionally, consideration should be given to providing incentives, such as per diems, for home visits, as social workers encounter numerous challenges in reaching beneficiaries. Additionally, there should be professional development opportunities for social workers to move up the government structure.

c) Strengthen governance and management of social workers.

The establishment of the Bureau of Women and Social Affairs has improved some of the structural challenges social workers face at the woreda level. However, some gaps in the governance and management of social workers remain, and these need to be addressed. First, there should be an effective oversight of social workers at the woreda administration. This would ensure that social workers' concerns about working conditions and case management are properly addressed by higher officials. Second, although financial resources are limited, there should be a commitment to earmark budget for social workers' activities.

2) Address the barriers to the enrolment and renewal of CBHI by enhancing knowledge about the entitlements, improving timeliness of renewals and affordability of premiums.

The extent of CBHI coverage is highly dependent on both the enrolment of new members and the retention of current ones. Given that health insurance is a complex notion and a relatively new concept in the Ethiopian context, continuous awareness is necessary for its successful implementation. Moreover, awareness campaigns designed to attract new members to the scheme should be executed with clarity and tact to avoid compromising retention efforts.

a) Ensure understanding of health insurance and transparency about entitlements.

It is imperative that awareness campaigns about the CBHI to also incorporate education about its fundamental principles, such as solidarity and mutual aid. This approach may help address concerns from members regarding utilization of their contributions, especially in

cases where they did not access health services. Additionally, transparency about CBHI entitlements is essential during campaigns. Communities need to understand that while there are benefits, the benefit package has limitations, and not all health services are 'free' under the scheme. Given that access to medicines is a major concern for beneficiaries, special attention should be given to the medicines list during awareness campaigns and enrolment processes.

Since CBHI sensitization and awareness campaigns involve multiple stakeholders, it will be vital for all partners to undergo consistent training on the health insurance. This ensures that public campaigns convey uniform messages.

b) Ensure timely and efficient enrolment and renewal processes.

The findings show that there are individuals interested in enrolling or renewing their CBHI, but they encounter obstacles during the process. The solutions to these challenges can ultimately be rectified by the health insurance authority, but the UPSNP, through its relations with the Health Insurance Authority, could advocate for remedies at woreda levels. First, it is important that CBHI activation offices located on higher floors are accessible to all, including those with reduced mobility. Second, during the peak of activation periods, additional staff may be necessary to reduce waiting times. Third, the activation process should be streamlined to function as a one-stop location for all steps, including registration and payment.

3) Address the barriers the enrolment in CBHI among PDS beneficiaries by supporting their health insurance renewals and introducing flexibility in the enrolment period.

Premium exemptions for PDS beneficiaries have removed the affordability barrier, but other challenges remain for universal insurance coverage among these beneficiaries. Tackling CBHI activation and renewal challenges for PDS beneficiaries will need a multisectoral collaboration among UPSNP implementers, CBHI coordinators, Health Bureau and community committees at the woreda and ketena levels.

a) Identify and support PDS beneficiaries likely to need assistance with renewal.

Stakeholders recognized the potential need of some PDS beneficiaries to have support with CBHI renewal and have been supporting beneficiaries to renew their membership. Nevertheless, renewal challenges remain for PDS beneficiaries for those with reduced mobility or memory problems. To increase renewal assistance, at least three months prior to the renewal period, UPSNP actors in collaboration with frontline workers including social workers, health extension workers and community committees at the ketena level should identify beneficiaries likely to need aid or at risk of forgetting renewal deadline and then coordinate among these stakeholders to ensure timely renewal among all beneficiaries.

b) Timely transfer of new PDS beneficiaries' information to CBHI authorities.

The health insurance should consider a flexible enrolment period for new PDS beneficiaries who missed the CBHI enrolment window as this discrepancy often occurs due to programmatic differences. While CBHI enforces a specific enrolment period to reduce adverse selection, where individuals delay enrolment until they anticipate needing health insurance, the UPSNP has multiple targeting periods throughout the year. Therefore, new

PDS beneficiaries may join the program outside the CBHI enrolment window, but the programme may not transfer their information to CBHI authorities. To prevent delays, the programme could consider automating transfers of PDS information to the scheme to ensure timely processing of CBHI cards.

4) Address the financial barriers to enrolling in CBHI among PW beneficiaries and enhance the financial sustainability of the scheme.

PW beneficiaries are required to pay their CBHI contributions because they receive a higher transfer from the UPSNP programme. However, due to the rising inflation, the monthly transfer is insufficient, and health insurance premiums are unaffordable for many PW beneficiaries. The UPSNP and CBHI should consider strategies to address the affordability barrier for PW households who are unable to afford CBHI premiums while also accounting for the financial viability of the scheme.

a) Encourage monthly savings for CBHI.

Given the annual increase in CBHI premiums and the evident inability of PW beneficiaries to cover the full contribution in a single payment, the programme could encourage monthly savings plan specifically for the CBHI premiums of interested individuals from their own income.

b) Establish a framework for public-private partnership.

The Government is subsidizing one-third of CBHI contributions by the informal sector, and it appears it does not have the financial capacity to expand further subsidies or exemptions for all vulnerable households at present. To fill the financial gap during this transition period, woreda administrators could temporarily enhance the existing public-private partnership for the enrolment of PW beneficiaries. NGOs and private entities have been instrumental in enrolling poor and vulnerable households, but this partnership needs a systematic approach. In collaboration with the Woreda administration, the programme could establish a formal partnership with entities in the Woreda that have previously covered the premiums of eligible households. To identify eligible households, health extension workers, social workers and public works coordinators should assess PW households that may not be able to afford CBHI premium months prior to the renewal period.

5) Collaborate with health partners to address supply-side constraints affecting the delivery of CBHI.

The effective uptake of health services through CBHI is highly dependent upon the quality of supply-side health insurance purchasing arrangements and the health system. Supply-side constraints disrupting health service utilization are external to the programme, but higher officials within the programme could advocate and inform their reform in collaboration with relevant government agencies. Reforms to purchasing arrangements of the CBHI could help mitigate some of the access barriers, while challenges related to health system quality could be addressed by the Bureau of Health.

a) Timely payment of indigent contributions

Interviews with CBHI coordinators suggest that payments by the Bureau of Health on behalf of PDS beneficiaries are not always timely. Timely payments are crucial to foster trust between the two agencies and preventing beneficiaries from facing the repercussions, such as discrimination and mistreatment by health facility staff.

Commented [GBK3]: This is not feasible as UPSNP cash transfer purpose is not for CBHI premiums? Please revise as the programme won't encourage saving for CBHI

b) Reexamine CBHI purchasing arrangements.

To maximize the insurance's income and improve accessibility for beneficiaries, the scheme should consider pooling funds at the city level. This is necessary to ensure that insurance members have the choice to access all health centres in the city in case of concerns about the quality of care in their designated health centres or temporary relocations to different parts of the city. This reform will be a highly political issue and there must be a careful political economy analysis of resistance from stakeholders before introducing this change.

c) Invest in the strengthening of health systems.

The government has made major improvements in strengthening the health system, but gaps remain that stakeholders acknowledge. It is necessary for these investments to continue, especially at the primary health care level to ensure that adequate resources (human, medicines, and diagnostics) are available to improve service quality and subsequently increase satisfaction with CBHI and its membership.

6) Enhance the responsiveness of the programme to inflation to ensure adequacy.

The findings highlighted that the programme has increased beneficiaries' awareness on various topics, but unfortunately, the current inflation rate has significantly affected implementation in relation to beneficiaries' ability to use their transfer payment and their knowledge gained in action. In collaboration with development partners and the government, there should be considerations to support beneficiaries in coping with the high inflation.

a) Provide cash top-up for PDS and TDS households.

The rising inflation in the country has led to an increase in food prices, impacting the effectiveness of transfers in addressing food security and improving nutrition among beneficiaries. In response, the UPSNP should explore collaboration with the city government to provide temporary cash top up for both PDS and TDS beneficiaries. Despite TDS beneficiaries receiving a higher transfer amount, it may not be sufficient to meet the nutritional requirements during pregnancy and lactation periods.

Commented [GBK4]: Good to remove this part as this won't be feasible?

b) Increase transfer size.

It is imperative to engage in a substantive discussion with development partners and the government about increasing the size of transfers as the rising inflation has disrupted the pathways to achieving many of the programme's mid and long-term outcomes, such as increased diversified nutrition and physical and mental well-being. Certainly, these discussions will account for the fiscal space and the country's wage rates but the final decision to increase the transfer size will be political as those responsible for approving the increase are held accountable through political processes and their commitment to the most vulnerable population.

7) Strengthen fidelity of implementation to programme objectives by undertaking assessments of programme provisions.

Despite major implementation efforts, certain programme provisions, such as TDS and BCC sessions, are not achieving their full potential. These provisions are critical pathways for achieving programme outcomes, and it is important for all programme participants to benefit from them. However, there are discrepancies in the reasons for the uptake of these provisions, indicating the need for assessments of various components to enhance programme fidelity.

a) Undertake qualitative analyses to assess TDS implementation

The findings show that female public workers are aware of the programme provision to take 18 months leave after three months of pregnancy. However, the uptake of this provision is often delayed. It is crucial to conduct a critical assessment of the implementation fidelity of TDS to understand the bottlenecks of timely transition. For example, it will be necessary to assess whether the delayed transition is due to cases where women detect their pregnancy late or women intentionally attempting to conceal their pregnancy.

More importantly, it is crucial to assess the reasons for the varied implementation of TDS in different woredas and how the programme could make this provision consistent for all pregnant women. The participation of woreda officials, public works coordinators, and team leaders in the assessment will be necessary to ensure that the provision is implemented as expected.

b) Explore how to tailor BCC delivery mechanisms for UPSNP beneficiaries according to the social demographics.

BCC sessions play a crucial role in increasing beneficiaries' knowledge on various topics, but their delivery mechanisms are not suitable for all beneficiaries. Programme staff often prefer community-based delivery due to limited resources, but this approach may not be accessible for individuals with reduced mobility or lactating women. For example, requiring lactating women to attend community BCC sessions, even with the availability of childcare centres, may be difficult for women with young infants. Implementing more suitable BCC delivery mechanisms could help ensure that participants are fully engaged and present. Therefore, it is vital to assess tailored and feasible BCC delivery mechanisms for all beneficiaries.

Furthermore, ensure that BCC sessions are provided in a manner that incentivize the beneficiaries to take them and there are no opportunity costs for the beneficiaries to attend these trainings.

c) Identify and involve partners in the targeting process to optimize its effectiveness

The targeting of beneficiaries has seen improvements, yet some stakeholders raised concerns about their limited involvement in this process which may have hindered its optimization. It is pertinent to designate the suitable government agency with comprehensive knowledge for each of the beneficiary category to lead the targeting process. For instance, considering the close engagement of the Bureau of Women and Social Affairs with PDS beneficiaries, their leadership or inclusion in choosing these beneficiaries would be more suitable. Additionally, involving family health teams in the targeting process could further enhance its effectiveness.

8) Strengthen institutional arrangements to ensure the sustainability of multisectoral collaboration.

There has been substantive improvement in multisectoral collaboration, but bureaucratic hurdles jeopardize the sustainability of established collaborative efforts. Bureaucratic challenges such as high staff turnover and structural changes hinder sustainability and progress in implementation. To maintain programme knowledge, it is necessary to strengthen institutional arrangements.

Additionally, as case management, a core component of the programme involves multiple stakeholders, it is crucial to have detailed guidelines of roles and responsibilities for all, especially frontline workers.

a) Define roles and responsibilities for case management

Frontline workers cited the absence of clear and coherent institutional and operational mechanisms for case management as a major barrier to their successful implementation. For instance, while social workers serve as the initiators of case management, the ambiguity surrounding their roles and responsibilities in resolving cases means that effective management of cases largely hinges on the motivation of social workers to address them. While this variability is expected, given the diverse nature of cases encountered by social workers, it is important to establish clear guidelines regarding who assumes responsibility for managing cases after they have been submitted by social workers. Ideally, at each level of implementation, it is essential to define individuals or entities responsible for ensuring cases are resolved adequately.

b) Develop action plans and procedures for change in staff.

High staff turnover at the various levels of implementation is a major concern that hinders the continuity of implementation activities and the maintenance of institutional knowledge. To address this barrier, it is necessary to develop strategic policies and action plans for programme staff and government employees. These plans should include provisions for proper handover and ensuring that staff are adequately briefed and informed about the programme's objectives and processes.

Research recommendations

This evaluation analysed the implementation of the Addis Ababa UPSNP for CBHI enrolment, uptake of social services, and perceived outcomes. The analytical approach offers insight into the programmatic and contextual factors influencing the pathways to outcomes, but its analysis is limited from the perspectives of PDS beneficiaries. One of the challenges in conducting this evaluation among programme participants was their interpretation of programme benefits as only tangible aid, such as cash transfers and food items. Although some of the beneficiaries benefited from CBHI premium waivers and BCC sessions, they viewed the cash transfer as the only benefit from the programme. Therefore, additional research using ethnographic methods to investigate the social-cultural norms surrounding the perception and definition of assistance and how these norms shape individuals' behaviour and decision-making processes. Such research can offer insights into developing more tailored and effective interventions or suitable research designs to assess programme outcomes.

In determining the impact of CBHI on households, it will be necessary to support the findings of the evaluation with a household survey of the CBHI members. Researchers could expand on the role of CBHI by investigating its impact on health outcomes and household expenditures on food and education.

References and Endnotes

- Alemayehu, Y. K., Dessie, E., Medhin, G., Birhanu, N., Hotchkiss, D. R., Teklu, A. M., & Kiros, M. (2023). The impact of community-based health insurance on health service utilization and financial risk protection in Ethiopia. *BMC Health Services Research*, *23*(1), 67. <https://doi.org/10.1186/s12913-022-09019-6>
- Ali, S. N. (2023). *Distributional Impacts of Inflation in Ethiopia*.
- Anselmi, L., Lagarde, M., & Hanson, K. (2015). Health service availability and health seeking behaviour in resource poor settings: evidence from Mozambique. *Health Economics Review*, *5*(1), 26. <https://doi.org/10.1186/s13561-015-0062-6>
- Arif, G. M. (2006). *Targeting efficiency of poverty reduction programs in Pakistan*. Asian Development Bank, Pakistan Resident Mission.
- Bellele, M., Boke, M., & Kindie, M. (2021). Child Caregiver's healthcare seeking behavior and its determinants for common childhood illnesses in Addis Ababa, Ethiopia: a community-based study. *Italian Journal of Pediatrics*, *47*. <https://doi.org/10.1186/s13052-021-01049-w>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Corchero-Falcon, M. del R., Gomez-Salgado, J., Garcia-Iglesias, J. J., Camacho-Vega, J. C., Fagundo-Rivera, J., & Carrasco-Gonzalez, A. M. (2023). Risk factors for working pregnant women and potential adverse consequences of exposure: a systematic review. *International Journal of Public Health*, *68*, 1605655.
- Davis, B., Handa, S., Hypher, N., Winder Rossi, N., Winters, P., & Yablonski, J. (Eds.). (2016). *From Evidence to Action: The Story of Cash Transfers and Impact Evaluation in Sub Saharan Africa*. Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780198769446.001.0001>
- Demissie, B., & Gutema Negeri, K. (2020). Effect of Community-Based Health Insurance on Utilization of Outpatient Health Care Services in Southern Ethiopia: A Comparative Cross-Sectional Study. *Risk Management and Healthcare Policy*, *13*(null), 141–153. <https://doi.org/10.2147/RMHP.S215836>
- Demissie, G. D., & Atnafu, A. (2021). Barriers and facilitators of community-based health insurance membership in rural Amhara region, Northwest Ethiopia: a qualitative study. *ClinicoEconomics and Outcomes Research*, *343–348*.
- Ethiopia Ministry of Labour and Social Affairs. (2016). *National Social Protection Strategy*.
- Ethiopian Public Health Institute (EPHI), Ministry of Health (MoH) [Ethiopia], & ICF. (2023). *Ethiopia Service Provision Assessment 2021–22 Final Report*.

- Fite, M. B., Roba, K. T., Merga, B. T., Tefera, B. N., Beha, G. A., & Gurmessa, T. T. (2021). Factors associated with enrollment for community-based health insurance scheme in Western Ethiopia: Case-control study. *Plos One*, *16*(6), e0252303.
- Hussien, M., & Azage, M. (2021). Barriers and facilitators of community-based health insurance policy renewal in low-and middle-income countries: a systematic review. *ClinicoEconomics and Outcomes Research*, 359–375.
- INSP Evaluation Team. (2020). *Impact Evaluation of the Integrated Safety Net Programme in the Amhara Region of Ethiopia: Baseline Report*.
- Kaso, A., Yohanis, Y., Debela, B., & Endashaw Hareru, H. (2022). Community-Based Health Insurance Membership Renewal Rate and Associated Factors among Households in Gedeo Zone, Southern Ethiopia. *Journal of Environmental and Public Health*, *2022*, 11. <https://doi.org/10.1155/2022/8479834>
- Koroso, N. H., Lengoiboni, M., & Zevenbergen, J. A. (2021). Urbanization and urban land use efficiency: Evidence from regional and Addis Ababa satellite cities, Ethiopia. *Habitat International*, *117*, 102437.
- Kuwawenaruwa, A., Wyss, K., Wiedenmayer, K., Metta, E., & Tediosi, F. (2020). The effects of medicines availability and stock-outs on household's utilization of healthcare services in Dodoma region, Tanzania. *Health Policy and Planning*, *35*(3), 323–333. <https://doi.org/10.1093/heapol/czz173>
- Larrinaga-González, C. (2011). Engaging Crystallization in Qualitative Research: An Introduction. *European Accounting Review*, *20*(2), 422–425. <https://doi.org/10.1080/09638180.2011.580948>
- Levy, S. (2003). Are we targeting the poor?: Lessons from Malawi. PLA Notes 47. *International Institute for Environment and Development*.
- Mebratie, A. D., Sparrow, R., Yilma, Z., Abebaw, D., Alemu, G., & Bedi, A. S. (2019). The impact of Ethiopia's pilot community based health insurance scheme on healthcare utilization and cost of care. *Social Science & Medicine*, *220*, 112–119. <https://doi.org/https://doi.org/10.1016/j.socscimed.2018.11.003>
- OECD. (2023). *Worries about affording essentials in a high-inflation environment*.
- Otchere, F., Mussa, C. Essa, Damoah, A. K., Gavrilovic, M., & Cullen, E. (2022). *Socioeconomic conditions of Urban Productive Safety Net Programme clients in Addis Ababa*.
- Roelen, K., Devereux, S., Abdulai, A.-G., Martorano, B., Palermo, T., Ragno, L. P., & Unicef, O. of R.-I. (2017). *How to Make 'Cash Plus' Work: Linking Cash Transfers to Services and Sectors* (Innocenti Working Papers).

Schnitzer, P., & Stoeffler, Q. (2023). Targeting Social Safety Nets: Evidence from Nine Programs in the Sahel. *The Journal of Development Studies*, 1–22.
<https://doi.org/10.1080/00220388.2023.2291325>

The World Bank. (2021). *GDP per capita indicators, Ethiopia*. Databank.
<https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD?locations=ET>

UNDP. (2022). *Poverty, Human Development, and the Macro-Economy in Ethiopia, 2020-23*.

UNDP. (2023). *Briefing note for countries on the 2023 Multidimensional Poverty Index-Ethiopia*.

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

Wooldridge, J. M. (2010). *Econometric Analysis of Cross Section and Panel Data, second edition*. MIT Press.

World Bank. (2022). *World development report 2022: Finance for an equitable recovery*. The World Bank.

Yusuf, M. (2010). *Community targeting for poverty reduction: lessons from developing countries*.

Annex

Annex 1: Characteristics of Qualitative Sample

KII Participants

Roles and Positions	N (%)	Gender of participants	N (%)	Years of experience within PNSP or CBHI	N (%)
Social worker	4 (11)	Male	21 (60)	1-3	14 (40)
Health extension worker	4 (11)	Female	14 (40)	4-6	16 (46)
Public Works Team Leader	2 (6)			>7	5 (14)
CBHI coordinator	4 (11)				
Health Provider	2 (6)				
Health Facility director	3 (9)				
Public Works Coordinator	3 (9)				
BoWSA safety net team leads	2 (6)				
Management Information System (MIS) manager	2 (6)				
City PNSP coordinators	2 (6)				
UNICEF staff	4 (11)				
Director, Supervisor at MoWSA, Health Insurance Agency	3 (9)				

IDI participants

	N (%)	Average age	Average number of Dependants*
PDS	9 (30)	64	1.4
PW	10 (33)	46	2.1
Lactating woman	5 (17)	33	2.8
Pregnant woman	6 (20)	28	1.3
Total	30		

FGD sample

	Number of participants	Ages of participants	Average number of children under 18
Lactating women in Addis Ketema, Woreda 10	9	26.9	2.3
Pregnant women in Addis Ketema, Woreda 2	6	30	2.8
PW beneficiaries in Addis Ketema, Woreda 10	5	36.8	2.6
PDS beneficiaries, Addis Ketema, Woreda 2	8	68	2
Lactating women in Arada, Woreda 2	7	28.6	2.1
Pregnant women in Arada, Woreda 6	5	32.6	1.4
PDS beneficiaries in Arada, Woreda 2	5	54.8	1
PW beneficiaries in Arada, Woreda 6	5	46.6	0.6
Total	50		

Annex 2: The number of clients that received care within a one-month time

Variable	(1)	(2)	(3)
	Baseline	Follow-up	N
Number of clients seen last month: outpatient services	2391.61	3761.05	38

Number of clients seen last month: deliveries	118.78	40.45	38
Number of clients seen last month: child vaccination	373.94	351.80	37
Number of clients seen last month: ANC	118.22	296.55	38
Number of clients seen last month: PNC	88.00	444.60	38
Number of clients seen last month: Family planning	427.39	312.75	38
Number of clients seen last month: growth monitoring services	147.11	301.50	38
Number of clients seen last month: treatment of acute malnutrition for children	68.94	32.25	38
Number of clients seen last month: HIV testing/ counselling	127.72	174.25	38
Number of clients seen last month: prevention of mother to child transmission	46.71	63.00	35
Number of clients seen last month: HIV treatment	433.83	285.40	38
Number of clients seen last month: GBV	7.91	7.95	30
Number of clients seen last month: Psychosocial support	29.25	46.00	30
Number of clients seen last month: Lab services	1815.00	2128.00	37
Number of clients seen last month: CMAM	262.17	111.72	24
Observations	19	20	

Note: this table does not include statistical tests due to small sample size. Some of the observed trends, such as the number of children treated for malnourishment, need to be interpreted with caution as further data are needed to understand the reasons behind. For example, the reason behind the decline in the number of children treated for malnutrition could be due to a decline in the malnourished children and not necessarily due to service unavailability at the facilities. As can be seen from **Error! Reference source not found.**, the number of health facilities that have nutritionist increased from 15 per cent at baseline to 25 per cent at follow-up.

Annex 3: Availability of various supplies at the health facility on the day of the interview

Variable	(1) Baseline	(2) Follow-up	(4) N
In stock: Condoms	94.74	95.00	39
In stock: Spermicides	42.11	20.00	39
In stock: Contraceptive Pills	94.74	100.00	39
In stock: IUD	89.47	100.00	39
In stock: Injectable contraceptive	94.74	100.00	39
In stock: Contraceptive implants	94.74	100.00	39
In stock: Paracetamol	84.21	100.00	39
In stock: Aspirin	68.42	85.00	39
In stock: Oral Rehydration Salt	89.47	100.00	39
In stock: Coartem	68.42	85.00	39
In stock: Fansidar	15.79	5.00	39

Variable	(1) Baseline	(2) Follow-up	(4) N
In stock: Iron	100.00	90.00	39
In stock: Folic Acid	89.47	100.00	39
In stock: Penicillin	100.00	100.00	39
In stock: Cotrimoxazole	89.47	100.00	39
In stock: ARVs for adults	94.74	100.00	39
In stock: BCG injection	100.00	100.00	39
In stock: DPT injection	100.00	100.00	39
In stock: Tetanus injection	94.74	95.00	39
In stock: Measles injection	94.74	100.00	39
In stock: Polio injection	94.74	100.00	39
In stock: Meningitis injection	73.68	85.00	39
In stock: IT mosquito bed nets	21.05	25.00	39
In stock: Deworming medicines	100.00	95.00	39
In stock: Vitamin A droplets	100.00	100.00	39
In stock: Hand sanitizer	100.00	70.00	39
In stock: Surgical mask	100.00	95.00	39
In stock: Gloves	94.74	100.00	39
Observations	19	20	

Note: this table does not include statistical tests due to small sample size. Additionally, it only shows whether the suppliers were in-stock at the day of interview but does not indicate whether the supplies are available in sufficient amount to meet the clients' demand.

Acronyms

ANC	Antenatal Care
ARV	antiretroviral
BCC	Behaviour Change Communication
BCG	Bacillus Calmette-Guérin
BoWSA	Bureau of Women and Social Affairs
CBHI	Community Based Health Insurance
CCF	Christian Children's Fund
CMAM	Community Management of Acute Malnutrition
DPT	Diphtheria, pertussis, and tetanus
ECG	Electrocardiogram
ESSSWA	Ethiopian Society of Sociologists, Social Workers and Anthropologists
ETB	Ethiopian Birr
FGD	Focus Group Discussions
FGM	Female Genital Mutilation
HEW	Health Extension Worker
IDI	In-depth interview
IRB	Institutional Review Board
ISNP	Integrated Safety Net Programme
IT	Insecticide Treated

IUD	Intrauterine Device
KII	Key Informant Interview
MIS	Management Information System
MoWSA	Ministry of Women and Social Affairs
NGO	Non-governmental Organization
ORS	Oral Rehydration Salt
PDS	Permanent Direct Support
PSNP	Productive Safety Net Programme
PW	Public Works
RUTF	Ready-to-use therapeutic food
SBCC	Social Behaviour Change Communication
SDG	Sustainable Development Goals
SW	Social Worker
TCC	Technical Coordination Committee
TDS	Temporary Direct Support
UNICEF	United Nations Children's Fund
UPSINP	Urban Productive Safety Net and Job Project

Acknowledgements

Evaluation Team and Authors

UNICEF Innocenti – Global Office of Research and Foresight
Kaku Attah Damoah (Principal Investigator), Doris Osei Afriyie, Essa Mussa Chanie, Hiwot Mekonnen Mesfin, Nyasha Tirivayi, and Frank Otchere

UNICEF Ethiopia Country Office

Valentina Prospero, Martha Kinbur, Samson Muradzikwa, Getachew Berhanu Kebede, Erblina Elezaj

DAB – Development Research and Training

Nuru Hussein, Kebede Awgechew, Hunegnaw Ayele

The research team at UNICEF Innocenti – Global Office of Research and Foresight is highly grateful to UNICEF Ethiopia Country Office, DAB – Development Research and Training, the Ministry of Women and Social Affairs, the Bureau of Women and Social Affairs at Addis Ababa, other Government stakeholders at the sub-cities and Woreda levels, as well as implementation partners for their support and collaboration during fieldwork. The team is also grateful to Augustine Joachim and Chanyalew Seyoum Aweke for their highly constructive feedback, which greatly improved the report. The immense dedication of fieldwork teams during data collection is greatly appreciated. Finally, we were able to draw lessons from this programme due to the significant collaboration of households that opened their doors to the research and data-collection teams.

Disclaimer

This is a working document. It has been prepared to facilitate the exchange of knowledge and to stimulate discussion. The text has not been edited to official publication standards and UNICEF accepts no responsibility for errors. The statements in this publication are the views of the author(s) and do not necessarily reflect the policies or the views of UNICEF. The designations in this publication do not imply an opinion on legal status of any country or territory, or of its authorities, or the delimitation of frontiers.



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.

Published by

UNICEF Innocenti – Global office of Research and Foresight

Via degli Alfani, 58
50121, Florence, Italy

Email: innocenti@unicef.org

Social media: @UNICEFInnocenti on Facebook, Instagram, LinkedIn, YouTube, and X/Twitter)

In partnership with

Full Name of Partner Organization

Suggested citation

Afriyie Doris Osei, Damoah Kaku Attah, Mesfin Hiwot Mekonnen, Tirivayi Nyasha, on behalf of UPSNP Evaluation Team *Understanding the implementation and perceived outcomes of integrated social protection in Addis Ababa: a mixed-method study*, UNICEF Innocenti, Florence, September 2024.

-
- ¹ Woreda is an administrative unit next to sub-cities and above ketenas.
 - ⁱⁱ Ketena is the lowest administrative unit in Addis Ababa.
 - ⁱⁱⁱ Kenema is a publicly owned pharmacy that supplies drugs at lower prices.

for every child, answers