



Cash 'plus' - Integrated Nutrition and Social Cash Transfer (IN-SCT) Pilot in Ethiopia: perceptions and feedback from clients and service providers

**RESEARCH REPORT
- revised draft -**

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List of Acronyms

BA	Beneficiary assessment
BCC	Behaviour change communication
CCC	Community Care Coalition
CFSTF	Community Food Security Task Force
DA	Development Agent
DS	Direct Support
FGD	Focus group discussions
HEW	Health Extension Worker
IDS	Institute of Development Studies
IGA	Income Generating Activity
IN-SCT	Integrated Nutrition and Social Cash Transfer
KFSTF	Kebele Food Security Task Force
KAP	Knowledge, Attitude and Practices
KII	Key informant interviews
MoANR	Ministry of Agriculture and Natural Resources
MoE	Ministry of Education
MoH	Ministry of Health
MoLSA	Ministry of Labour and Social Affairs
NGO	Non-governmental organisation
NNP	National Nutrition Programme
PDS	Permanent Direct Support
PLW	Pregnant and lactating women
PO	Participant observation
PSNP	Productive Safety Net Programme
PTA	Problem Tree Analysis
PW	Public works
SHM	Stakeholder Mapping
SW	Social Worker
TDS	Temporary Direct Support
UNICEF	United Nations Children's Fund

Executive summary

The Integrated Nutrition Social Cash Transfer (IN-SCT) pilot project is embedded within phase 4 of Ethiopia's Productive Safety Net Programme phase 4 (PSNP4), and is being implemented in four PSNP woredas, two in Oromia region and two in SNNPR. Since 2005, PSNP has delivered support to millions of rural households throughout rural Ethiopia, in the form of temporary employment (Public Works), unconditional cash transfers (Direct Support), and asset transfers. Several evaluations have confirmed that the PSNP has improved household food security and protected productive assets against distress sales. However, impacts on nutrition have been limited.

Several innovations have been introduced on PSNP4 to enhance programme outcomes, specifically in terms of child nutrition. Most significantly: (1) Permanent Direct Support (PDS) clients now receive payments all year instead of only 6 months per year; (2) pregnant and lactating women (PLW) and caregivers of malnourished children are moved from Public Works (PW) to Temporary Direct Support (TDS); (3) co-responsibilities have been introduced for TDS and PDS clients, particularly to strengthen linkages between PSNP with health care and other social services.

The IN-SCT pilot aims to support increased uptake of social services by PSNP households; improved knowledge, attitudes and practices (KAP) of DS households in terms of nutrition, hygiene, health, education and child protection; the implementation of nutrition-sensitive components of PSNP4; and cross-sectoral collaboration between a range of stakeholders at regional, woreda and local levels.

Objectives and methodology

This report presents findings from a qualitative assessment of the IN-SCT pilot after its first year of implementation. The assessment had the following objectives: (1) to obtain feedback from clients and service providers on IN-SCT implementation; (2) to identify constraints to take-up of services by clients; (3) to provide recommendations for improved pilot implementation and future programming; and (4) to contribute to global lesson learning on the use of innovations such as BCC to deliver more nutrition-sensitive social protection.

Qualitative research methods were used for this assessment, which aims to complement the impact evaluation by providing feedback from clients and service providers on IN-SCT implementation issues. The main data collection methods were key informant interviews with 20 service providers (social workers, health extension workers, etc.), 25 focus group discussions with PSNP clients, 16 case studies of PSNP clients, and participant observation. Participatory techniques were incorporated into all the interviews and discussions, including problem tree analysis (to understand service providers' perceptions about the causes of bottlenecks towards improved nutritional outcomes and potential solutions, including the contribution of IN-SCT), stakeholder mapping (to map key stakeholders how they collaborate to implement the IN-SCT, and barriers to collaboration), and project history diagrams (to understand changes over time, including those attributable to the IN-SCT pilot). Participant observation consisted of fieldworkers observing PSNP and IN-SCT-related activities and interacting with clients, community members and service providers, in two kebeles over five days.

Clients' perspectives and experiences

Generally, clients expressed satisfaction with the support they receive from PSNP4 and IN-SCT overall, and from specific service providers such as Social Workers (SWs), Health Extension Workers (HEWs), Development Agents (DAs) and school directors. Not only are the individual programme components

appreciated – cash transfers, TDS for PLW, BCC sessions and co-responsibilities related to access to services – the overall package of support combines to generate improved outcomes for clients and their communities.

Positive feedback was recorded with respect to receiving continuous cash transfers, especially in terms of meeting household food needs and preventing hunger. However, these outcomes were compromised for some by irregular and inadequate payments – delays, deductions from transfers and small amounts of cash, which leaves poor clients unable to invest in income generating activities or even to buy soap for hand-washing.

The transition of PW women into TDS during pregnancy and after childbirth is appreciated because it gives mothers more time for child-care, which combines well with improved knowledge acquired from BCC sessions about good feeding and hygiene practices. Co-responsibilities are also viewed positively, because they are associated with receiving valuable information and better access to social services. However, knowledge about co-responsibilities, either in general or about clients' specific obligations, and about the consequences of non-compliance, is not uniform across all respondents. Also, problems such as lack of financial resources and water scarcity present obstacles to compliance – so improved knowledge and awareness does not automatically result in improved practices.

Clients also value the increased contact and support from service providers such as SWs and HEWs, although experiences vary across kebeles. Some SWs do regular home visits, individual BCC sessions and case management (e.g. following up on co-responsibilities), but clients in other kebeles report only occasional meetings with SWs or no contact at all. There was little engagement with CCCs among clients in our sample, or even awareness of CCCs. While clients have interactions with CCC members in their respective capacity of service providers – such as with HEWs and DAs – they are not aware of the CCC as a community mechanism or its role beyond the distinct services that are provided by individual members.

Several external (non-programme) factors constrain the ability of many clients to apply the advice and knowledge they are receiving. These constraints include poverty and lack of non-farm income-earning opportunities, undiversified food production and lack of produce markets (which restricts access to nutritious food such as vegetables), lack of water (for drinking, hygiene and agriculture), and lack of time to implement good feeding and hygiene practices (especially for women, who take responsibility for these aspects of domestic reproduction).

BCC sessions appear to be most effective if messages are repeated, if the content delivered is focused and consistent, if sessions are regular, if their messages are reinforced through home visits, and if non-attendance at mandatory BCC sessions is followed-up through monitoring and case management. In certain areas, such as family planning, cultural resistance to the messages means that awareness does not necessarily result in behaviour change.

HEWs are perceived very positively by clients, and are known personally by all clients interviewed, who find the services, information and advice they provide valuable. Caregivers especially appreciate regular health check-ups by HEWs on themselves and their children, and the nutrition supplements they give when their child is identified as malnourished. Interactions between HEWs and clients occur at health posts, through home visits, at PW sites (for group BCC sessions), and during immunisation drives. HEWs are central to the referral process for pregnant women to transition out of PW into TDS.

The support provided by DAs is also widely regarded as helpful, especially in the area of agricultural production – how to improve productivity through improved agronomic practices and use of inputs,

how to grow vegetables and fruit for more nutritious diets, and how to keep livestock for food security. Interactions with DAs are most frequent during the farming season, when DAs often make farm visits, especially if they live in the kebele. PW clients and TDS clients report more frequent contact with DAs than PDS clients, because most PDS households are not actively engaged in agriculture. Also, men appear to receive more personal attention from DAs than women, who typically receive advice only indirectly, through their husbands.

Overall, clients have good awareness and regular contact with longstanding local service providers, especially HEWs and DAs, and the support provided by HEWs and DAs is highly valued. However, they have less exposure to recently introduced service providers at community level such as SWs, CCCs and Concern staff. This could change over time, but awareness might be expedited if the mandates and roles within PSNP4 and IN-SCT of these service providers are clarified and communicated to clients.

Service providers' perspectives and experiences

The innovative features of PSNP4 are endorsed by service providers, who agree that these inputs are likely to enhance positive outcomes in terms of behaviour change, uptake of services, and nutrition. Several aspects of PSNP design and implementation are identified as responsible for these potential improvements in programme impacts.

In terms of programme design, providing continuous cash transfers allows DS clients to finance their basic needs and achieve food security, also to access health and education services. Innovations such as BCC sessions, co-responsibilities, and the transition of PLW out of PW and into TDS all reinforce the broader objectives of PSNP4, by disseminating useful information and incentivising behaviour change. Another significant design feature is additional inputs provided by the placement of extra SWs and by contracting Concern Worldwide to deliver nutrition-sensitive agricultural components, such as food gardens and nutrition clubs at local schools. CCCs are another institution with a mandate to support aspects of PSNP4, such as the complaints mechanism.

In terms of programme implementation, service providers pointed to the crucial role of collaboration between sectors and service providers – especially SWs, HEWs and DAs – such as referral mechanisms so that clients benefit from an integrated package of services. From the service providers' perspective, BCC sessions transfer useful knowledge about nutritious diets, good feeding and sanitation practices, while co-responsibilities backed up with home visits and monitoring of compliance all encourage behaviour change that is in the best interest of clients. This can be seen in higher enrolment rates at schools and higher uptake rates of health services such as ante-natal and post-natal care.

On the other hand, the potential positive impacts of the PSNP4 are likely to be limited by a range of challenges. A fundamental issue remains the low value of cash transfers, which are also subject to delayed payments. Implementing some of the advised behavioural changes cost money, for example to purchase nutritious food items and to construct latrines.

Programme implementation is also constrained by shortages of human resources – too few staff with heavy workloads, high staff turnover, staff living outside the communities, infrequent visits to remote communities because of inadequate transport, and not enough staff training. These factors reduce the ability of HEWs, SWs and others to deliver BCC sessions and home visits, or to monitor compliance. CCCs also have a more limited role than anticipated. Many are not yet active and those that are have received inadequate training, they are under-funded, and most CCC members have jobs that need priority attention.

Apart from these programme-related challenges, positive impacts are likely to be compromised by factors unrelated to the programme which define the context of poverty within these communities: shortages of cash, potable water and non-agricultural livelihood options, low agricultural productivity and undiversified agricultural production. Taken together, these programme and non-programme constraints could significantly undermine the extent to which support delivered by PSNP4 and IN-SCT actually achieves its intended nutritional and other outcomes.

Conclusions

The IN-SCT pilot is a well-designed intervention in support of the fourth cycle of the PSNP. Its innovative features are valued by clients as well as the service providers who deliver these. Since baseline, service providers display improved awareness of their roles and responsibilities, they work more collaboratively with each other, the new provisions within PSNP4 are being well implemented, and clients report positive changes in their behaviour because of BCC sessions, co-responsibilities, home visits and case management.

On the other hand, to some extent the potential positive impacts from these innovations could be compromised by challenges in implementation because of capacity constraints, related to shortages of staff who have heavy workloads and often limited day-to-day contact with clients. These issues vary between communities, resulting in different levels of effectiveness in implementation across woredas and kebeles, depending on how present and active are key actors such as SWs and CCCs. Possibly as a consequence of this reality, DAs and HEWs are perceived as most crucial for delivery of BCC sessions, monitoring of co-responsibilities and referral of PLW from PW to TDS, while SWs and CCCs are not perceived as playing a central role.

There are two noteworthy divergences in the perspectives of respondents in this study. Firstly, service providers claim more interaction with clients and programme awareness (e.g. of co-responsibilities and the consequences of non-compliance) than do clients themselves. Secondly, service providers appear to believe that the PSNP can deliver major changes in clients' wellbeing on its own, whereas clients highlight the constraining role played by factors outside the scope of PSNP or IN-SCT. These perspectives suggest that complementary interventions are needed in areas such as water supplies, agricultural productivity and access to non-agricultural livelihoods, if poverty and food insecurity are to be overcome in rural Ethiopia.

Recommendations

1. Engage with MoANR to reduce delays in PSNP cash transfer payments, and to end deductions.
2. Clarify precise co-responsibilities with clients, and the consequences of non-compliance.
3. Increase the number of SWs and provide them with transport to access remote communities.
4. Incentivise service providers such as SWs and HEWs to live in or close to PSNP communities.
5. Capacitate CCCs by providing more training and remuneration for expenses to CCC members.
6. Strengthen nutrition-sensitive interventions such as FTCs, nutrition clubs and school gardens.
7. Provide additional support to Concern to deliver enhanced access to water for PSNP clients.
8. Create linkages to alternative non-farm income-generating opportunities for PSNP clients.
9. Increase agricultural productivity and diversified food production through provision of inputs.
10. Address gender inequalities and disproportionate burdens on women by gender sensitisation.

1. Introduction

1.1. Background

The Improved Nutrition through integrated linkages to Social Services and Social Cash Transfer (IN-SCT) pilot project falls under the umbrella of Ethiopia's Productive Safety Net Programme phase 4 (PSNP4). The PSNP was launched in 2005 in response to widespread food insecurity and continual need for emergency food relief, by providing food insecure households with transfers in lean times to avoid asset depletion and protect livelihoods (Devereux et al. 2014). The two main components are public works (PW) for poor and food insecure households with labour capacity and direct support (DS) that provides unconditional cash or food transfers to poor and food insecure households without labour capacity. Since its inception the programme has been widely expanded and has undergone a number of reforms. It has also been subject to rigorous mixed methods programme evaluations, indicating that the programme has reduced household vulnerability, food insecurity, and distress sale of assets among others (Berhane et al. 2013).

In 2015, the government launched Phase 4 of the PSNP. PSNP4 includes several innovations designed to strengthen the programme and improve its outcomes (MoARD, 2016). Changes include increases in the quantity and duration of transfers and greater integration with delivery of social services such as health and nutrition services. Permanent Direct Support (PDS) clients – clients who experience no temporary changes in their labour capacity – will now receive payments all year round as opposed to just 6 months per year; pregnant and lactating women (PLW) and caregivers of malnourished children will move from Public Works (PW) to Temporary Direct Support (TDS); and co-responsibilities are introduced for TDS and PDS clients.

The IN-SCT pilot is embedded within PSNP4 and is implemented in two PSNP woredas (Adami Tulu and Dodota) in Oromia region and two PSNP Woredas of SNNPR (Halaba and Shashego). The IN-SCT pilot aims to achieve increased uptake of social services by PDS and TDS households, improved knowledge, attitudes and practices of PDS and TDS households regarding nutritional, sanitary, health, child protection and educational behaviour, and better understanding of the roles and responsibilities of actors such as social workers and community-based committees in achieving improved outcomes (Schubert, 2015). In addition, it also aims to support implementation of the nutrition-sensitive interventions of PSNP4 – which hopes to contribute at goal level to improvements of proportion of children 6-23 months of age who receive a minimum acceptable diet. For nutrition, the programme will specifically focus on improving Knowledge, Attitude and Practices (KAP) of nutrition-related behaviour (Bossuyt, 2015) through the use of nutrition-sensitive interventions such as BCC for PW clients and linking DS clients to health and other social services (MoARD, 2016).

The Ministry of Labour and Social Affairs (MoLSA), with support from UNICEF and Irish Aid, implement the pilot programme in collaboration with the regional and woreda level representatives of the Ministry of Agriculture and Natural Resources (MoARD), Ministry of Education (MoE), Ministry of Health (MoH). The pilot promotes linkages and tests tools in terms of information sharing, case management and capacity building that might later be used in other PSNP woredas. This includes the roles for social workers and the Community Care Coalitions (CCCs) – in Oromia – and Community-Based Social Protection Committees (CBSPCs) – in SNNP – in providing case management and setting up linkages between services for PDS and TDS clients, and the process of shifting responsibility for PDS clients from MoARD to MoLSA. The lessons drawn from this pilot will inform the design and implementation of the future NNP and the next phase of the PSNP.

In SNNP region, the IN-SCT pilot is complemented with additional interventions that seek to strengthen nutrition-sensitive interventions for PDS, TDS and PW clients. This component includes support to community structures and awareness creation in schools, support to health services, promotion of nutrition-sensitive public works and support of multi-sectoral interventions. Capacity building and related support to nutrition-sensitive agriculture activities – including support of the farming training centres, promotion of school gardens and promotion of nutrition-sensitive social protection and implementation of comprehensive training curriculum – are provided by Concern Worldwide.

1.2. Objectives of study

The objectives of this client and service provider assessment are to (i) obtain feedback from clients and service providers regarding the implementation of the IN-SCT pilot, (ii) identify constraints and barriers in take up and provision of services, with a particular focus on co-responsibilities for DS clients and behaviour change communication (BCC) for PW clients and PLW in TDS, and (iii) to provide recommendations for implementation during the remainder of the pilot and for future programming. More broadly, this assessment aims to shed light on the feasibility of implementation of advice and BCC activities in a bid to provide more nutrition-sensitive social protection.

These objectives are further shaped against the backdrop of findings of a baseline study that was undertaken in 2016 as part of the IN-SCT impact evaluation (Gilligan et al. 2016). Findings from this study provided important contextual information regarding children's and their families' situation with respect to nutrition, hygiene, education and other issues. Results indicated that the food security and nutrition situation in SNNP region was very challenging, particularly due to the severe drought at the time of the baseline survey; experiences with hygiene practices were mixed with fairly widespread use of improved toilet facilities and handwashing practice but limited use of soap for handwashing; awareness of nutrition and hygiene practice and child protection issues is relatively high, including the importance of exclusive breastfeeding and risks of early marriage; and school enrolment rates are high, particularly at primary level, but that education is valued as being more important for boys than girls.

Against the backdrop of the study's overall objectives and key findings from the baseline surveys, this assessment aims to particularly understand the pathways to positive change in nutrition outcomes, identifying bottlenecks and barriers to impact from the perspectives of clients and service providers.

This assessment focuses on the two IN-SCT woredas in SNNP region. The region (and the two woredas under consideration – Halaba Special Woreda and Shashago Woreda) were selected as additional nutrition-sensitive interventions are carried out in these areas with co-funding of UNICEF and Irish Aid, offering a multisectoral package of nutrition interventions. With support of the NGO Concern, the IN-SCT pilot in SNNP further reinforces the capacities to implement the nutrition sensitive interventions under PSNP for PW, TDS and PDS clients and their communities.

The remainder of the report is structured as follows: We first provide a brief literature review of nutrition-sensitive social protection, discussing pathways to improved nutrition and considering different models for achieving improved outcomes. Secondly, we discuss this research' methodology by describing its core themes, methods and sampling. Findings are presented and analysed in the subsequent three sections, offering separate assessments of clients', service providers' and CCC members' perceptions and experiences. We conclude with a summary of findings regarding positive lessons learned and challenges and provide an overview of recommendations.

2. Literature review on nutrition-sensitive social protection

Cash transfers, either conditional or unconditional, have become the dominant instrument in social assistance programmes globally. Cash transfers have been found to have significant positive impacts on a range of food security indicators at household level, including food expenditure, meals consumed per day, and dietary diversity (Bastagli et al. 2016; Hidrobo et al. 2014). These direct pathways to improved nutrition follow from the income effect of cash transfers, and can also be achieved through food transfers (including school meals and supplementary feeding schemes), or commodity vouchers that increase individual or household access to food.

However, evidence indicates that cash transfers alone have achieved only limited impact on nutrition indicators at individual level. Specifically, evaluations of cash transfer programmes have found that child stunting rates tend to fall more slowly than other indicators of food insecurity (Ruel and Alderman 2013). In South Africa, for instance, the Child Support Grant now reaches two-thirds of all children, but there has been no reduction in the national prevalence of child stunting since the 1990s. The grants are not enough, and grants alone are not enough (Devereux and Waidler 2017).

In light of such findings, cash transfers have recently been complemented with other transfers and services to create ‘cash plus’ social protection interventions, in an effort to improve the nutritional impacts of social protection. These indirect pathways to improved nutrition follow from using social protection to leverage access to services, for instance via conditional cash transfers, provision of free or subsidised health insurance, fee waivers for poor households and targeted vulnerable individuals, or awareness raising about breastfeeding, nutritious diets, hygiene and sanitation practices.

The logic underpinning ‘cash plus’ interventions derives from UNICEF’s conceptual framework (UNICEF 1990), which identifies three distinct pathways to child malnutrition, only one of which – inadequate access to food – is directly affected by cash transfers. The other two pathways to malnutrition – inadequate care for children and women, and insufficient health services and unhealthy environment – are better addressed through other instruments, or by linking cash transfers to complementary services. The evidence base is building that this holistic approach is more effective at tackling child malnutrition than a single instrument on its own.

A recent report on the evidence of nutrition-sensitive social protection identifies three conceptual pathways linking the sectors of nutrition and social protection, namely (i) increasing incomes through cash, (ii) providing subsidies and price supports, and (iii) addressing preferences and behaviours (Alderman 2015). The review of evidence suggest that a combination of pathways – most crucially of the first and third – is imperative for achieving positive change.

The following case studies illustrate how different combinations of transfers and services can be designed and delivered to have nutrition-sensitive outcomes.

2.1. Cash plus BCC

In Bangladesh, the Transfer Modality Research Initiative (TMRI), implemented by WFP and rigorously evaluated by IFPRI, aimed to test the effectiveness of alternative combinations of cash, food, and nutrition-related behaviour change communication (BCC). Overall, the TMRI generated significant increases in consumption expenditure and diet quality, and significant reductions in self-assessed hunger. In terms of nutrition impacts, the most powerful package was found to be ‘cash + BCC’, which

reduced child stunting by 7.3 percentage points during the two years of project implementation. This demonstrated that the power of cash transfers and nutrition BCC can be magnified if they are administered together rather than separately. BCC sessions provide information about nutritious diets, while cash transfers facilitate the purchase of nutritious food items (Ahmed et al. 2016).

2.2. Cash plus conditionalities

Conditional cash transfer (CCT) programmes typically make cash transfers conditional on children attending school and going to clinics, and for this reason they invariably achieve enhanced use of education and health services. However, this increased demand and utilisation does not necessarily result in improved outcomes. “Although CCTs increase the likelihood that households will take their children for preventative health check-ups, only in some cases has this been shown to improve child nutritional status among beneficiary households” (Ferré and Sharif 2014: 3). The Shombhob CCT programme in Bangladesh aimed to improve the nutritional status of children aged 0 to 36 months old, by delivering cash transfers conditioned on regular growth monitoring of beneficiary children aged 0-36 months, as well as participation in monthly nutrition-related education sessions by their mothers or caregivers.

Positive nutrition impacts were recorded in several areas: more mothers knew about the importance of exclusive breastfeeding up to 6 months, dietary diversity improved among children older than 6 months, and spending by programme participants on proteins such as meat, dairy, fish and pulses increased significantly. In terms of anthropometric indicators, a significant reduction was recorded in wasting (low weight-for-height, an indicator of current or recent nutritional deficits), but not for stunting (low height-for-age, an indicator of long-term undernutrition). The authors conclude that this is consistent with expectations that cash transfers plus improved diets will immediately improve short-term nutrition indicators such as wasting, whereas stunting is “more stubborn to affect and ... does not vary appreciably according to recent dietary intake” (Ferré and Sharif 2014: 33, 27).

2.3. Cash for services

The Philippines Social Welfare Development and Reform Project is a type of CCT that links cash transfers directly to uptake of health and education services. The ‘health grant’ pays \$11 every month to every household with pregnant women or children under 18 years old. The ‘education grant’ pays \$6–\$11 for 10 months per year for up to three children aged 6–18 years. The health grant is conditional on pregnant women accessing pre-natal and ante-natal services, children under 6 years attending health centres for growth monitoring and to receive child health services, and school-aged children complying with deworming protocols. The education grant is conditional on school-aged children enrolling in school and attending 85% of classes every month. In addition, caregivers (usually mothers) in participating households are required to attend one ‘family development session’ each month, which deliver nutrition-related messages including good breastfeeding, food preparation, and hygiene and sanitation practices.

The programme reduced severe stunting of children under 3 years old by 10 percentage points relative to a control group. Children’s diets became more protein-rich – their consumption of eggs and fish increased. Participating parents are more likely to purchase health insurance from the PhilHealth scheme, and to seek health-care for sick children. Growth monitoring is not only a conditionality, it is also used as an indication of children’s nutrition status and as a mechanism for targeting supplemental feeding to malnourished young children (Spray 2016).

2.4. Food vouchers plus nutrition supplements

A Nutrition-Sensitive Urban Safety Net Program was launched in the Republic of Congo in 2015, following a pilot phase running from 2012 to 2014. Targeted households receive electronic vouchers for 18 months that can be exchanged for selected food items – cereals, vegetables, fruit and meat – in local shops. The voucher is worth \$60 each month, based on household food expenditure data and the cost of a nutritious diet. In addition, moderately malnourished beneficiaries receive fortified corn-soy blend (CSB+) and vitamin-enriched cooking oil. Pregnant and lactating women (PLW) and children under two years old are also given micronutrient powders. Nutrition messaging and monitoring of households are achieved through home visits, awareness workshops and integrated health centres. The program’s nutrition-sensitive design has already achieved results in terms of food security and nutrition. “The last annual evaluation of the project showed improved food security, nutritional status, and socioeconomic status, as well as access to basic social services for vulnerable households. The project demonstrated the effectiveness of food transfers through mobile money against food insecurity and in stimulating economic activity” (Spray 2016: 66).

2.5. Principles for nutrition-sensitive social protection

FAO (2015) proposes several principles for making social protection more nutrition-sensitive, which should be considered in designing and implementing all social protection programmes. Some of these principles are generic while others apply specifically to cash transfers, school feeding schemes, public works programmes and other social protection instruments.

1. Incorporate explicit nutrition objectives and indicators in programme design;
2. Target nutritionally vulnerable households and vulnerable individuals within households;
3. Empower women and make them the recipients of social protection benefits;
4. Promote strategies that enable households to diversify their diets and livelihoods;
5. Integrate nutrition education measures such as BCC to social protection programmes;
6. Scale up safety nets in times of crises to protect nutrition status and ‘leave no-one behind’;
7. Promote local purchase for food transfers;
8. Improve the nutritional quality of food transfers and school feeding programmes;
9. Include micronutrient supplementation where relevant;
10. Strengthen linkages of vulnerable groups to health care services and sanitation facilities;
11. Promote an integrated approach that includes the improvement of health care services;
12. Ensure social protection interventions do not compromise maternal and child care practices;
13. Be careful not to increase caregivers’ workloads, in particular pregnant and lactating women.

This final point is often under-appreciated. Alderman (2014) argues that social protection programmes often require primary caregivers, who are overwhelmingly women, to commit additional time in order to access programme benefits – for instance, to comply with conditionalities such as attending BCC sessions, utilising public services and implementing good food preparation and hygiene practices. While the intentions are positive, poor women are often time-constrained. These features of social protection programmes should be adapted to reflect such realities, otherwise their potential impacts on child nutrition and other intended outcomes could be compromised.

3. Methodology

3.1. Overview of core themes

Fieldwork for this assessment was guided by a set of core themes. We provide a brief overview of these themes here.

Theme #1: Pathways to improved nutrition

This theme focuses on the main bottlenecks to improved nutrition for ultra-poor and labour-constrained households. The main rationale underpinning the IN-SCT pertains to lifting barriers that prevent PSNP clients from improving nutritional outcomes. As indicated in the literature review above, the theory of change assumes that barriers on part of the individual and household relate to lack of cash, inadequate care (resulting from lack of knowledge and poor practice) and lack of availability of or access to high-quality services. Barriers also operate at more structural levels, including lack of availability of food and high food prices (as a result of the drought, for example).

This assessment considers main bottlenecks to improving nutritional outcomes PSNP clients by explicitly asking clients and service providers about the main problems they experience in improving nutrition and to what extent the various components of IN-SCT contribute to addressing those problems. It does so from three perspectives: (i) lack of access to nutritious foods, (ii) poor hygiene practices and (iii) lack of access to services.

Theme #2: Co-responsibilities

The IN-SCT facilitates linkages with health and nutrition services with the objective of improving nutritional outcomes for clients and children. Some of these linkages are being implemented through co-responsibilities for PDS and TDS clients. Co-responsibilities include attendance of four antenatal care visits, obtainment of postnatal care, obtainment of vaccination of children, attendance of monthly growth monitoring for children, attendance of BCC sessions, completion of birth registration and for children aged 6-18 to go to school (in PDS HH only). The introduction of co-responsibilities implies that clients continue to be entitled to receive their transfers but also are encouraged to undertake specific actions.

This theme focuses on co-responsibilities from three angles: (i) whether they are well implemented (ii) whether they lead to desired behaviour change, and (iii) how they are perceived from a rights and responsibility perspective.

Theme #3: Behaviour Change Communication (BCC)

Behaviour change is be crucial for achieving improved outcomes for clients and their children, most notably with respect to nutrition outcomes but also in terms of meeting other basic needs such as education, health care, clothing and shelter. BCC interventions within IN-SCT consist of two components: (1) community-based sessions for PW clients, and (2) tailored services for PDS and TDS clients (consisting of counselling and more individual-level support). The sessions for PW clients represent a 'hard' conditionality in the sense that (parts of) the PSNP transfer will be withheld in case of non-attendance. The services provided to PDS and TDS clients represent a co-responsibility as indicated above. The BCC sessions included in the package of co-responsibilities for DS clients is examined in the broader theme of co-responsibilities. This theme of BCC specifically focuses on community-based sessions for PW clients and representing a hard conditionality.

BCC sessions are delivered through community-based sessions during the public work season for male and female PW clients. The FSCD and MOH, in collaboration with MOLSA, UNICEF and other PSNP and NNP stakeholders have produced separate BCC materials for PW clients. These cover 7 selected topics, including Gender, Social Development and Nutrition Provisions; Special provisions of PSNP for women and vulnerable people; Maternal Nutrition; Breast Feeding; Complementary Feeding; Water, Sanitation and Hygiene (WASH); Nutrition Sensitive Agriculture; Household Resource management. These BCC efforts complement what HEWs already do at the health facilities and in the communities.

Issues that are explored as part of this theme include how community BCC sessions are implemented by service providers and how they are received and perceived of by clients. In particular, it focuses on whether there are any bottlenecks or issues preventing effective implementation of these interventions, and on the perception of participation in BCC sessions as a hard condition.

Theme #4: Community workers and social services

Social Workers (SWs), Health Extension Workers (HEWs), Development Agents (DAs) and teachers are crucial for delivering a more integrated model of social services within the IN-SCT pilot. Their support is hypothesised to be crucial in facilitating access to basic social services and achieving behaviour change towards improved nutrition, health, education and child protection outcomes, particularly for pregnant and lactating women and for children.

The investigation as part of this theme focuses on the supply of services, clients' knowledge of available services, accessibility and use of services. Has the demand for services increased following the implementation of the IN-SCT? Have the IN-SCT activities increased the workload for programme staff? This may of particular concern to HEWs and DAs who have a broad set of other tasks. It also pays particular attention to the role of social workers given their mandate for monitoring co-responsibilities within the IN-SCT. How is the support of the social worker perceived to carry out these interventions perceived? Do clients think they would have the same results without the support of the social worker?

Theme #5: Community Care Coalitions (CCC)

Community Care Coalitions (CCCs) are expected to play a pivotal role in the implementation of integrated services in the IN-SCT pilot. They include volunteers from across the community, including service providers such as teachers, HEWs, DAs and SWs, representatives from women's groups and local leaders. They are asked to lead community-based efforts to help PDS and TDS clients comply with co-responsibilities and to monitor such compliance, working closely with SWs, DAs and HEWs. Their services also extend to supporting community BCC sessions for PW clients and monitoring mandatory participation.

Questions in relation to this theme investigate (i) clients' knowledge of CCCs and perceptions of the support that they receive from CCCs, (ii) service providers' – SWs, HEWs and DAs – experiences collaborating with the CCCs, and (iii) CCC members' own experiences with respect to implementing their tasks and identify challenges or concerns to be addressed. In doing so, we also reflect on the value-added of CCCs over and above the existing kebele and community-level PSNP structures (such as the Community Food Security Task Force – CFSTF and Kebele Food Security Task Force – KFSTF) and kebele school committees.

Theme #6: Multi-sectoral collaboration

As an integrated approach, the IN-SCT depends for its success on effective coordination across several ministries (including MoARD, MoLSA, MoH) and their staff at all levels, who are responsible for delivering different components of the programme or for referring participants from one service to another. This includes the implementation of co-responsibilities for DS clients as well as mandatory BCC for PW clients. It also includes the nutrition-sensitive component of the pilot, which is supported by Concern.

This study explores the experiences of service providers on the ground (such as members of CCCs, HEWs, SWs and DAs) in terms of coordinating their activities, differentiating between services focused on DS clients and PW clients. It aims to identify bottlenecks in coordination of support and referral of cases, but also to highlight good practice. Do programme staff (particularly HEWs, DAs and teachers) receive the necessary support by woreda offices to carry out these tasks? Do the planning and reporting requirements represent an additional burden on their normal day to day workload? How does Concern's support contribute to the implementation and effectiveness of the pilot's nutrition-sensitive component?

3.2. Methods

This study is premised on qualitative research methods. Instead of measuring attributable changes in outcomes of interest – the focus of the impact evaluation – this study examines processes around programme implementation and potential bottlenecks towards achieving impact as perceived by clients and service providers. Methods are therefore focused eliciting the opinions, perceptions and experiences of people involved, both as service providers and as clients.

The methods employed in this study draw heavily on traditions of participatory appraisal and beneficiary assessment (BA). The tradition of participatory appraisal and participatory methods focuses on research methods giving voice to respondents rather than making the research process a merely extractive process (Chambers, 1992). The method of beneficiary assessments emphasises the opportunity for programme participants to freely and openly share concerns regarding how the development process affects their lives (Salmen, 2002). It also advocates for the use of participant observation, referring to a protracted presence of an outsider within selected communities (ibid).

Main methods for data collection were (1) individual interviews, (2) group discussions, and (3) case studies. Individual interviews were primarily used for discussions with service providers while group discussions and case studies were undertaken with PSNP clients. Methods were undertaken in a semi-structured manner, integrating participatory and open-ended elements that allowed for respondents to shape and give meaning to the themes under discussion.

Participatory exercises were integrated in the individual interviews, group discussions and case studies respectively, thereby building on the strengths of interviewing and participatory techniques to obtain the desired breadth and depth of information without overburdening the respondents. Participatory techniques are time-intensive and more open-ended in orientation; hence to ensure data collection on all themes within the project parameters, we sought to achieve an appropriate mix of conversational and participatory techniques. Main participatory techniques included Problem Tree Analysis (PTA), Stakeholder Mapping (SHM) and project history diagrams. The Problem Tree Analysis (PTA) seeks to understand service providers' perceptions about the main causes underlying the bottlenecks towards improved nutritional outcomes, potential solutions to addressing these causes and the extent to which the IN-SCT contributes to doing so. The Stakeholder Mapping (SHM) exercise

seeks to understand who the key stakeholders are and how they collaborate to implement the IN-SCT, identifying power dynamics and potential barriers to collaboration. This tool primarily contributed to the themes of ‘social services’ and ‘multi-sectoral collaboration’. The project history diagram is a tool aiming to understand changes over time since the start of the IN-SCT pilot and how the pilot may have contributed to such changes. This activity was used in case studies with clients and helped to reflect on the role of the IN-SCT in improving food security outcomes.

Picture 1 Examples of PTA and SHM



A final method for data collection that was included in this research is participant observation. Participant observation was undertaken in one kebele in each woreda (see Annex 1). Observation was undertaken by one fieldworker over the course of five days and consisted of observing PSNP and IN-SCT-related activities in the kebele as well as nutrition- and hygiene-related practices as supported by the IN-SCT. It also included unstructured conversations with clients, community members and service providers. Fieldworkers were trained and supervised ahead of their five-day observation period, were conversant in the local language and used a daily reporting template to record observations.

3.3. Sampling

Pilot testing of fieldwork tools was undertaken in Adami Tulu woreda in Oromia region in March 2017. Fieldwork for this study was undertaken in two kebeles within each woreda – Halaba and Shashego – in March and April 2017. Kebeles were selected on the basis of their access to main roads, availability of services and performance in PSNP/IN-SCT as advised by the woreda and by the Concern coordinator in Halaba. An overview of considerations is presented in Table 1.

Table 1 Selection criteria for kebeles

Woreda	Kebele	Selection criteria
Halaba	Galato	Good community participation, good accessibility and close to Halaba town; among better performing PSNP/IN-SCT kebeles; kebele-level government structures such as DAs, HEWs and SWs are assigned and working well in a coordinated manner; good take-up of primary health care services.
	Udana Cholkosa	Far from the woreda capital (about 50 km); among poorer performing PSNP/IN-SCT kebeles; limited number of kebele government structures such as HEWs and DAs are assigned and working; limited coordination among kebele government staff.
Shashego	Shayambe Wanchikota	Good community participation, good accessibility and close to woreda town; fair performance of PSNP/IN-SCT; kebele-level government structures such as DAs, HEWs and SWs are assigned and function well in a coordinated manner, better up take of primary health care services.
	Shemsa Jemaye	Remote kebele (about 27 km from woreda town); poor performance in PSNP/IN-SCT, kebele government structures such as HEWs and DAs are not assigned or not functioning at kebele level, limited coordination among kebele government staff.

Sets of fieldwork activities were undertaken in each of the four kebeles, collecting views and experiences of service providers and clients. This was complemented with additional interviews at woreda and regional level. In total, 20 key informant interviews (KIIs), 25 focus group discussions (FGDs) and 16 case studies (CSs) were undertaken. The full sampling frame is presented in Annex 1. Data was collected by a team of four field researchers, working in teams of facilitators and notetakers respectively.

3.4. Fieldwork challenges

A few challenges were encountered during fieldwork but were managed in such a way to ensure quality and consistency of the overall data.

- The team struggled to find male PDS clients to participate in male-only focus group discussions. Kebele officials explained that the number of PDS clients was reduced significantly in SNNP region from PSNP3 to PSNP4; the PDS quota in the region was reduced from 20% during PSNP3 to 10% during PSNP4. In order to mitigate the impact of this challenge on the quality of data collection, the field researchers captured as much information as possible about male PDS clients through the male PDS case studies and in discussion with female PDS clients in their group discussions.
- Delays of PSNP payments affected fieldwork as because many of the respondents – particularly those most vulnerable – were expecting some payment from the research team. Moreover, many of them considered the field researchers to be facilitators of PSNP payment, leading to confusion and unmet expectations. Field researchers responded to this confusion and expectations by listening to views of respondents and appreciating their problems while at the same time systematically drawing their attention to the purpose of the assignment.

4. Clients' perspectives and experiences

This section explores clients' perspectives and experiences in relation to IN-SCT. This pertains to clients' overall perceptions of the programme and its impact as well as more detailed experiences with service providers and innovations within PSNP4. The research assesses clients' perceptions of interactions with service providers – including Social Workers (SWs), Community Care Coalitions (CCCs), Health Extension Workers (HEWs), Development Agents (DAs), teachers and school directors (SDs) and Concern staff – and satisfaction with services provided and the extent to which the interactions and services lead to improved outcomes. The research also considers clients' understandings of the innovations within PSNP4 and the extent to which these are considered to lead to change. We conclude this chapter with an overview of positive experiences and challenges as experienced by clients.

4.1. Overall perceptions of IN-SCT

Clients are generally appreciative of PSNP4 and of the support provided through IN-SCT. This pertains to individual components – including cash transfers, the transition from PW to TDS for PLW, co-responsibilities and BCC sessions – as well as the combination of these various components into one package of support.

Cash transfers are crucial to meeting basic food needs, preventing hunger and improving outcomes, particularly for PDS and TDS clients. PDS, TDS and PW clients also reported various bottlenecks in terms of cash transfers. Many clients had experienced **late payments**: *“When there is a payment for several months at a time we buy food and availability will increase significantly. But we pass a period of food gap whenever the payment is delayed”* [SN-S-SJ-CS-PDS-F] while a few clients also reported **deductions** from their transfers to go towards large infrastructure projects. When asked about barriers in terms of improving hygiene practices, some clients also highlighted that the cash transfer is too small for buying soap: *“We are poor and the cash we receive is small. We don't have sufficient money to purchase soap. Thus we usually wash our hands with water only”* [SN-H-G-FGD-PDS-F]. The **small size of the cash transfer** was also deemed a constraint with respect to improving feeding practices and improving income generation in the long run as it does not allow for investment.

The case study of Abrehet in Box 1 illustrates the need for PSNP payments to be regular, predictable and timely.

Clients are appreciative of the innovations within PSNP4, notably the transition from PW to TDS for PLW and co-responsibilities. TDS clients mentioned how the very transition from PW into TDS has helped to improve care for children as it takes away the burden of work. Co-responsibilities are considered to increase knowledge and awareness, stimulating changes in behaviour. Similarly, BCC sessions are appreciated in terms of the knowledge and information that is provided with respect to agricultural practices and feeding and hygiene practices.

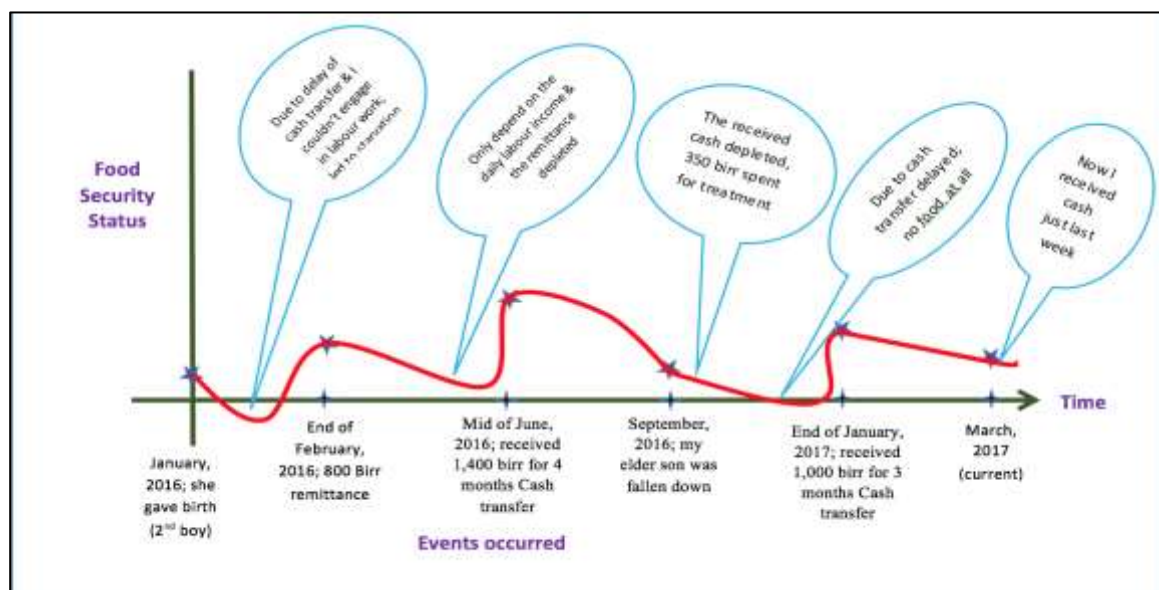
Clients also appreciate interactions with and support from service providers. It has to be noted that **experiences vary from kebele to kebele**. In kebeles with more intense and frequent interactions with the SW and other service providers, clients are more aware of the programme and their co-responsibilities and are also more appreciative of the programme overall. From a comparative perspective, interactions are most frequent and intense with HEWs (for TDS clients in particular) and DAs (for PW clients). Knowledge of CCCs is more sporadic with clients reporting limited support across the board.

Abrehet is a 32-year old mother of two young boys. She lives together with her husband in Shayambe Wanchikota kebele in Shashego woreda. Her oldest son is four years old and her youngest son is one year and three months old. Abrehet is a PDS client and has been receiving PSNP transfers for a few years now because her husband is blind and has a mental illness.

The PSNP transfer represents the only regular stream of income for Abrehet and her family and is therefore extremely important. In itself it does not suffice to meet all demands, and Abrehet undertakes casual labour to earn additional income. However, her pregnancies have meant that she is no longer able to do so or at less regular intervals: *“Since the amount of money I received doesn’t cover all the basic needs of the family, I also sometimes engaged in labour works and got 20-30 birr/day. I usually received 300-400 birr per month. I was interrupted to work when I became weak due to pregnancy of the youngest child up to 2 months after delivery. During this time we were fully depend on the PSNP cash.”*

This period during which she was most depended on the transfer coincided with a delay in PSNP transfer payments, leading to great hunger in the family: *“Immediately after I gave birth, I remember that payments were delayed for a longer time for about 3-4 months. I didn’t know the reason. During these times the whole family were severely suffering with starvation.”* Abrehet’s brother offered temporary respite from this situation by sending 800 Birr in remittances. Yet a recurrent delay in payments later in the year caused renewed drops in the food security situation. Abrehet also reported that 50 Birr had been deducted from her latest payment to support the Abay dam construction.

The impact of delayed PSNP transfers on the family’s food security situation is depicted in the history diagram below. Negative trends in food security status are clearly associated with the delay in payments. This is not surprising given the importance that Abrehet attaches to the transfers: *“Really, without it, we all in the family would have died from starvation. I can say that its support is lifesaving”*.



While the research asked clients to comment on individual components of PSNP4 and IN-SCT, a few clients also commented on the value of a combined package of support. The **combination of cash with advice and support was deemed most valuable**: *“Of course, the transfer saves our life and the advice is important to be productive.”* [SN-H-UC-FGD-TDS-Mixed].

At the same time **clients also face considerable external challenges** in following advice and implementing the lessons learned. Despite the provision of cash transfers, **lack of financial resources and income earning opportunities** presents the most important barrier to accessing nutritious foods,

improving hygiene practices and accessing services. Lack of investment opportunities and access to credit further compounds these constraints.

Lack of markets and undiversified food production undermines the ability to purchase or grow more nutritious foods: *“Access to markets is our challenge. There is no market in nearby area and the next centre is far from us. Even in the nearest market place there is not enough fresh foods – vegetables and fruits – to purchase by those who have cash. Because there is no market infrastructure and poor road, there is no conducive environment for traders to bring vegetables from other places”* [SN-H-U-FGD-TDS-PLW].

Another factor that was mentioned frequently was the **lack of access to water** for drinking, household use and agricultural purposes: *“Water scarcity is very severe in our kebele. Due to water shortage most of us couldn’t keep our personal hygiene as frequently as we need. We are traveling long distances to get water”* [SN-H-U-FGD-PDS-F].

Finally, **lack of time** – particularly on behalf of women – was considered an obstacle to preparing nutritious foods, diversifying diets and changing behaviours more generally. The combination of household work, care for children, water and fuel collection and paid work – often with little help from spouses – leaves women with little time to focus on hygiene and sanitation or to change feeding practices: *“Work burdens at home and outside limit us from keeping our houses and children clean and sanitary, because we are responsible to do all household activities and support our husbands at the farm. Some of us further participate in casual labour work”* [SN-S-SJ-FGD-PSNP-PW-F].

4.2. Perceptions of SWs and CCCs

The majority of clients who received support from SWs considered the **information that was provided to be useful**. Clients particularly mentioned that knowing about the importance of school attendance, as well as learning about children's health and nutrition was useful: *“Yes, it was very helpful as it was a good lesson to know about the importance of sending children to school and ways of improving our sanitation and children health”* [SN-H-G-CS-PDS-M].

Clients received support either through **direct advice at home or in community meetings**. In terms of issues discussed with the SW, PDS and TDS clients mainly mentioned talking to the social worker about co-responsibilities, BCC sessions as well as about how to use the transfer money. Clients also mentioned that the social worker had informed them about to provision within PSNP4 allowing PLW to transition from PW to TDS, as well as encouraging them to use the grievance and complaints mechanisms: *“He visits our home, advises us to go to health post when we are sick, to send our children to school, and he follows up”* [SN-H-G-FGD-PDS-F].

It should be noted that **experiences with social workers are mixed with varying degrees of intensity of interactions across locations**. A few clients mentioned receiving regular monthly visits by the SW. However, the majority of respondents indicated that meetings did not follow a strict schedule with most respondents having met the SW only once or twice, as illustrated by these quotes: *“We meet the social worker when he comes to the kebele but we don’t have regular meeting. We may meet once or two times a month”* [SN-H-G-FGD-TDS-PLW] and *“We do not know the social worker in person. There is no regular meeting or speaking with us. We saw him twice since the start of the programme”* [SN-H-U-FGD-TDS-PLW]. Some clients also reported not having been assessed and not knowing the social worker at all.

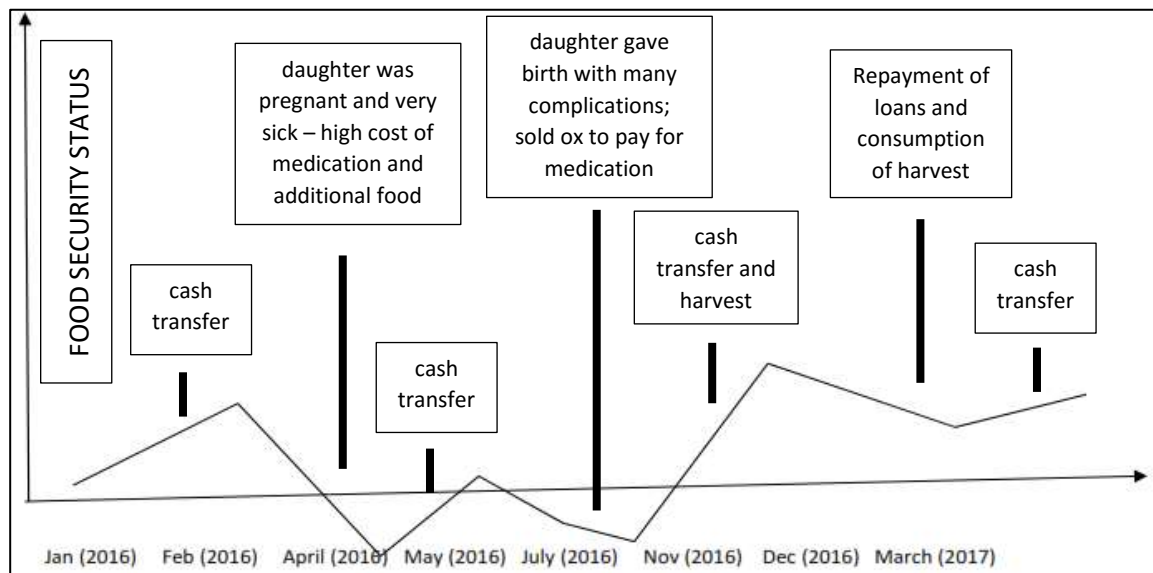
Awareness of CCCs among clients was generally low. Respondents in Shashego woreda reported not to know of the existence of a CCC in their kebele or community. Experiences are more mixed in Halaba woreda with some respondents reporting direct experience with the CCC, others talking about the services that they provide and still others indicating that they are unaware of such a committee.

Given the widespread lack of awareness of the CCC’s existence, responses to questions regarding the types of support provided by or received from the CCC were very limited. **Only very few clients reported direct interaction with the CCCs.** Those who were unaware of the CCC, indicated to discuss any issues related to PSNP with the kebele chairman or the DA.

The case study of Ayalu from Halaba woreda in Box 2 provides an example of interactions with social workers and other service providers and reflects on compliance with co-responsibilities.

Box 2 Case study – Ayalu from Halaba woreda [SN-H-G-CS-PDS-M]

Ayalu is a 76-year old man living with his 18-year old daughter and grandson of seven months. He was PSNP PW client up until January 2016. Due to his age and poor health, he was retargeted to become a PDS client. Since then, Ayalu’s food security situation fluctuated mostly as a result of his daughter’s health situation.



Ayalu has had multiple interactions with the social worker, both at home and in the community. He received information about co-responsibilities and hygiene and feeding practices: *“He told me that I have to send my daughter to school and he teaches me about hygiene and sanitation, about nutritional food consumption and preparation.”* He finds co-responsibilities a good thing, particularly in relation to education: *“Yes, because it is important to send children to school which increase school enrolment to increase number of educated people in our kebele.”*

Ayalu is able to comply with the co-responsibility regarding school attendance: *“I sent my daughter back to school. She dropped out at the age of 16 because of marriage. But she divorced while she was pregnant and came back to me. I sent her to school after she gave birth and she is attending school now.”* But he also struggles to change hygiene practices as a result of lack cash for soap and lack of water: *“Even though I was told to keep my household sanitation, I am not keeping my personal and household hygiene and sanitation as expected due to absence of water source and lack of cash to buy soap. But I am trying my best.”*

Ayalu also regularly meets the HEW and DA. The last interaction with the HEW was during a community meeting with the SW that focused on the importance of school enrolment, child protection, hygiene and sanitation. The DA provides advice about how to improve agricultural productivity. Ayalu is not aware of the CCC or its role within the IN-SCT or community.

4.3. Perceptions of co-responsibilities

Clients generally consider co-responsibilities to be a positive aspect of the programme. Clients find them useful since they provide them with valuable information on how to take better care of their children through better nutrition, hygiene and health care: *“Yes, it protects my kid from disease and illness and I also benefited by getting nutrition services. My kid is recovered for malnutrition”* [SN-H-U-CS-TDS-F] and *“Yes, they are. They are good because, if we do not follow her advice our children will not be healthy and deliver may hurt us. Latrine use is also good to prevent disease”* [SN-S-SW-FGD-TDS].

Exact knowledge of co-responsibilities proved mixed across the research locations. One reason for clients not being exactly aware of the set of co-responsibilities is that clients have been informed of their co-responsibilities orally rather than in written form: *“No form but they orally told us what do. They gave us co-responsibilities on antenatal and postnatal care, child immunization, child care and management and feeding”* [SN-H-G-FGD-TDS]. **Knowledge differs across IN-SCT kebeles** with differences apparently linked to the availability of service providers within the community – most notably HEWs – and the frequency of visits by SWs to those communities. In extreme cases this has led to some clients not being aware of co-responsibilities at all: *“No, I didn’t receive any form and I don’t have any information about the co-responsibility what you are telling me now”* [SN-S-SJ-CS-PDS].

While clients reported that increased awareness as a result of co-responsibilities helped towards changing practices for improved outcomes for children – particularly with respect to school enrolment – they also experience **obstacles to complying with co-responsibilities**. The main obstacle is lack of financial resources but water shortages also present an important barrier: *“Although I was told to keep my household sanitation, I am not keeping my personal and household hygiene and sanitation as expected due to absence of water source and lack of cash to buy soap. But I am trying my best”* [SN-H-G-CS-PDS-M].

Awareness of what happens in case of non-compliance was limited. A few clients correctly articulated that no punitive action follows non-compliance. However, many clients also reported not to know about what consequences might entail of and indicated not to have been informed: *“I don’t know what will happen as nobody has told me”* [SN-H-G-CS-PDS-F]. A few indicated that were told that they would be excluded from PSNP following non-compliance and also referred to the 1,000 Birr fine for home deliveries in relation to non-compliance with co-responsibilities.

4.4. Perceptions of BCC and public works

PW clients are generally positive about the BCC sessions. BCC sessions were reported to have contributed to behaviour change, particularly in Halaba woreda. This pertains to agricultural practices as well as feeding, hygiene and health practices: *“Due to the education by the DA and HEW, we changed our daily practice. For example, we started planting for fruits, vegetables and coffee, which we were not planting before. We improved our personal and environmental hygiene and sanitation. For example, we wash dishes before use regularly wash our children’s bodies, which we were not doing before”* [SN-H-G-FGD-PW-F]. One client indicated that the repetition of messages was conducive for the information to take hold, while another client suggested that sessions could be improved if they focused solely on the topics at hand rather than being mixed with other topics. Clients in Shashego woreda reported that family planning is an area in which there is considerable resistance towards changing practices, despite having knowledge.

Notwithstanding positive perceptions of BCC sessions among PW clients, **the reported content and frequency of BCC sessions varied across locations** included in this research. In Halaba woreda, PW clients indicated sessions to happen every two weeks at the PW site. Female clients also referred to BCC sessions that are provided at the health post on a weekly basis for all pregnant and lactating women. Experiences appear to be more mixed in Shashago woreda with response patterns across male and female PW clients pointing towards differential experiences across clients. Some clients referred to regular sessions covering topics related to agriculture, nutrition and hygiene. Other clients suggested that no BCC sessions were held in the kebele or at least that they had not been informed.

Those clients that are aware of BCC sessions and have participated in them pointed at the **two-fold purpose of BCC sessions**, including advice regarding agricultural practices as provided by the DAs and advice on hygiene and health by the HEWs: *“BCC sessions focus on improved agricultural practices and technology use by DA; promotion of personal hygiene and sanitation, antenatal and postnatal service anti and postnatal care by HEW”* [SN-H-U-FGD-PW-M].

Correct awareness of follow-up action following non-attendance of BCC sessions is relatively limited. The majority of PW clients indicated that they don't think that there are any repercussions when missing BCC sessions. A minority of PW clients appeared aware of the rule that payment would be reduced when not attending BCC sessions. However, non-attendance was not deemed to be a major issue as meetings take place immediately after PW activities on-site and are therefore easy to attend.

4.5. Perceptions of service delivery

In this section, we consider clients' perceptions of service delivery by service providers other than SWs and CCCs – namely HEWs, DAs and Concern staff – before discussing perceptions of service delivery from an overall perspective.

4.5.1. HEWs

Clients are very appreciative of the support provided by HEWs. **All clients know the HEW and most clients have received advice or support** from her. The large majority of respondents mentioned that the services provided by the HEW were very helpful. The HEW proves to be a key source of information on issues regarding health, hygiene, feeding practices and family planning. For example, female clients mentioned that the information provided on keeping their house clean and the importance of immunisation helped them to keep their children in good health. Additionally, the information provided on antenatal and postnatal care assisted them in improving the mother's and child's health, as well as ensuring safe delivery in the health centre. This included being informed about the benefits of delivering at the health clinic, as well as the services available to pregnant women. Caregivers also appreciated the regular check-ups on the nutritional status of their children, as well as the supplements provided when a child was identified to be malnourished: *“Yes, it is very useful. After the HEW advises us we improved our children management and feeding. We are also keeping our home, surrounding and personal hygiene and sanitation. As a result our children are not ill like before”* [SN-H-G-FGD-TDS-F].

Most clients meet the HEW once or twice per month through a variety of interactions, including home visits, organised meetings at the health point, BCC sessions at PW sites and immunisation campaigns. **The format of interactions differs across client groups.** Female TDS and PDS clients interact frequently with the HEW through home visits or sessions at the health point: *“She visits households once per month, and visits villages every 15 days. She is mostly on duty and clients who have sick kids go to the*

health post and meet her. So meeting frequency also depends on the cases such as pregnancy or vaccination appointments. She frequently meets with 1 to 5 network leaders" [SN-S-SW-FGD-TDS]. PW clients meet the HEW at the PW site during BCC sessions, or when the HEW meets with different groups (e.g. women groups) at the community.

HEWs provide a wide range of services, with clients referring to advice on household hygiene and sanitation awareness raising, information on maternal and child nutrition and health: "During BCC sessions she also advised us to personal and environmental hygiene and sanitation, child immunization and family planning" [SN-H-G-FGD-PSNP-PW-F]. She also plays an important role in informing female PW participants about their right to move to TDS after four months of pregnancy. The HEW visits public works sites to ensure participants eligible for TDS are transitioned. Visual messaging at health posts – as provided through IN-SCT – support these activities (see Picture 2).

Picture 2 Visual messaging on TDS at Udana Cholkosa health post, Halaba woreda



Awareness of the services provided by the HEW are high across all client groups, despite not necessarily everyone having benefited from them directly. Male PW clients are aware of the services provided to TDS and PDS clients related to antenatal and postnatal care and children's health. **TDS and PDS clients as well as female PW clients have more direct engagement with the HEW** through home visits, receiving nutritional supplements for the children as well as tailored awareness raising on BCC issues such as hygiene and sanitation, child feeding and breastfeeding. Comparatively, **TDS clients receive more intense services**. These are in line with co-responsibilities and focus on children's health, including the provision of food supplements, information on how to prepare nutritious foods for children and pregnant women, as well as conducting regular health check-ups on children to assess their nutritional status. For pregnant women, the HEW provides antenatal and postnatal care and information, including advice to ensure a safe delivery.

4.5.2. DAs

Quality and frequency of support as provided by DAs is considered very helpful by all clients having received services from the DA. DAs primarily provide advice on activities linked to agriculture, including fruit and vegetable production and livestock keeping. Services include the provision of advice at community level and PW sites but also extend to home visits, facilitation or provision of BCC sessions and advice related to the transition from PW to TDS for PLW, co-responsibilities and better outcomes for children: "The DA visits us at the farm or at home during planting season. He teaches us about planting, proper land preparation, ploughing and sowing techniques. He advises us to buy and use improved seed and fertilizer. He also told us to send our children to school" [SN-S-SJ-FGD-PW].

Respondents commented on how **the advice of DAs helped to improve agricultural practices**: *“Yes, it is very important, as a result we are planting fruits, vegetable and coffee, we also adopted row planting and input use”* [SN-S-SW-FGD-PW-F]. One respondent highlighted that the repetition of messages helps to lead to sustained change in practices. The advice is also considered improve agricultural productivity and subsequently food security: *“Yes, the information is useful. If we were not implementing their advice, we would face more difficult situations like severe food shortage even worse than now”* [SN-S-SJ-FGD-TDS]. The combination of the DAs’ support in combination with the PSNP transfers was particularly appreciated.

Across all kebeles, **DAs meet most frequently with PW clients**, often several times a week or biweekly. Interactions are particularly intense during the agricultural season. TDS clients also report frequent support from DAs while PDS clients have few interactions with the DA, mostly because the support provided by DAs is not deemed relevant as PDS clients consider themselves too old or incapable of undertaking activities. Regardless of client group, **Frequency of interactions and intensity of support differs across kebeles**. One factor informing this difference appears to be whether the DA lives in the kebele. Living in the kebele facilitates interaction across all client groups: *“We meet him every day because he lives her in our kebele”* [SN-H-U-FGD-TDS].

Support from DAs appears to be subject to a gender bias. Female TDS respondents across kebeles mentioned that DAs interact more directly with their husbands, rather than with them directly: *“DAs have direct contact with men. We do not get much support but we got services such as advice on vegetable production, planting and overall crop production mostly through our husbands”* [SN-S-SJ-FGD-TDS].

4.5.3. Concern staff

Clients provided very few accounts of support received from Concern. This is partly a reflection of the generally low levels of support received through IN-SCT as well as Concern’s collaboration with other stakeholders in provision of IN-SCT services.

A response by a TDS client reflects the low level of visibility of Concern and also the general challenge for clients to distinguish who provides what kind of support: *“Someone who speaks Amharic came from some organisation (NGO) and told us to give birth at health centre and take children for vaccination at a meeting organized at health post. I do not know whether he was a social worker but he said some other organisation name. That was six months ago”* [SN-S-SW-CS-TDS-F].

4.5.4. Overall perceptions

An overall consideration of clients’ perceptions of and experiences with service providers indicates that **clients have strong awareness of and positive experiences with traditional service providers**, namely HEWs, DAs and also teachers and school directors. Although the intensity and quality of support differs across kebeles – primarily as a result of availability and presence of staff in kebeles – support is generally well-received and clearly understood. Services have been longstanding and the remit of support is clearly delineated with HEWs providing advice regarding health, hygiene and nutrition and DAs offering agricultural extension services. It should therefore not come as a surprise that **clients are comparatively less aware of relatively new service providers**, notably SWs and CCCs. In addition to their posts and mechanisms having been established fairly recently, their mandate is also less clearly delineated. These factors are compounded for Concern staff, who prefer to work behind the scenes rather than promote their own brand.

While the incipient role of social workers and CCCs poses challenges to the implementation of IN-SCT, clients' experiences also give rise to positive lessons learned. Notwithstanding the relatively recent establishment of SW posts and CCCs, clients have strong awareness of new provisions within PSNP4 and their processes. Although we do observe difference across kebeles, awareness is present across IN-SCT locations among all client groups. This points towards a **strong cross-sectoral collaboration in terms of implementing PSNP4 and IN-SCT** with service providers working together to fill capacity gaps and fulfilling each other's roles if need be. Clients may therefore not be exactly aware of whom is supposed to offer what kind of support and whom they can appeal to if support isn't provided, but it does ensure that a minimum level of services is available.

4.6. Conclusion

Overall **clients perceive of PSNP4 and IN-SCT positively** and find the support and services that they receive helpful and beneficial. The transition from PW to TDS for PLW, advice and support associated with co-responsibilities and case management, BCC sessions and interactions with service providers are all considered to contribute to improved outcomes. Clients particularly referred to having more awareness about the need for ante- and postnatal care, growth monitoring, school enrolment, nutritious diets and agricultural practices. The combination of interventions with cash transfers is particularly powerful as a regular flow of adequate cash transfers was deemed essential for food security and agricultural productivity, among others.

The assessment of clients' perceptions and experiences also highlighted various challenges.

Firstly, **cash transfers are subject to delays**. Some clients also experience deductions. More generally cash transfers are considered too low to meet all food and basic needs and to put lessons learned through IN-SCT into practice.

Secondly, while clients are generally positive about support received, **experiences regarding frequency and intensity of interactions with service providers are very mixed**. Experiences differ across kebeles, with clients in kebeles in more remote locations and suffering capacity constraints receiving fewer services. Experiences also differ across service providers, with clients generally having more exposure to traditional service providers such as HEWs and DAs compared to new service providers such as SWs and CCCs.

Finally, various **external factors form strong impediments for clients to put advice and knowledge into practice** and to ultimately change feeding, hygiene and health practices. Lack of cash (despite receiving transfers), limited income generating opportunities, lack of access to markets, poor access to water, low agricultural productivity, and time burdens on behalf of women were all mentioned as constraints to improving livelihoods.

Positives and challenges for each sub-section are summarised in Table 2.

Table 2 Positives and challenges based on clients' perceptions and experiences

Positives	Challenges
Overall experiences with IN-SCT	
<ul style="list-style-type: none"> • Cash transfers are crucial: receipt of cash is crucial for meeting basic food needs and improving other outcomes such as education; • Transition from PW to TDS benefits PLW and children: no longer having to work decreases time burden and improves health of women and children; 	<ul style="list-style-type: none"> • Delayed PSNP payments: payment delays constrain the ability to secure intake of nutritious foods and improve other outcomes— this is compounded by deductions and generally small transfer amounts; • Mixed exposure to service providers: varying levels of interactions with traditional and new

<ul style="list-style-type: none"> • Co-responsibilities and BCC sessions increase knowledge and change behaviour: provision of information and monitoring of co-responsibilities incentivises behaviour change. 	<p>service providers lead to mixed experiences across IN-SCT locations;</p> <ul style="list-style-type: none"> • External constraints impede impact of PSNP4 and IN-SCT: factors such as low agricultural productivity, lack of income generating activities, poor access to water, lack of access to markets and time burden limit the extent to which clients can put knowledge into practice.
Social workers and CCCs	
<ul style="list-style-type: none"> • Useful advice and follow-up: clients having received support from SWs find the information helpful and appreciate regular follow-up in applying lessons learned. 	<ul style="list-style-type: none"> • Mixed experiences with SWs: while clients in some areas have regular interactions with SWs, clients in other areas are unaware of SWs or meet infrequently; • Limited knowledge of CCCs: awareness of CCCs was mixed across locations but generally low with few clients being aware of the existence of CCCs and their role; • Limited experiences with CCCs: exposure to CCCs was very limited across the board.
Co-responsibilities	
<ul style="list-style-type: none"> • Positive impact of co-responsibilities: greater awareness leads to increased use of services and positive practices. 	<ul style="list-style-type: none"> • Confusion regarding co-responsibilities: clients have a general awareness of co-responsibilities but limited exact knowledge of their own co-responsibilities.
BCC sessions	
<ul style="list-style-type: none"> • Easy to attend: clients find it manageable to attend sessions at PW sites after activities; • Behaviour change: BCC sessions have helped to change agricultural, hygiene and health practices, particularly in Halaba woreda. 	<ul style="list-style-type: none"> • Limited knowledge: some clients displayed limited awareness of BCC sessions and attendance requirements.
Service delivery	
<ul style="list-style-type: none"> • Overall positive interaction with service providers: clients report positive experiences with service providers when such interactions take place; • Strong outreach and high exposure to HEWs: all clients are aware of the HEW and have received one of many services; • Useful advice and follow-up from HEWs: all clients appreciated the support from the HEWs, findings the advice on hygiene, health and nutrition most helpful. • Frequent interaction of DAs with PW and TDS clients: services are frequent and highly relevant, leading to positive change. 	<ul style="list-style-type: none"> • Mixed experiences: quality of service delivery in terms of frequency and intensity of support differs across kebeles and service providers; • Gender bias: many female TDS clients indicate that the DAs primarily talk to their husbands, both with respect to agricultural advice and child- or TDS related issues. • Limited awareness of support by Concern: clients are largely unaware of support provided by Concern.

5. Service providers' perspectives and experiences

This section explores the perceptions and experiences of service providers, namely SWs, HEWs, DAs and teachers and school directors. It also considers the role of and collaboration with Concern. The section assesses service providers' overall perceptions before discussing service providers' perceptions of the extent to which the IN-SCT is relevant, effective and impactful. The second half of the section assesses experiences regarding implementation and collaboration. The section concludes with an overview of positive experiences and challenges.

5.1. Overall perceptions of IN-SCT

Service providers' perceptions of the IN-SCT are mostly positive, both in terms of implementation as well as perceived impacts. **Service providers generally work together in a collaborative manner**, aiming to overcome capacity constraints and other obstacles as constructively as possible. They have **good awareness** of their own roles and responsibilities within PSNP4 and IN-SCT. The element of advice and awareness creation through co-responsibilities, case management and BCC sessions is deemed to **change knowledge and behaviour**.

Service providers also point towards considerable challenges on behalf of clients and in terms of implementation that form barriers to achieving positive impacts. **Lack of cash or income as well as limited access to water inhibit clients** to put theory into practice. **High workloads, capacity constraints and staff turnover impede effective implementation** of IN-SCT and PSNP4. Notwithstanding the positive work undertaken by SWs, their **limited presence in kebeles** and interactions with other service providers weakens their perceived roles within IN-SCT and PSNP4. The **potential of CCCs was largely unexplored** at the time of the research with few activities having taken place since their establishment.

5.2. Perceptions of IN-SCT along OECD-DAC evaluation criteria

This section considers service providers' perceptions of the IN-SCT along three of four OECD-DAC evaluation criteria, namely relevance, effectiveness and impact. The criteria of relevance assesses whether service providers consider services provided as part of PSNP4 and IN-SCT to be appropriate for and responsive to the communities' needs. The criteria of effectiveness focuses on perceptions regarding implementation and to what extent the programme is implemented meaningfully and efficiently. The impact criterion considers service providers' perceptions about the impact of the services that are provided as part of PSNP4 and IN-SCT.

5.2.1. Relevance of IN-SCT services

On the whole, **service providers consider IN-SCT services relevant for meeting community's needs** and addressing issues regarding nutrition, health and hygiene, particularly in terms of creating awareness and changing behaviours in relation to feeding, health, nutrition and agricultural practices. At the same time they also point to the **importance of constraints that are not addressed directly or adequately by PSNP4 or IN-SCT**, most notably lack of adequate income and income-generating opportunities and limited access to water. In acknowledgement of constraints faced by clients in meeting their co-responsibilities, **service providers build on the structures established through IN-SCT to offer further support to those in need**.

The **creation of awareness and knowledge through the integrated package of co-responsibilities, follow-up and case management** was reported most frequently by service providers as being a key element of IN-SCT. Lack of awareness regarding the importance of education, exclusive breastfeeding

as well as agricultural practices on behalf of the clients was reported to be an impediment to improving outcomes. One school director indicated the lack of awareness to be the most important constraint: *"Here also some families have less resources and some have no awareness about education. Parents' lack of awareness and limited follow up are more critical problems than financial issues and students' interest"* [SN-S-SJ-KII-SD]. One DA pointed out that bringing about attitudinal change does require continued effort: *"We need more time to bring attitudinal change and attain intended result in full. [...]"* [SN-S-SJ-KII-DA].

While the set of services provided through PSNP4 and IN-SCT are deemed relevant in relation to community's needs, there was also consensus among service providers that there are other important constraints that are not addressed adequately or directly by PSNP4 and IN-SCT.

Widespread poverty and lack of cash is as a main barrier for clients to comply with co-responsibilities and obtain nutritious foods. This is despite the fact that cash transfers are being provided through PSNP4. For example, one of the reasons for non-attendance in school is that children were sent to work due to immediate financial needs of the households: *"From another kebele, four children of one household dropped out of school due to problems of having food and cash to cover school costs"* [SN-H-U-KII-SW]. More broadly, lack of economic resources also undermines adherence to co-responsibilities, prevents the ability to provide nutritious diets and to adopt hygienic practices such as washing hands with water and soap. The amount of transfers is considered to be too low and income generating opportunities too scarce to secure a flow of regular and adequate income.

Service providers also repeatedly highlighted the **barriers posed by water shortages**. The lack of access to water is addressed through IN-SCT but only marginally through the establishment of water points constitutes a small component in the set of nutrition-sensitive interventions supported by Concern. However, lack of access to water for drinking, washing and irrigations greatly undermines positive impacts in terms of nutrition due to water's crucial role in all pathways towards better nutrition. Consumption of clean drinking water, handwashing practices and vegetable production are directly undermined with school attendance and care practices being affected due to time involved in collecting water.

When external factors – mostly lack of cash - limit clients' abilities to meet their co-responsibilities, **service providers aim to offer additional support**. For example, in both Shashego and Halaba woredas, school directors reported to have mobilised support from the community to raise money or collect food for the households that depended on child labour for survival, so as to allow their children to come back to school: *"I follow up and report cases/drop outs and absents to the management when non-compliance happened. [...] If families have certain problems, we mobilize support from the community and let their children attend school"* [SN-S-SJ-KII-SD].

5.2.2. Effectiveness of IN-SCT services

Service providers reported that **IN-SCT is generally well-implemented**, although effectiveness of implementation does differ across components of PSNP4 and IN-SCT and across IN-SCT kebeles. Experiences are largely positive in relation to implementation of co-responsibilities (including the transition from PW to TDS for PLW); experiences are more mixed in relation to the implementation of BCC sessions. In terms of geographical differences, implementation is more efficient and effective in kebeles closer to the woreda centre, towns and main roads.

In terms of co-responsibilities, **TDS and PDS clients across all sites have been informed about their co-responsibilities**. Provision of information occurred mostly verbally, either during home visits or

during village meetings by SWs or HEWs. While forms were not used as most people are illiterate, the fact that clients were informed only verbally at the start of the pilot might lead to them forgetting their actual co-responsibilities. Compliance with co-responsibilities is high with monitoring by all service providers contributing to high rates of compliance.

Participation in BCC sessions by PW clients is good across kebeles, mainly due to the fact that they are delivered right after the public work activities, which all clients have to attend to receive the cash payment. While some DAs indicated that when clients to miss one session there are no negative consequences for them and they are merely advised to attend the next one, others firmly suggested that payment will be withheld: *“Every client attended the [BCC] session, because attendance is documented at the closing time and otherwise the client may record as absent”* [SN-H-U-KII-DA].

Based on service providers’ responses, there appears to be **considerable variation across kebeles with respect to implementation of BCC sessions**, in terms of when they take place, who provides them and who participates. Responses also differ by service provider. In Galato kebele in Halaba woreda, for example, the DA indicated to have a clear schedule for BCC sessions for PW clients, using these sessions to provide advice about agricultural practices every fortnight. By contrast, the HEW indicated that BCC sessions for PW clients are not regular. DAs emphasise the agricultural nature of BCC sessions, with the content focusing on improving agricultural practices, HEWs highlight the topics of health and education as being core to the sessions. In general, kebeles with greater capacity operate a more regular schedule for BCC sessions with clear objectives for each session and DAs and HEWs alternating their roles.

Various challenges undercut IN-SCT’s effectiveness.

Firstly, service providers refer to **lack of (full) capacity**, particularly in remote kebeles. With respect to HEWs, for example, lack of two fulltime HEWs per kebele and absenteeism of HEWs (as a result of sickness, pregnancy or other commitments) were mentioned as bottlenecks. Also, service providers that are supposed to live in the kebele – notably HEWs and DAs – tend to live away from the community when the kebele is close to towns, limiting the amount of time that they spend with clients. Reasons for service providers to live away from the kebele include poor living conditions in the communities.

Staff turnover is another factor that constrains effectiveness of implementation. Examples that were reported in the research pertained particularly to SWs and DAs with other service providers such as HEWs and school directors highlighting that these changes in staff result in new service providers having limited knowledge about the programme and their roles and responsibilities within it as well as lacking the strong relationships across service providers that are crucial to effective implementation. Quotes from a SW and CCC member illustrate how staff turnover affects implementation: *“There are repeated changes in the DA heads; that creates difficulties with planning”* [SN-S-SW-KII-SW] and *“His overall responsibility for PSNP is high as there is high turnover of social workers and handing over of PDS and TDS responsibilities is going on”* [SN-H-G-FGD-CCC].

5.2.3. Impact of IN-SCT services

Service providers generally hold the view that PSNP4 and IN-SCT improves outcomes. **Positive impacts were mentioned most frequently in reference to implementation and monitoring of co-responsibilities**, having led to positive behavioural changes in terms of school enrolment, and health care utilisation. The latter was also considered to be promoted by the transition from PW to TDS for PLW: *“Clients’ children are attending their classes [...] Pregnant and lactating women attending ANC*

and PNC services increased over time. We believe that the transition of PLWs to TDS has contributed for this." [SN-H-GA-KII-SW].

Service providers also reported that **advice about feeding practices, nutritious diets and agricultural practices improve outcomes in relation to nutrition**: "Yes, because I noticed that the number of malnourished children has decreased in our kebele because of improvement in nutritious food preparation and care for children" [SN-H-G-KII-HEW]. Such advice is provided through BCC sessions and interactions with service providers, mostly HEWs and DAs. DAs and HEWs indicated that the BCC sessions lead to an increased awareness of the issues that are discussed during the meetings. They have observed behavioural changes as a result: "Because of the BCC sessions, children's health and growth has improved due to the fact that women changed their ways of food preparation as a result of the training they received through teaching and cooking demonstration" [SN-H-G-KII-HEW].

External constraints, notably lack of income and water shortages, do represent a strong barriers to improving outcomes particularly in terms of nutrition. For example, when it comes to feeding their household members more nutritious food, clients face financial barriers to purchasing higher quality food items in the market, or lack the resources necessary to produce these at home. In the case of vegetable production, water shortages and lack of irrigation systems represent a further challenge for households: "But feeding of nutritious food to children and pregnant and lactating mothers is determined by the household's economic capacity and availability of resources like water to produce nutritious food (vegetable, fruit, poultry and dairy products" [SN-S-SJ-KII-DA].

5.3. Perceptions of practical issues in implementing IN-SCT services

This section focuses on how service providers' roles and responsibilities in IN-SCT impacts the day-to-day performance of their jobs, specifically considering challenges or bottlenecks that they experience.

All service providers generally convey a good awareness of the programme. **Awareness of roles and responsibilities regarding monitoring and follow-up on co-responsibilities as well as the transition from PW to TDS for PLW has increased in comparison to the baseline**. Responses indicate that service providers are aware that co-responsibilities do not serve as conditions; rather than sanctioning clients for non-compliance, SWs and HEWs aim to understand what types of challenges clients face when trying to fulfil their co-responsibilities and whether solutions can be found. This is done through home visits by either the SW or HEW or both. The SWs in all four kebeles indicated to have undertaken home visits to collect data from the client to add to their case management file, as well as to follow-up on any cases where co-responsibilities were not complied with by the clients.

High workload is one of the main challenges for service providers in implementing IN-SCT. This holds particularly true for HEWs; both HEWs themselves and other service providers pointed at the constraints associated with their busy schedules that include tasks at the health point, as well as providing training and awareness sessions in the kebeles and conducting home visits. The HEWs' pivotal role in implementing and monitoring co-responsibilities in conjunction with their already extensive set of activities leads to frustration on behalf of themselves and other service providers: "The HEW is very busy as she is working alone. One of the other HEWs is not around due to training, thus she is busy handling both health post level and outreach service" [SN-S-SJ-KII-DA-M]. The lack of capacity was also mentioned by HEWs themselves: "I am only one HEW in this kebele, and I also have a health problem [...] thus I do home visits rarely. When I plan to do home visits, I select some special cases like non-compliant TDS clients and ask about the problems she faced, why she couldn't comply and I give advice based on her problems" [SN-H-U-KII-HEW]. HEWs' absence from the kebeles was mentioned as an additional barrier to collaboration, particularly when HEWs do not live in the kebele.

A few service providers referred to **the need for more training**. In response to how limited level of nutrition knowledge on behalf of HEWs could be addressed, a HEW in Shashego woreda [SN-S-SW-KII-SW] indicated that refresher sessions and follow-up training based on the earlier training by Concern would be helpful. She indicated that one training was provided but this was not sufficient. In reference to discussions about staff turnover, service providers also indicated that new service providers lacked sufficient knowledge. As such refresher training would also be beneficial for maintaining consistency in programme implementation.

5.4. Perceptions of collaboration between service providers

This section unpacks the collaborative relationships between service providers. The IN-SCT cross-sectoral approach call for strong collaboration across stakeholders, particularly among frontline workers at kebele level.

5.4.1. Collaboration with SWs

Collaboration between SWs and other service providers is generally positive. It mainly takes place in relation to monitoring and follow-up of co-responsibilities but also in relation to improvement of clients' situations more widely. Responses by service providers in Galato kebele in Halaba woreda provide an illustration of the remit of collaboration: *"We discussed conditions of PLW and malnourished child caregivers after being transferred to TDS. We also discussed vegetable production with a focus on TDS clients and how to improve their nutrition"* [SN-H-G-KII-DA] and *"[We met] end of February, we discussed 3 non-compliant students who missed their classes more than 5 days. I gave their names on a list for the SW to visit their homes and to discuss with their parents"* [SN-H-G-KII-SD].

Notwithstanding these positive collaborations, the role of SWs in implementation of IN-SCT as perceived by other service providers is possibly weaker than envisaged. When asked about the importance of various stakeholders in implementation of IN-SCT, **SWs generally rank among the less important stakeholders.** Reasons for this low ranking include limited presence of SWs in the communities and staff turnover, both resulting in few engagement opportunities between SWs and other service providers. Service providers reported the lack of frequent visits to be an important challenge in working with the SWs: *"He doesn't come to the kebele frequently and this affects especially the work that is related to PDS clients"* [SN-H-U-KII-DA] and *"He is not available in the kebele and comes here very rarely. I saw him once since I started working in this kebele"* [SN-S-SJ-KII-SD].

An important reason for the limited visits of the SWs is that **they are overstretched and in charge of too many kebeles.** This issue was raised by the SWs themselves but also by other service providers. Increasing the number of SWs was suggested as a solution by one HEW: *"He has a lot off responsibilities and he can't come to us regularly. But it will be good if number of SW can be increased since social workers are the ones who know the project well and have direct contact with the programme implementers"* [SN-H-G-KII-HEW]. The ability to cover all kebeles and provide adequate support to clients within those kebeles was most limited in remote kebeles, partly because transport by motorbike makes it difficult to reach those areas.

Social workers themselves also pointed out that the **lack of a clear mandate presents a considerable obstacle** to their work. The roles of other stakeholders in implementing co-responsibilities and case management makes them very dependent on others for service provision, but the inability to hold others to account regarding their responsibilities within IN-SCT undermines their ability to secure an effective and appropriate response to clients. As indicated by one SW in reference to collaboration with HEWs: *"[HEWs] are usually busy with the routine activities and may neglect me to respond my*

questions, I don't have a mandate to order them. This issue was repeatedly discussed in the management meetings but they were unable to give appropriate remedies" [SN-H-G-KII-SW]. Another SW had experienced that some of the DAs had requested to be remunerated for their work within IN-SCT, either through per diems or covering mobile phone costs.

Finally, the assessment of service providers' perceptions also reveals that **collaboration with SWs differs markedly across kebeles**. Strong collaboration with fairly recent, regular and productive meetings were reported in kebeles in Halaba woreda. Collaboration in kebeles in Shashego woreda was reportedly more irregular and infrequent. In one location, the SW had reportedly only visited the kebele once and service providers did not know the SW. Although this situation is not representative across IN-SCT kebeles, it does highlight that individual performance is imperative for successful collaboration.

5.4.2. Collaboration with CCCs

The section explores service providers' experiences regarding collaboration with CCCs. **Intensity of collaboration with CCCs differs across kebeles**, with experiences proving a direct extension of CCCs' establishment and functioning. For example, at the time of research no CCC was active in Shayambe Wanchikota kebele in Shashego woreda. SWs and DAs indicated to work directly with the kebele chairman in absence of a CCC. Despite a CCC being in place in Shemsa Jemaye kebele in Shashego woreda, the SW, DA and HEW indicated it to be non-functional: *"I don't know CCC but I know food security task forces and grievance committee"* [SN-S-SJ-KII-DA] and *"I don't know CCC, but I know woreda food security task force. I work with kebele food security task force related PSNP-4 targeting"* [SN-S-SJ-KII-HEW]. In Halaba woreda, the service providers indicated to meet with the CCCs regularly ranging from once every month to once every four months.

Intensity of collaboration with CCCs also varies across service providers, with some service providers with CCCs more intensely than others. In Udana Cholkosa, for example, the SW reported to meet with the CCC every month while the HEW last met the CCC three months previously. School directors collaborate with the CCCs on a more ad hoc basis when the need arises in relation to challenges related to PSNP4 and IN-SCT, such as payment delays that undermine clients' abilities to send their children to school.

Service providers mentioned several challenges in working with the CCCs. A recurrent challenge refers to the **multitude of responsibilities on behalf of CCC members** and how this undermined ways of working with the CCC and the CCC's functionality: *"this committee is not that much active as all the members are involved in different committee sat the same time and they have their one job responsibilities. So it's difficult to meet them whenever you need to discuss some issue"* [SN-H-G-KII-HEW].

One SW commented that there is a lack of commitment following from a **lack of understanding of the CCCs' responsibilities** within the IN-SCT and that they considered it to be an NGO project rather than government programme. Other service providers stated more directly that CCC members did not have adequate levels of commitment and argued for such members to be replaced.

5.4.3. Collaboration with Concern

This section considers Concern's support to IN-SCT and particularly its role in supporting nutrition-sensitive interventions. Findings indicate that **Concern has undertaken key activities in the various areas of work but that many activities still need to be rolled out**. Concern's support has been beneficial in supporting service providers and affecting change through IN-SCT but that positive impact

is undermined by limited follow-up and irregular visits due to staff and transport constraints. In addition, Concern's approach of trying to work closely with local government and playing a catalytic role rather than presenting themselves as a distinct actor appears to make their work less visible, particularly to clients. Service providers deemed the support provided by Concern helpful and to have a positive impact: *"women changed their ways of food preparation as a result of the training they received through teaching and cooking demonstration [by Concern]"* [SN-H-G-KII-HEW].

Tasks include the provision of support to SWs in following up on co-responsibilities, providing and supporting cooking demonstrations (within the remit of BCC sessions), offering in-kind support to PLW and malnourished children (such as chickens), the establishment of nutritional clubs and vegetable gardens at school, upgrading of FTCs and the development of some water points. They also provide training to service providers at kebele level and organise meetings for reviewing activities (such as with DAs to discuss how nutrition-sensitive agriculture can be promoted further). While **some work had been carried to completion or according to plan** (such as the provision of training and cooking demonstrations), **other activities were not yet carried out or lacked follow up**. Nutrition clubs were found to be formed with training provided, but they were not functional and no school gardens had yet been established. Similarly, the FTC grounds in kebeles included in these research looked bare without any activity.

Concern staff in both Halaba and Shashego woredas referred to **high workload, lack of transport and low pay and remuneration as obstacles to successful implementation**. Concern implements its activities at kebele levels using so-called 'supervisors'. Supervisors are stationed at woreda level and cover multiple kebeles. In Shashego woreda, four supervisors cover 34 kebeles. In Halaba woreda, four supervisors cover 46 kebeles. The high number of kebeles to be covered, the remoteness of some kebeles and the lack of adequate transport make it difficult to complete all tasks on time and effectively. For example, the supervisor in Shashego has access to one vehicle, which he has to share with three other supervisors to cover 34 kebeles. Supervisors do not receive compensation for communication (airtime) expenses and find that they are generally underpaid. An added challenge for supervisors in Shashego pertains to work environment; there is no office in Shashego woreda and all supervisors work from home.

5.4.4. Overall collaboration

Overall collaboration between service providers is positive and constructive. **Service providers are generally cooperative and work together to the best of capabilities**, filling gaps that might be left by others due to capacity constraints or other obstacles: *"We (DAs, HEW, SW and teachers) work together in collaboration and sense of helping each other"* [SN-H-G-KII-DA]. Tasks associated with ensuring clients' compliance with co-responsibilities are widely considered to be shared responsibilities. Co-responsibilities that are related to health and sanitation issues are generally followed-up by HEWs, whereas school directors monitor school attendance. If clients fail to comply with education or health related co-responsibilities, the school directors and HEWs respectively communicate this to the SWs or sometimes CCCs, who subsequently follow-up with clients. Aligning work schedules and harmonising transport needs is a specific way in which some service providers try to pool resources and help each other (see the case study in Box 3).

When unpacking collaborative relationships, the **degree of collaboration and strengths of relationships varies across service providers**. A few stakeholders take a more central position across the board. Although not explicitly mentioned within structures of IN-SCT implementation, **the kebele administration is considered imperative for successful implementation of PSNP and IN-SCT**: *"[...] he is the most powerful person who help to convince the community. Without knowing him, nothing can*

be done in the kebele. He follows up on all my activities” [SN-S-SW-KII-DA]. DAs are also deemed to be pivotal stakeholders as a result of strong community presence and linkages to kebele administration: *“The DA is always available in the kebele and works closely with the decision maker and chairman”* [SN-H-G-FGD-CCC]. HEWs are also considered to be crucial to implementation of IN-SCT as many co-responsibilities link to health and hygiene practices that are within the HEW’s remit. SWs, DAs and school directors indicated to meet regularly with HEWs. All service providers mentioned having met the HEW at least once in the last 10 month to discuss different issues. As indicated above, SWs are not considered among the prime stakeholders within IN-SCT.

Box 3 Case study – Social worker and supervisor from Halaba woreda

Tassew and Yisak work in Halaba woreda as a social worker and Concern supervisor respectively. They are both quite new in their jobs.

Tassew says: *“I have been a social worker since 7 months. I replaced a social worker who was posted somewhere else for another programme. Since I started, I took training on child protection and legal issues for children as well as child protection charities. Training was provided by ALSA and UNICEF. I also received training in IN-SCT operation manual. I also took TOT training on programme manual to provide training at kebele level.”*



Yisak explains: *“I applied for the job – it was advertised at the Concern office. My contract is for two years – one year has gone. The activities and the job are interesting to me because working at the community level is interesting.”*

Both Tassew and Yisak face difficulties reaching all the kebeles that they cover. As social worker, Tassew covers five kebeles. As Concern supervisor, Yisak covers 12 kebeles. Tassew has a motorbike provided through the project but two of the five kebeles are too far away to be easily reached by motorbike. Yisak can use a Concern vehicle, but only one vehicle is available for four supervisors. Given these logistical constraints, Tassew and Yisak try to synchronise their schedules:

Tassew: *“There are three kebeles that are close to each other and two are far. I can only visit the two kebeles that are far away with the Concern car together with [Yisak]. Otherwise I use my own motorbike to travel to the three kebeles. All social workers have their own motorbikes but it is not always safe to travel with the motorbike.”*

Yisak: *“There are 4 supervisors in Halaba woreda to cover 46 kebeles. We only have two cars, one in Halaba and one in Shashego – there is shortage of transport. Sometimes I go with SW on motorbike. We have to work together. Before coming this kebele, I consult with [Tassew].”*

The main bottleneck in achieving successful collaboration is the high workloads of all stakeholders involved. HEWs and DAs are reported overstretched but also the kebele administration has to juggle many different responsibilities. This makes coordination of efforts with respect to IN-SCT difficult and delays interactions between service providers and thereby programme implementation: *“The major challenge to work together and coordination is the workload among stakeholders. For example, the kebele chairman and manager are frequently travelling to Woreda for meetings and training and I am*

also busy handling different activities in the health post and outreach activities like immunization” [SN-S-SJ-KII-HEW].

It should be noted that collaboration patterns do differ considerably across IN-SCT kebeles, with **collaboration being weaker in more remote kebeles** as a result of greater capacity constraints and absenteeism by service providers. One CCC member from one of the remote kebeles – Udana Cholkosa kebele in Halaba woreda – indicated: *“In fact contribution of the stakeholders is not similar. Due to the remote location of the kebele, supervision and monitoring backstopping by woreda is weak, which results in some stakeholders not actively engaging in committee work”* [SN-H-U-FGD-CCC]. By contrast, collaboration is conducive when facilities are close together, avoiding challenges related to transport and distance: *“We have good collaboration. The school and health post are located at the same place which eased our communication and collaboration”* [SN-S-SW-KII-SD-M].

More generally, **service providers’ presence in the community is seen as vital to positive collaboration**. Collaboration in less remote kebeles is undermined by HEWs and DAs living in nearby towns as rather than in the communities, which was indicated to undermine collaborative service provision. Similar concerns were also raised in reference to collaboration with SWs, who cover multiple kebeles: *“There is no gap with any stakeholders except the SW. If the SW is assigned to our kebele and lives in the kebele, the condition will be improved”* [SN-H-U-KII-DA].

5.5. Conclusion

Service providers are generally positive about PSNP4 and IN-SCT, **The new innovations within PSNP4 are considered to instil knowledge, change attitudes and induce behaviour change**, ultimately leading to positive impacts. IN-SCT contributes to the positive effects following a system of follow-up, support from SWs, and input from Concern regarding nutrition-sensitive social protection. **Collaboration across service providers is positive**, leading to clients benefiting from an integrated package of services.

Constraints that inhibit effective implementation of IN-SCT are mainly related to **high workloads in combination with capacity constraints and staff turnover**. These constraints are compounded in kebeles with limited presence of service providers, either because too few staff are available or because they don’t live in the kebele. **Lack of adequate transport** forms an obstacle for SWs and Concern staff having to service more remote areas. **Refresher training** on IN-SCT was deemed to be helpful for ensuring effective implementation, particularly for service providers from other sectors (such as HEWs and DAs) and in light of staff turnover.

External factors that are either not addressed directly or not very strongly by PSNP4 and IN-SCT are considered to undermine the ability of both programmes to achieve positive impacts. **Lack of cash, and lack of potable water** are considered to underpin lack of access to nutritious foods and poor hygiene practices, while **low agricultural productivity and undiversified food production** are also deemed to be root causes of lack of access to nutritious foods. While PSNP4 provides cash transfers, PW addresses agricultural productivity and IN-SCT includes nutrition-sensitive interventions as supported by Concern, these do not offer enough support.

Positives and challenges for each sub-section are summarised in Table 3.

Table 3 Positives and challenges based on service providers' perceptions and experiences

Positives	Challenges
Overall perceptions of IN-SCT	
<ul style="list-style-type: none"> • Cash transfers are crucial: receipt of cash is crucial for meeting basic food needs and improving other outcomes such as education; • Transition from PW to TDS benefits PLW and children: no longer having to work decreases time burden and improves health of women and children; • Co-responsibilities and BCC sessions increase knowledge and change behaviour: provision of information and monitoring of co-responsibilities incentivises behaviour change. 	<ul style="list-style-type: none"> • Delayed PSNP payments: payment delays constrain the ability to secure intake of nutritious foods and improve other outcomes—this is compounded by deductions and generally small transfer amounts; • Mixed exposure to service providers: varying levels of interactions with service providers lead to mixed experiences across IN-SCT locations; • Lack of adequate income and water: external factors such as low agricultural productivity, lack of income generating activities and poor access to water limit the extent to which clients can put advice into practice.
Relevance of IN-SCT services	
<ul style="list-style-type: none"> • Advice and awareness creation responds to communities' needs: co-responsibilities and BCC sessions create knowledge that is crucial for behaviour change. 	<ul style="list-style-type: none"> • External factors present key barriers to improving outcomes: lack of income earning opportunities, low agricultural productivity and lack of access to water undermine positive behaviour change and are not directly or fully addressed by IN-SCT.
Effectiveness of IN-SCT services	
<ul style="list-style-type: none"> • High awareness of co-responsibilities among clients: everyone has been informed of their co-responsibilities; • Regular home visits: both SWs and HEWs make regular home visits – either on the basis of a follow-up schedule or in response of reports of non-compliance; • High participation in BCC sessions: PW clients take part in sessions immediately after work activities. 	<ul style="list-style-type: none"> • High workloads and competing pressures undermine implementation: service providers – and HEWs in particular – have heavy workloads that constitute the main obstacle to implementation of IN-SCT. • Limited capacity of HEWs: kebeles do not have enough HEWs in place to support co-responsibilities and BCC sessions as planned.
Impact of IN-SCT services	
<ul style="list-style-type: none"> • Greater use of services: co-responsibilities have helped support higher school enrolment and antenatal and postnatal care; • Behaviour change: BCC sessions have helped to create awareness and change attitudes and practice towards improved feeding, hygiene and health practices. 	<ul style="list-style-type: none"> • Poverty and time constraints: presenting main barriers for clients to comply with co-responsibilities; • Water shortages and traditional practices: presenting barriers for clients to adopt new practices; • Delay in PSNP payments and lack of services: add to clients' constraints in complying with co-responsibilities.
Practical issues in implementation	
<ul style="list-style-type: none"> • Strong awareness of roles and responsibilities: Awareness of roles and responsibilities regarding monitoring and follow-up on co-responsibilities as well as the transition from PW to TDS for PLW has increased in comparison to the baseline. 	<ul style="list-style-type: none"> • High workloads and competing pressures undermine implementation: service providers – and HEWs in particular – have heavy workloads that constitute the main obstacle to implementation of IN-SCT.

	<ul style="list-style-type: none"> • Limited training: some service providers felt that refresher training would help to improve implementation of IN-SCT.
Collaboration with social workers	
<ul style="list-style-type: none"> • Positive collaboration: when SWs visit the kebeles, they work well with DAs, HEWs and SDs to implement IN-SCT/PSNP. 	<ul style="list-style-type: none"> • Infrequent visits: SWs pay irregular and infrequent visits to the kebeles, undermining collaboration; • High workload: SWs cover too many kebeles to be able to spend ample time in each kebele; • Lack of adequate transport: remote kebeles are hard to reach by motorbike; • Lack of plan and mandate: SWs have no mandate to push for support from HEWs and lack clear planning process.
Collaboration with CCCs	
<ul style="list-style-type: none"> • Positive support: where CCCs are available and functioning, they provide positive support to service providers in implementing IN-SCT as well as providing additional support to PDS clients. 	<ul style="list-style-type: none"> • Limited functioning of CCCs: CCCs are not in place, not active or function poorly; • Competing pressures: CCC members are often part of other committees and have busy jobs, making it difficult to work with them; • Lack of commitment: CCC members are not fully committed to the CCC, partly because of low understanding of its role.
Collaboration with Concern	
<ul style="list-style-type: none"> • Helpful support: service providers appreciated the trainings and input into cooking demonstrations; • Economic strengthening: agricultural inputs and advice to clients help to ensure income even if PSNP payments are delayed. 	<ul style="list-style-type: none"> • Lack of follow-up: provision of one-off trainings only and lack of follow-up on nutrition clubs undermines sustainability of interventions.
Collaboration	
<ul style="list-style-type: none"> • Shared sense of responsibility: service providers share responsibilities for monitoring and cases management; • Central role of kebele administration: kebele chairman and manager are crucial in effective implementation of IN-SCT and supporting collaboration across stakeholders; • Strong collaboration with HEWs and SDs: DAs meet frequently with HEWs and SDs to discuss and work on mostly IN-SCT/PSNP-related issues – mostly in Halaba woreda. 	<ul style="list-style-type: none"> • Limited capacity: collaboration with the HEWs is undermined by most kebeles having fewer than two HEWs present; • High workload: high workload on behalf of DAs and HEWs undermines ability to collaborate; • Living away from kebele: collaboration is more difficult when service providers don't live in the kebele; • High staff turnover: frequent changes in staff undermine planning.

6. CCC members' perspectives and experiences

This section explores the perceptions and experiences of CCC members. It explores their opinions regarding their role and practical implications in terms of working on IN-SCT and in collaboration with others.

The CCCs in the kebeles under study were established between September 2015 (Udana Cholkosa in Halaba) and November 2016 (Shemsa Jemaye in Shashego). It should be noted that no CCC appears to have been established or is currently functioning in Shayambe Wanchikota in Shashego. The CCC had been convened for the focus group discussion but throughout the conversation it became clear that this was in fact the recently established Disaster Risk Management Committee.

6.1. Overall perceptions of IN-SCT

CCC members understand their role in PSNP and IN-SCT to consist of **supporting the implementation of existing provisions as well as identifying and responding to additional needs within the community**: *“The role of CCC is PSNP client (beneficiary) targeting, identifying community problems which can be handled through PSNP PW labour and supporting the PSNP/SCT programme”* [SN-S-SJ-FGD-CCC] and *“to help and facilitate smooth implementation of the program by mobilizing community and supporting identification and case management of weak and disabled community members”* [SN-H-G-FGD-CCC].

CCC members in Galato kebele in Halaba woreda also pointed at the particular situation of women and their role in monitoring this situation: *“Women have special circumstances and living conditions compared to men. They work longer hours at in the house while they are also pregnant and lactating. They are also expected to perform tasks outside their home. So we follow up on their condition and support them to transition to TDS. Then, we also follow up on how they are implementing the co-responsibilities while they are on TDS”* [SN-H-G-FGD-CCC].

6.2. Perceptions of practical issues and collaboration in implementing IN-SCT services

There is **great variation across CCCs in terms of the range of activities that they undertake** and the amount of time that they spend on these activities. The CCC in Galato in Halaba woreda reports to provide a wide variety of support, both within the remit of PSNP and IN-SCT as well as to other vulnerable households and families in need [SN-H-G-FGD-CCC]:

- Support school enrolment by supporting families;
- Support women's empowerment by helping them participate in BCC sessions;
- Facilitate smooth implementation of the programme by mobilising the community and supporting identification and case management of weak and disabled community members;
- Follow-up on TDS clients by discussing with HEWs and DAs.

The sets of activities undertaken by the CCCs in Udana Cholkosa in Halaba and Shemsa Jemaye in Shashego are reportedly more limited but do also include resolving grievances and complaints regarding PSNP and mobilising additional support for PDS clients. The latter consists of generating additional financial resources to support access to health services and education materials as well as supply of labour to construct latrines or undertake house maintenance for PDS clients.

CCC members from **all three CCCs have received training**. The training took place during one to two days and was implemented by government staff and Concern staff: *“As a committee we took one-time training that was provided by Concern. The contents of the training were about food security, co-responsibilities, how to transition women from PW to TDS, child malnutrition in general, supplementary feeding including cooking demonstration, and vaccination”* [SN-H-G-FGD-CCC]. While members reported the training to be useful, they also indicated that **it was inadequate to prepare them for their roles**. This applied both to the content of the training, as well as the length of the training and its frequency. In terms of content, respondents suggested that the trainings could have a more practical focus on the actual implementation of the CBSPC duties: *“No, we do not think [it was adequate]. We need more training as many of us may forget some aspects of the training. We need more practical oriented training such as cooking demonstration with cooking utensils at least at a central place (HP or FTC) to demonstrate to the community”* [SN-H-G-FGD-CCC].

CCC members considered a **specific training on nutrition and gender** to be important for building capacity on these issues to be vital for performing their role. The trainings themselves were believed to be too short to cover all the issues necessary to adequately build the capacity of the CBSPC members, and trainings should be delivered more frequently to 'refresh' people's memories: *“Yes we need a refreshment training that may give detailed information about its implementation”* [SN-S-SJ-FGD-CCC].

CCC members reported various other challenges to performing their duties. A **lack of resources** was mentioned across all CCCs, particularly transport to reach remote areas as well as airtime to communicate with clients were considered obstacles to deliver the support requested from them. This results in either CCCs not being able to go to the remote areas or having to cover the costs themselves: *“The distance to be covered to reach all clients in the kebele is too much without transportation facilities for the sectoral staff and the committee”* [SN-H-G-FGD-CCC].

Competing responsibilities and high workloads on behalf of all CCC members were also mentioned as barriers to effective functioning of the CCCs. As most CCC members perform specific functions at kebele level, the additional tasks associated with CCC membership pose an unmanageable additional burden. One CCC member in Shashego woreda elaborated on these challenges as follows: *“When we see its effectiveness, we can't say that we are working well [...]The problem was that everybody is busy with the routine activities that he or she evaluated and gives less emphasis to the committee. The other thing is that there was no follow ups from the woreda side. As you know if things which have no follow-ups will be considered as it is neglected.”* [SN-S-SJ-FGD-CCC]

Another challenges pertains to **mishaps in programme implementation that clients complain about and that create mistrust, but that are beyond the CCCs' remit to resolve**. These are mainly related to delays in payments, the coverage of the programme which is considered to be too low in relation to the number of poor households, as well as the size of the transfer. This is reflected in the following comment: *“Delays in the payment of the transfer to clients is creating stress to them and also creating mistrust on the committee as the client's priority is the transfer. Sometimes, three to four months' payment is transferred at a time. The clients complained several times but the problem is beyond our control. We have reported this several times through the social worker and also to the coordinator”* [SN-H-G-FGD-CCC].

6.3. Conclusion

The role and contribution of CCCs to the implementation of IN-SCT depends greatly on the CCC under consideration. Similarly, the **types and intensity of support that they provide to clients and other community members varies from CCC to CCC**. While CCCs have been established in most kebeles, the number of meetings that have been held since and activities undertaken differ considerably.

In kebeles where the CCCs are active, they provide **meaningful support to SWs and other service providers** in monitoring and following up on co-responsibilities, and successfully **mobilise the community to help clients** that are unable to comply with co-responsibilities due to lack of resources. CCCs also keep an eye on targeting procedures and serve as a point of contact in case there are complaints about inclusion or exclusion from PSNP4.

Various **challenges** undermine CCCs and their members' abilities to perform their tasks. Firstly, **training was deemed useful but inadequate**, with CCC members requesting follow-up and refresher training to remain updated and motivated. Secondly, **lack of resources** such as transport and compensation for airtime limits the ability to provide support – particularly in remote areas. Thirdly, **CCC members face competing pressures** as they generally have many responsibilities, making it difficult to allocate time to meetings and activities associated with CCC membership. Finally, the **lack of mandate to resolve complaints** on behalf of community members creates distrust, ultimately undermining CCCs credibility and effectiveness.

Table 4 Positives and challenges based on CCC members' perceptions and experiences

Community Care Coalitions (CCCs)	
Positives	Challenges
CCC members	CCC members
<ul style="list-style-type: none"> • Collaboration to support: CCC members reported working well together with other service providers; • Ability to mobilise additional support: CCCs are able to seek additional support from CCC members to help clients that are unable to comply with co-responsibilities; • Helpful training: although not sufficient, the training that was provided was deemed helpful and relevant. 	<ul style="list-style-type: none"> • Lack of adequate training: members did not feel that they received enough training to perform their duties; • Lack of resources: no provision of transport or airtime limits ability to support PSNP clients, particularly in rural areas. • Competing pressures: CCC members have many tasks and find it difficult to allocate time to CCC tasks; • Mistrust due to inability to resolve complaints: CCCs inability to resolve complaints makes community members distrustful and undermines CCCs' credibility and position within the community.

7. Conclusion

The analysis in this report leads to a number of main findings regarding the functioning of the IN-SCT pilot and its contribution to improved outcomes as well as to wider observations with respect to bottlenecks to improved nutrition outcomes. Findings also give rise to a more detailed consideration of challenges – both within the remit of the IN-SCT pilot and outside of the pilot – and how these could be addressed. These will be elaborated in turn.

7.1. Overall findings for clients

Clients generally have positive perceptions and experiences of PSNP4 and the integrated IN-SCT pilot. The innovations introduced – such as higher amount of cash transfers, BCC sessions about nutritious diets, transfers from PW to TDS for PLW, more contact with local service providers, and improved access by PLW to ante-natal and post-natal care – are all considered to have resulted in improved outcomes. For example, the introduction of TDS for PLW has reduced time constraints for PW women, improving their own health and the child-care they can provide to their infants. Positive synergies were also noted between the material and non-material programme components. For example, a higher amount of cash transfers enable more investment in household food security, agricultural productivity and sanitation facilities – putting into practice the knowledge transferred to clients by service providers.

Clients report positive interactions with service providers, especially with HEWs whose advice and support is highly valued, and who have good outreach into local communities. DAs are also highly regarded, and their advice on farming-related issues is especially valued, although some women identified a gender bias, complaining that DAs talk mainly to their husbands. Those clients who have received support from SWs appreciate their advice and follow-up case management. On the other hand, the nature, frequency and intensity of interactions with SWs are variable across kebeles, with some clients reporting limited exposure and only occasional meetings with SWs. Two reasons for this are geographic remoteness, and service providers not living within the community but visiting only once a week or less frequently. Awareness of CCCs and interactions with CCCs is even lower. There is similarly low awareness of Concern's contribution to the IN-SCT package of support.

Some of the challenges identified by clients provide useful feedback for improved implementation, because they could potentially undermine achievement of desired impacts. For instance, while cash transfers are acknowledged as crucial, payments are subject to delays and sometimes deductions, and are considered to be too small to meet all the household's basic needs, invest in income-generating activities, and also apply learnings from BCC sessions regarding sanitation, nutritious diets, and so on.

BCC sessions are seen as a worthwhile innovation by most clients, who report that they have acquired useful information and awareness that has led to positive behavioural changes in several aspects of their lives, ranging from hygienic sanitation to nutritious diets to more productive farming. Sessions that are delivered at PW sites or on home visits are seen as convenient and manageable by clients.

Even co-responsibilities under PSNP4 are regarded in a favourable light by most clients, who accept that their co-responsibilities increase their awareness of good practices and their access to essential services, especially health care and education. Monitoring of co-responsibilities also incentivises these positive changes and ensures their sustainability. However, many clients have no specific knowledge of their co-responsibilities, and are confused about the consequences if they do not comply.

Several external constraints impede the extent to which clients can put the knowledge they acquired into practice, which could compromise the impacts of PSNP4/IN-SCT, which will be quantified in the

evaluation. Such constraints include low agricultural productivity, lack of non-agricultural income-generating alternatives, limited access to water and to markets, and time constraints, especially for women. Underlying these challenges are more fundamental constraints posed by widespread poverty and water constraints in the study area, which the PSNP and IN-SCT can only partially address.

7.2. Overall findings for service providers

Service providers expressed positive attitudes about the innovations introduced within PSNP4, which they perceive as providing complementary inputs to cash transfers that should enhance the beneficial impacts of PSNP. Cash transfers are crucial for meeting basic needs, achieving food security and facilitating access to essential services. Innovations such as the transition of PLW from PW to TDS, BCC sessions and co-responsibilities support these objectives, by transferring knowledge and incentivising positive behaviour change.

An important factor explaining the success of PSNP4 is the collaboration between different sectors and across service providers, for example in referral mechanisms that lead to clients benefiting from an integrated package of services. IN-SCT reinforces these impacts by providing additional support and follow-up by SWs, and inputs by Concern in support of nutrition-sensitive social protection. When all service providers – SWs, DAs, HEWs and SDs – are in place, they work well together to deliver the full package of PSNP/IN-SCT support. In some kebeles, additional inputs are provided by Concern, notably in cooking demonstrations, agricultural advice, and the promotion of food gardens and nutrition clubs at schools. Also in some kebeles, CCCs provide useful support to service providers in implementing the IN-SCT, for instance in mobilising the local community to assist clients who are struggling to comply with co-responsibilities, in monitoring compliance, and in managing complaints about PSNP4, mainly around exclusion from the programme.

According to service providers, the knowledge transferred on BCC sessions and the co-responsibilities introduced on PSNP4 respond to communities' needs and promote positive behavioural change. Service providers assert that all clients have been informed of their co-responsibilities and are fully aware of these, that SWs and HEWs make regular home visits either according to a regular schedule or to monitor non-compliance, and that clients' participation in BCC sessions is high. These inputs have resulted in higher school enrolment and uptake of ante-natal and post-natal care services, as well as positive attitudinal and behavioural change in areas such as feeding, hygiene and health practices.

Challenges identified by service providers relate both to the programme and the broader context. In terms of programme design, although cash transfers have been extended from six to 12 months, their value remains too low to finance adequate investments in nutritious foods, agricultural production, off-farm livelihood activities, hygienic practices such as latrine construction, and access to services. Cash payments are also often delayed, which compounds these difficulties facing poor households.

At the programme implementation level, human resource constraints arise from having too few staff in post and heavy workloads, exacerbated by high staff turnover. In particular, most kebeles have too few HEWs in place to monitor co-responsibilities of clients and deliver all scheduled BCC sessions. Also, SWs visit kebeles irregularly and infrequently, which undermines collaboration across sectors, and each SW covers too many kebeles to spend enough time and deliver adequate support to clients in each kebele. Staff who do not live in the community where they work face difficulties travelling to work because of lack of adequate transport. This in turn negatively affects the delivery of services to PSNP and IN-SCT clients, especially those in remote communities. Given high staff turnover and the need for service providers from several sectors to work closely together, refresher training is urgently needed and should be repeated at regular intervals.

CCCs are either not yet established or not active in many kebeles, so in practice their contribution is limited. Challenges include lack of adequate training for CCC members to perform their duties; lack of resources such as transport, as CCCs are generally under-funded and rely on voluntary contributions; and limited commitment due to most CCC members having busy jobs that they need to prioritise. Communities also have limited trust in CCCs, as they do not have any power to resolve complaints.

In terms of challenges that are external to the programme but negatively affect its potential impacts, service providers identified a similar set of issues to clients themselves. These include lack of cash, lack of potable water, low agricultural productivity, undiversified food production and lack of off-farm income-generating opportunities. Some service providers also mentioned traditional attitudes and practices as creating resistance to certain BCC messages. These constraints are significant and in certain circumstances dominate the support provided by PSNP4 and IN-SCT.

7.3. Overall reflections

Findings suggests that **the IN-SCT pilot operates a promising model for improving nutritional and other outcomes for children and their families**, and that its implementation has improved since the baseline. The various individual components – co-responsibilities, BCC sessions, case management – were deemed valuable by both service providers and clients and deemed to contribute to positive change. Notwithstanding the already relatively high knowledge levels regarding feeding and hygiene practices that were reported at the time of the baseline, training and advice is much appreciated by clients and reported to lead to behaviour change. In reference to baseline findings, service providers’ awareness of their own roles and responsibilities has expanded and improved, especially among HEWs. Moreover, despite implementation challenges related to capacity constraints and high workloads, service providers operate in a collaborative manner and together manage to implement the new provisions within PSNP4, most notably the shift from PW to TDS for PLW and monitoring of and follow-up on co-responsibilities.

Comparative analysis across locations and service providers and between clients and service providers also give rise to the following observations:

- There are **considerable differences in effectiveness of programme implementation across woredas and kebeles**. This can primarily be attributed to the functionings of the social workers (SWs) and CCCs and the extent to which they are active and present in the kebeles and perform their roles as stipulated in the Operational Manual. For example, SWs and CCCs played a conducive role in Halaba woreda but support from SWs and CCCs in Shashego woreda was very minimal. Similarly, implementation of BCC sessions was generally more regular and coherent in Halaba woreda compared to Shashego woreda. Cross-kebele differences were reflected in both clients’ and service providers’ responses with clients reportedly having fewer interactions with service providers and less knowledge of their co-responsibilities and service providers reporting weaker collaboration.
- Among all stakeholders involved in implementing the IN-SCT, **SWs and CCCs are not deemed to play a central role** in implementing key components of the IN-SCT pilot and PSNP by either service providers or clients. DAs and HEWs are considered most central to implementation of co-responsibilities, BCC sessions and the shift from PW to TDS while kebele managers are vital to overall coordination.
- While findings across clients and service providers are mostly similar, there is **notable mismatch between clients’ and service providers’ perspectives** in two areas. Firstly, service

providers appear to attach more weight to the need for awareness creation and transfer of knowledge for achieving behaviour change than clients do. Clients more strongly emphasise the need for more income, water, and agricultural and income-earning opportunities for achieving positive impacts, and putting knowledge into practice. Secondly, service providers appear to overestimate clients' knowledge of and interaction with the programme, reporting strong knowledge of co-responsibilities on behalf of clients' and frequent interactions with SWs and other service providers. Perceptions and experiences of clients, however, suggest lower levels of awareness regarding their own co-responsibilities and the process for monitoring and follow-up as well as fewer and less tailored interactions with SWs, particularly in Shashego woreda.

- Notwithstanding the programme's positive impacts, findings clearly indicate that **affecting positive change with respect to nutrition requires support in that is not currently directly or strongly supported by the IN-SCT pilot**. This primarily pertains to income, agriculture and water and the strong need for initiatives that support an increase in agricultural productivity, livelihood diversification and improved access to water. These issues are addressed within the wider remit of PSNP but low productivity, limited diversification and water scarcity remain key barriers to improving dietary diversity, hygienic practice and nutritional outcomes despite existing levels of support as provided through PSNP and wider agricultural extension.

8. Recommendations

This section provides recommendations in relation to challenges and bottlenecks as observed throughout the report. Bottlenecks divide between issues that are within the remit of IN-SCT while others are related to more external factors, and recommendations are offered within these two categories.

8.1. Challenges and recommendations within remit of IN-SCT

Challenges within the direct scope of the IN-SCT pilot pertain to implementation of PSNP4 and IN-SCT components, including cash transfers, co-responsibilities, service provision and nutrition-sensitive interventions. Recommendations include adjustments to programme implementation that are immediately actionable by programme staff as well as actions that require the collaboration with and input of other service providers and ministries. Recommendations also differ in terms of their relative contribution to changes in outcomes with some recommended changes to design and implementation being more or less crucial to affecting change.

Table 5 provides recommendations for each bottleneck identified in the report. It also provides an indication of how actionable and how crucial these recommendations are, together allowing for prioritisation of interventions.

Table 5 Bottlenecks and recommendations within the remit of IN-SCT pilot

Within the remit of the IN-SCT pilot			
Bottlenecks	Recommendations	Actionable	Crucial
Delayed and deductions from PSNP payments	<ul style="list-style-type: none"> • Engage with MoANR to discuss and increase timeliness of transfer payments 	<ul style="list-style-type: none"> • Fairly actionable but requires collaboration with MoANR 	<ul style="list-style-type: none"> • Highly crucial for positive impact in all outcome areas

<p>Confusion about co-responsibilities: many clients were not clear about their own co-responsibilities and consequences in case of non-compliance</p>	<ul style="list-style-type: none"> • Reconfirm co-responsibilities with clients using visual information leaflet • Make other service providers (HEWs, DAs, SDs) aware that co-responsibilities are not compulsory and that there will be no punishments in case of non-compliance so that they can adequately inform clients • Produce and use adequate visual materials for service providers to adequately inform clients of rights and responsibilities in relation to co-responsibilities 	<ul style="list-style-type: none"> • <i>Highly actionable</i> with action entirely within remit of IN-SCT • <i>Highly actionable</i> through the provision of direct training to service providers in IN-SCT kebeles • <i>Highly actionable</i> with action entirely within remit of IN-SCT 	<ul style="list-style-type: none"> • <i>Fairly crucial</i> for compliance with co-responsibilities • <i>Fairly crucial</i> for improving knowledge of rights and responsibilities within programme • <i>Fairly crucial</i> for improving knowledge of rights and responsibilities within programme
<p>Limited awareness of and exposure to SWs: due to high caseload, SWs covering many kebeles and transportation constraints in reaching remote areas</p>	<ul style="list-style-type: none"> • Increase number of SWs • Provide improved transportation (vehicle) for access to remote areas • Strengthen mandate of SWs 	<ul style="list-style-type: none"> • <i>Poorly actionable</i> with strong budget implications and concerns regarding sustainability of SWs in government system • <i>Fairly actionable</i> with limited budget implications within IN-SCT • <i>Fairly actionable</i> with need for cross-sectoral consensus and collaboration 	<ul style="list-style-type: none"> • <i>Fairly crucial</i> for creation of stronger linkages between clients and services and improving clients' practices • <i>Fairly crucial</i> for creation of stronger linkages between clients and services and improving clients' practices • <i>Fairly crucial</i> for creation of stronger linkages between clients and services and improving clients' practices
<p>Limited involvement of CCCs: CCCs function sub-optimally or are inactive due to competing time pressures, limited understanding on behalf of CCC members and</p>	<ul style="list-style-type: none"> • Provide follow-up training in relation to IN-SCT, its programme components and how CCCs can support IN-SCT clients and other vulnerable community members • Embed CCCs more strongly in kebele and woreda 	<ul style="list-style-type: none"> • <i>Highly actionable</i> through the provision of direct training to CCCs • <i>Fairly actionable</i> with need for cross- 	<ul style="list-style-type: none"> • <i>Highly crucial</i> for embedding new PSNP and IN-SCT components and ensure sustainability • <i>Highly crucial</i> for embedding

few incentives for CCC members	government structures to improve monitoring and accountability	sectoral consensus and collaboration	new PSNP and IN-SCT components and ensure sustainability
Capacity constraints on behalf of HEWs: most kebeles have only one HEW in place and limited capacity undermines ability to implement IN-SCT/PSNP activities in addition to regular work; clients expect wider range of treatments	<ul style="list-style-type: none"> Engage with MoH to discuss issue and urge full capacity of HEWs at kebele level – this includes urging HEWs to live in the kebele Provide training to HEWs for more effective ways of working 	<ul style="list-style-type: none"> <i>Fairly actionable</i> but requires collaboration with MoH <i>Fairly actionable</i> but requires collaboration with MoH as it concerns overall ways of working for HEWs 	<ul style="list-style-type: none"> <i>Highly crucial</i> to ensure that clients can put knowledge about hygiene, health and nutrition into practice <i>Fairly crucial</i> to ensure that clients receive adequate set of services
Lack of follow-up to nutrition-sensitive interventions: many initiatives have been initiated – nutrition clubs, upgrading of FTCs – or have taken place – cooking demonstrations, training of kebele-level staff, but have not been completed or followed up on	<ul style="list-style-type: none"> Follow-up with Concern on their activities, including their embeddedness in government structures Provide initial financial support to government counterparts when taking over Concern-led activities 	<ul style="list-style-type: none"> <i>Highly actionable</i> as Concern activities are within remit of IN-SCT <i>Fairly actionable</i> in collaboration with government counterparts 	<ul style="list-style-type: none"> <i>Highly crucial</i> to ensure that clients’ knowledge and access to tools for improving nutritional outcomes in short-term <i>Highly crucial</i> for reinforcing and sustaining positive nutrition impacts

8.2. Challenges and recommendations outside remit of IN-SCT

Challenges outside of the remit of IN-SCT pertain to external factors that are not directly or only mildly addressed by the IN-SCT pilot but that undermine changes in support of positive impacts. These include lack of access to water, limited opportunities for income generation, shortage of agricultural inputs and gendered patterns of paid and unpaid work. Addressing these challenges is vital for establishing and reinforcing positive change and for maintaining it in the long run. Although components of the IN-SCT pilot do not currently address these factors in a strong manner, recommendations indicate that changes can be made so that the pilot responds to concerns more directly.

Table 5 lists recommendations for the main challenges that were identified throughout the research. As previously, it provides an indication of how actionable and how crucial these recommendations are, together allowing for prioritisation of interventions.

Table 6 Bottlenecks and recommendations outside the remit of IN-SCT pilot

Outside the remit of the IN-SCT pilot			
Bottlenecks	Recommendations	Actionable	Crucial
<p>Lack of access to water: this undermines behaviour change with respect to feeding practices, hygiene practices and agricultural practices</p>	<ul style="list-style-type: none"> Establishing links with relevant government authorities to ensure access to water Follow-up with Concern in support of their water-related activities 	<ul style="list-style-type: none"> <i>Fairly actionable</i> in collaboration with MoANR, possibly through PSNP <i>Highly actionable</i> as Concern activities are within the remit of IN-SCT 	<ul style="list-style-type: none"> <i>Highly crucial</i> for ensuring access to water in a sustainable manner for all <i>Highly crucial</i> for ensuring access to water in the short term for all
<p>Limited opportunities for economic strengthening: lack of income is the single biggest constraint to improving nutritional outcomes</p>	<ul style="list-style-type: none"> Argue to increase PSNP transfer amount on the basis of impact evaluation and operational research study findings Create linkages to opportunities for income generation – training, credit, cooperatives, micro-finance institutions – for PW and for PDS and TDS clients 	<ul style="list-style-type: none"> <i>Fairly actionable</i> in collaboration with government counterparts and donors <i>Highly actionable</i> for TDS and PDS clients as training and linkages could be provided within IN-SCT 	<ul style="list-style-type: none"> <i>Highly crucial</i> for clients being able to put awareness into action and improve outcomes <i>Highly crucial</i> for clients to generate income and improve outcomes in future
<p>Lack of agricultural inputs: lack of seedlings, fertiliser and other inputs undermines the ability to be agriculturally productive</p>	<ul style="list-style-type: none"> Provide agricultural inputs to clients Provide access to or linkages to credit providers and micro-finance institutions 	<ul style="list-style-type: none"> <i>Fairly actionable</i> to include additional support as part of the package in IN-SCT or PSNP <i>Highly actionable</i> for TDS and PDS clients as linkages could be provided within IN-SCT 	<ul style="list-style-type: none"> <i>Highly crucial</i> for all PSNP clients to improve agricultural productivity <i>Fairly crucial</i> to enhance productivity for most active clients
<p>Gendered division of roles and responsibilities: women carry disproportionate burden of paid and unpaid work; HEWs and DAs reinforce gendered norms by providing health and nutrition advice to women and agricultural advice to men</p>	<ul style="list-style-type: none"> Provide training to service providers about gender inequality and how to address it in service provision Discuss gendered roles and responsibilities with clients and how to engage with them during BCC sessions 	<ul style="list-style-type: none"> <i>Highly actionable</i> as training can be provided within the remit of IN-SCT <i>Highly actionable</i> as content of BCC sessions is within the remit of IN-SCT 	<ul style="list-style-type: none"> <i>Highly crucial</i> to address gender inequality across all areas of service provision <i>Highly crucial</i> to reduce burden on women and improve outcomes for all

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Annex 1: Overview of final sample

Location	Key Informant Interviews (KIIs)	Case studies (CSs)		Focus Group Discussions (FGDs)			
	Service providers	PDS clients	TDS clients	CCC	SCTP - PDS	SCTP – TDS	PSNP-PW
SNNP region							
	• SCT Regional coordinator						
Halaba woreda							
Woreda level	• Concern staff						
Participant observation in one community in Galato							
Kebele #1 (Galato)	<ul style="list-style-type: none"> • SW (PTA-food) • HEW (PTA-hygiene) • DA (SHM) • Teacher/ Director (SHM) 	<ul style="list-style-type: none"> • 1 male PDS client with young child • 1 female PDS client with young child 	<ul style="list-style-type: none"> • 1 female TDS client (PLW) • 1 female TDS client (caregiver of malnourished child) 	<ul style="list-style-type: none"> • CCC (PTA) 	<ul style="list-style-type: none"> • 1 female group 	<ul style="list-style-type: none"> • 1 female group (PLWs) • 1 mixed group (caregivers of malnourished children) 	<ul style="list-style-type: none"> • 1 male group • 1 female group
Kebele #2 (Udana Cholkosa)	<ul style="list-style-type: none"> • Concern supervisor • SW (SHM) • HEW (PTA-hygiene) • DA (SHM) • Teacher/ Director (SHM) 	<ul style="list-style-type: none"> • 1 male PDS client with young child • 1 female PDS client with young child 	<ul style="list-style-type: none"> • 1 female TDS client (PLW) • 1 female TDS client (caregiver of malnourished child) 	<ul style="list-style-type: none"> • CCC (SHM) 	<ul style="list-style-type: none"> • 1 male group • 1 female group 	<ul style="list-style-type: none"> • 1 female group (PLWs) • 1 mixed group (caregivers of malnourished children + PLW) 	<ul style="list-style-type: none"> • 1 male group • 1 female group
Shashego woreda							
Woreda level	• Concern staff						
Kebele #1 (Shayambe Wanchikota)	<ul style="list-style-type: none"> • SW (SHM) • HEW (PTA-food) • DA (SHM) • Teacher/ Director (SHM) 	<ul style="list-style-type: none"> • 1 male PDS client with young child • 1 female PDS client with young child 	<ul style="list-style-type: none"> • 1 female TDS client (PLW) • 1 female TDS client (caregiver of malnourished child) 	<ul style="list-style-type: none"> • CCC (PTA) 	<ul style="list-style-type: none"> • 1 female group 	<ul style="list-style-type: none"> • 1 female group (PLWs) • 1 mixed group (caregivers of malnourished children) 	<ul style="list-style-type: none"> • 1 male group • 1 female group
Participant observation in one community in Shemsa Jemaye							
Kebele #2 (Shemsa Jemaye)	<ul style="list-style-type: none"> • SW (SHM) • HEW (SHM) • DA (PTA-food) • Teacher/ Director (PTA-hygiene) 	<ul style="list-style-type: none"> • 1 male PDS client with young child • 1 female PDS client with young child 	<ul style="list-style-type: none"> • 1 female TDS client (PLW) • 1 female TDS client (caregiver of malnourished child) 	<ul style="list-style-type: none"> • CCC (SHM) 	<ul style="list-style-type: none"> • 1 female group 	<ul style="list-style-type: none"> • 1 female group (PLWs) • 1 mixed group (caregivers of malnourished children) 	<ul style="list-style-type: none"> • 1 male group • 1 female group
Total	20	8	8	4	5	8	8