

## Research Article

# Linkage between Productive Safety Net Program and Health Services in Somali Region, Ethiopia: Lessons, Challenges and Missed Opportunities

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## Abstract

### Background

The fourth phase of Ethiopia's Productive Safety Net Programme (PSNP 4) included a system of integrated health and nutrition service delivery for its categories of beneficiaries. This include the creation of a temporary direct support (TDS) category for clients that are pregnant and lactating women or caregivers of malnourished children, who are exempted from public work but expected to comply with co-responsibilities which counts towards their public works requirement. This is aimed at improving utilization of health and nutrition services.

### Methods

The study was a cross-sectional descriptive survey and used qualitative methods, in-depth interviews and focus group discussions conducted in Gursum and Kebribayah woredas (districts) in Farfan zone of Somali region. The study populations were key actors involved in the linkages of PSNP with health services and the beneficiaries. The study assessed the implementation of the linkage between PSNP4 and health services.

### Result

The implementing actors have adequate knowledge and their expected roles in the linkages between PSNP and the health services. The barriers to effective linkage were poor coordination among the implementing actors, poor monitoring and reporting

of compliance with the co-responsibilities by development agents and health extension workers and poor adherence to co-responsibilities by the TDSs clients.

## Conclusion

Considering the size of the program in the region which is targeted to the poor, the Productive Safety net program has the potential to improve access and utilization of health and nutrition services if more efforts are put to strengthen integration and linkages with the health sector and monitoring of compliance of co-responsibilities by the beneficiaries of the program.

**Keywords:** Productive safety nets program, linkage, health services, co-responsibilities

## 1. Introduction

Ethiopia's Productive Safety Net Programme (PSNP) which has been implemented since 2005 is a large-scale, social protection intervention aimed at improving food security. It involves a mix of public works, employment and unconditional cash and food transfers for chronically food-insecure households identified through a mix of geographic and community-based information. The main objective of the PSNP is to increase livelihoods and resilience to shocks and to improve food security and nutrition for vulnerable rural households [1].

The fourth phase of the PSNP was launched in 2015 and included a system of integrated health and nutrition service delivery and the creation of a Temporary Direct Support (TDS) category for clients that are pregnant and lactating women (PLW) or caregivers of malnourished children, who are exempted from public works as part of the several

innovations introduced on PSNP4 to enhance programme outcomes, specifically in terms of child nutrition [1].

The pregnant and lactating women (up to one year after birth) and primary caregivers of malnourished children designated as temporary direct support (TDS) clients are to comply with co-responsibilities which counts towards their public works requirement aimed at improving the health and nutrition of themselves and their children. The co-responsibilities have been introduced for TDS clients, particularly to strengthen linkages between PSNP with health care services [1].

These co-responsibilities include attendance of four ante-natal consultations, one post-partum health facility visits, and uptake of routine immunization, attendance at growth monitoring and promotion, behavioural change communication sessions, monthly follow up visits of the malnourished child at the closest health facility for appropriate treatment [1].

The effective linkage of PSNP with health services which is aimed at improving maternal and newborn and child health and nutrition outcomes is very relevant and essential in Somali region of Ethiopia which has shown less improvement in key maternal and child health and nutrition outcomes compared to the national average. The 2019 Mini DHS reports that the region has the lowest percentage of fully vaccinated children, with only 18.2% having received all basic vaccinations, and 48.8% had received no vaccinations at all compared to national average of 43.1% and 19.2% respectively [2]. The proportion of pregnant women who received at least four antenatal care services (ANC4) and delivered by skilled birth attendant is 11.1% and 26% compared to national

average of 43% and 49.8% respectively and post-natal care rate of 10.3 per cent compared to national average of 33.8% [2]. Malnutrition continues to be a serious issue in the region with wasting rate of 22.7% compared to 9.9% national average and contribute to approximately 25% of the total number of children with wasting in the country. Stunting prevalence in children less than 5 years of age stands at 30.5 per cent and 40 per cent of children are exclusively breastfed during the first six months of life, and 18.6% of pregnant women received Iron Folate [2].

The available evidence from various studies show that safety nets programs have improved food security, utilization of prevention, promotional and curative health and nutrition services by pregnant women and children, nutritional status of children and health and nutrition education practices [3-7]. However, studies from Ethiopia show mixed impact of PSNP on child nutrition, some studies reported positive impact [8-9]. However, most studies found no impact on nutrition outcome, utilization of health services by pregnant women for ANC and post-natal care visit and breastfeeding behaviors or nutrition education which are needed for improved maternal newborn and child health and nutrition outcome [10-13].

The study aimed to assess the implementation of the linkage between fourth phase of the productive safety net program (PSNP-4) and health services and use the gaps, opportunities and lessons learnt to improve on the implementation of the fifth phase of the program (PSNP 5) for better results for maternal newborn and child health and nutrition outcomes.

## 2. Methods

### 2.1 Study design and population

The study was a cross-sectional descriptive survey and used qualitative methods. The study was conducted in Gursum and Kebribayah woredas (districts) in Farfan zone of the region being the zone with highest number of PSNP beneficiaries in the region. Kebribayah woreda has estimated total population of 130,763 with 5 health centers and 33 health posts while Gursum woreda has estimated total population of 39,375, with 3 health centers and 16 health posts. The total number of PSNP 4 beneficiaries in the region is 1,673,009; Kebribayah woreda has the largest caseload of beneficiaries of 84,977 while Gursum woreda in the same zone has one of the lowest caseloads of 18,245 beneficiaries.

The study populations were key actors involved in the linkages of PSNP with health services at the regional, woreda and kebele levels and the beneficiaries identified based on the World Bank's framework on accountability [14].

Multistage sampling technique was used. In the first stage, two woredas and regional level bureaus were selected purposely, Kebribayah woreda which has the highest caseload of beneficiaries in the region and Gursum woreda which has one of the lowest caseloads in the same zone (Farfan) with Kebribayah woreda.

In the second stage, three kebeles (sub-districts) from each of the two purposely selected woredas (districts) were selected randomly from among the total list of PSNP kebeles in each of the two selected woredas.

The participants interviewed were purposefully identified and recruited based on their positions and roles in the implementation of PSNP and linkages with health services in the study sites. Study

participants were the agriculture and health sectors focal persons at the regional, woreda and kebele levels:

- Sectoral focal points for health and agriculture at the Regional Level
- Woreda Health Officers (WoHO) and Agriculture officers at the woreda level
- Development Agents (DA) and Health Extension Workers (HEWs) at the kebele level
- Temporary Direct Support (TDS) beneficiaries (pregnant women, lactating women and caretakers of children with malnutrition)

## 2.2 Data Collection and Analysis

Data was collected through in-depth interviews and focus group discussions (FGDs). Interview guide with semi-structured interview questionnaire was used to obtain information on a range of issues about PSNP implementation and linkages with health services from the participants.

The study participants during the Key informant interviews were asked about their knowledge and roles in the transition of eligible households from public works to temporary direct support (TDS) clients, the co-responsibilities of the beneficiaries and barriers to effective linkages. This was done at the region, two woredas and six kebeles (sub districts).

The Focus group discussions (FGDs) were conducted in the six selected kebeles among the TDS clients and assessed their knowledge about their rights, selection process and co-responsibilities and their adherence as required. The study was conducted between March and April 2021. The FGDs and KII were audio-taped and notes were also taken with prior oral consent obtained from the participants.

The FGD and KII data collected from different categories of respondents and responses to the same questions were triangulated and transcribed verbatim to produce transcripts of narrative text for thematic analysis. The data were coded according to the types of themes and issues and thematic analysis was used which comprised a mix of inductive and deductive coding.

The primary outcome of the study is identifying factors related to the linkage of the PSNP beneficiaries to the health services and the implementation of the co-responsibilities by TDS clients.

These co-responsibilities include a list of activities that TDS client are expected to undertake. However receipt of payments under PSNP4 is not conditional on the clients fulfilling the co-responsibilities.

These co-responsibilities include the following requirements [1]:

- Pregnant women should attend four antenatal care visits;
- Lactating women with a child less than one year old: attendance at one post-partum health facility visit; follow recommended immunization schedules for infants and attendance at growth monitoring and promotion/behavioural change communication sessions.
- Primary caregiver of a malnourished child under five years old during treatment are to attend the clinic monthly to complete the treatment (e.g., community management of acute malnutrition or targeted supplementary feeding) as advised.

## 3. Results

The results are organized in two major themes: (1) Process involved in the linkages between PSNP and health services and (2) barriers to effective linkages. Three subthemes emerged from the process involved in the linkages between PSNP and health services: (1) Transitioning of eligible households from public

### **Theme 1: Process involved in the linkages between PSNP and health services.**

#### **Sub theme 1: Transitioning of eligible households to temporary direct support clients**

The key informants were asked about their knowledge and roles in the process for transitioning of eligible households to temporary direct support (TDS) clients. All the key informants interviewed were familiar with the recommended process and their roles in the transferring of pregnant and lactating women and caregivers of children with malnutrition from the public work to temporary direct support clients which exempt them from the public work. However, there was variation in their knowledge about the exact duration the TDS clients are to be exempted from public work as detailed in the project implementation manual (PIM).

Even though actual implementation of linkage is done at the kebele level, the regional and woreda team are involved in the process and expected to provide needed monitoring and support to ensure this is effectively done.

‘PSNP is a multi-sectoral project in its nature and has relations with health, and when a mother is around three months pregnant, she contacts the development agent who completes a form and that allows the pregnant mother to get a leave from the public work until her return when her child is 10months old.’

(Regional Key Informant 1)

works to temporary direct support clients (2) co-responsibilities of temporary direct support clients and (3) Temporary direct support clients’ knowledge about their rights, selection process and co-responsibilities.

‘At the community level there are development agents and Health extension workers assigned in each kebele to implement the linkage but the woreda health office and the agriculture office provide support to the kebele level team in ensuring linkages between PSNP and health services.’

(Woreda key Informant 1)

‘Actually, the health office is more involved with the Temporary direct support group where we support at the kebele level with the identification of the eligible beneficiaries (pregnant, lactating and Households who have malnourished children).’

(Woreda Health Office Key Informant II)

Generally, the role of health extension workers (HEWs) is to identify pregnant women, lactation women and caregivers of children with malnutrition who are engaged in public work. They provide them letters upon confirmation in the health facilities to the Development Agents so they can be exempted from public works. The Development agents who keep the names of all PSNP beneficiaries are to effect their transfer to temporary direct support groups and continue to provide them with the support throughout the duration until they return back to public work. However, the Development Agents and Health Extension workers interviewed provided different expected duration of exemption from public works.

‘As the development agent, my role is to check and follow up to see that TDS beneficiaries (Pregnant and

Lactating women and primary caregivers of children with malnutrition) are transferred from public work into TDS category and still get their support from the program

(Development Agent Key Informant 1)

‘My role is to connect the variety of categories of the PSNP beneficiaries like the Public Work Clients, TDS clients, and the Permanent Direct Support clients in the community to the health facilities encourage to receive appropriate health services.’

(Development Agent Key Informant 2)

‘When women tell us that they are pregnant or we notice it ourselves, we ask them to bring confirmation letter from the health facility and based on that we exempt them from public work.’

(Development Agent Key Informant 2)

‘As a Health extension worker, my role is to register the pregnant and lactating mothers and caregivers of malnutrition children in the PSNP program and send them to the Development Agent to transfer them to Temporary direct support clients until 6 months after they deliver, and the child is cured from malnutrition.’

(Health Extension Worker Key Informant 1)

‘As HEW my responsibility is that when mothers realize they are pregnant they come to me, I give them a confirmation letter which will be used to exempt them from working during their pregnancy until six months after delivery.’

(Health Extension Worker Key Informant 2)

‘When mothers claim to be pregnant it’s our task as HEWs to confirm their pregnancy and then write confirmation report to the kebele DA for the project

to transfer the status of the pregnant women to TDS group and exempt them from work until a year after delivery.’

(Health Extension Worker Key Informant 3)

### **Subtheme 2:** Knowledge about the co-responsibilities of temporary direct support (TDS) clients

The Key informants were aware the Temporary direct support (TDS) clients are supposed to participate in some activities referred to as co-responsibilities in replacement of the public work. However, they did not appear to have precise knowledge of co-responsibilities about clients’ specific obligations other than the general advice of coming to the health facilities, but the schedules and number of visits expected not well articulated.

The development agents and health extension workers are expected to orientate the TDS beneficiaries about their co-responsibilities as detailed in the program implementation manual and follow them up to monitor compliance.

However, after linking them up with the development agents who registers them, they do not follow strictly to monitor the co-responsibilities but manage them like other patients who are to come to the health facilities routinely.

“Once we transfer them and exempt them from public work, they are to be seen and monitored by the health workers in the clinics to ensure they go to the clinic regularly to receive services.”

(Development Agent Key Informant 1)

‘It is the responsibility of the HEWs to monitor their attendance in the clinic, we don’t work in the clinic,

we only keep their record of transfer and provide them with the money and other supplies monthly services.'

(Development Agent Key Informant 2)

'They are supposed to come to the clinic regularly to receive ANC, immunization for themselves and children and post-natal visit so for their pregnancy and children can progress very well. Since they are exempted for work, they so should have time to come regularly.'

(Health Extension Worker Key Informant 1)

'The mothers of malnourished children are to attend Outpatient Therapeutic (OTP) clinic regularly and give their children plumpy nuts as provided for them.'

(Health Extension Worker Key Informant 2)

'There is no special clinic for them, we are busy, so we attend to them like other patients when they come and sometimes, they don't come to the clinic again. We don't have a special register for them.'

(Health Extension Worker Key Informant 3)

'Anytime the TDS client's come to the clinic, we provide them with health awareness and all the services and drugs they need and ask them to always come back. We don't usually follow them up if they don't come back to the clinic.'

(HEW Health Extension Worker Key Informant 4)

'Many of the TDS clients only come to the clinic so they can be given letter to stop working but later they don't come to the clinic and we are busy to follow them to their houses, some of them leave very far.'

(Health Extension Worker Key Informant 5)

**Subtheme 3:** Temporary direct support clients' knowledge about their rights, selection process and co-responsibilities

3.1: Knowledge of the TDS clients about their Right and selection process

The knowledge of the pregnant women, lactating mothers and mothers of children with malnutrition seen during the various focus group discussions (FGDs) show that they are aware of the process for identification of households eligible to be excluded from the public work and transferred to the TDS categories and still receive their monthly benefits both money or food or other materials.

'When a woman gets pregnant, she comes to the clinic for the nurse to confirm her pregnancy and give her a letter to the Development Agents and then she will not work again until her baby reaches two years, and she will still continue to collect the money even though not working.'

(FGD participant I)

'When we become pregnant, we become free from the public work until we give birth and that child becomes one year, after that we return back to the public work.'

(FGD participant 2)

'When a women is lactating and breastfeeding her children she is not expected to work in the public work again, also she gets the payment and other materials she has been getting even though she is not working in the public work.'

(FGD participant 3)

'When a malnourished child is seeing in the clinic, the mother will be given a letter so the mother will be

free from the public work until the child recovers so they can have time to treat the child, and they will get the payment without working.’

(FGD participant 4)

### 3.2 Knowledge of the temporary direct support (TDS) clients about their Co-responsibilities

Most of participants in the focus group discussions were not aware of the specific obligation and required number of visits to the health facility for their co-responsibilities in lieu of the public work other than the general advice on health seeking behavior and clinic attendance for relevant services.

‘We are expected to participate in different community awareness related activities and attend immunizations before and after delivery for our children and ourselves.’

(FGD participant 1)

‘We are expected to go to the health clinics always to see the health workers to monitor us and our babies, to deliver in the health center and to participate in different meetings and awareness creation of the project.’

(FGD participant 2)

‘We are to continue to breastfeed our children and keep ourselves and environment clean and take them for immunization in the health centers regularly until we go back to public work.’

(FGD participant 3)

‘We take our children with malnutrition to the clinic in our kebele regularly to receive plumpy nuts until the child recovers or if the child doesn’t recover on time, they will transfer us to the woreda health centre to continue treatment.’

(FGD participant 4)

‘Sometimes we don’t go to the clinic regularly because the clinic is far from our house and no means of transportation in our area.’

(FGD participant 5)

‘There is no specific time to go to the clinic but regularly for immunization or for nutrition clinic for malnourished children and antenatal care or when our children are sick.’

(FGD participant 6)

## **Theme 2: The barriers to effective linkages between the PSNP and health services**

This focused on identification of barriers to effective linkages by the stakeholders at all levels.

Most of the barriers/challenges to the linkages were expressed by the woreda key informants and this ranges from poor coordination and communication between the key actors (HEWs and DAs). Poor knowledge due to lack of training on the project, especially clear guideline to clarify the expected roles of each of the actors especially in reference to the monitoring of the beneficiaries was also mentioned as a barrier. Other barriers mentioned included lack of dedicated budget for the health sector either to follow up or monitor the compliance, lack of clear guideline on reporting or mechanism to track the co-responsibilities and limited access to health services for TDS beneficiaries who live far from health facilities or live in kebele with no health facilities. Some also mentioned that the project is seen and being implemented more as belonging to the agricultural sector and not as a key element of local development planning as designed.



‘There is poor awareness and capacity regarding linkage between agriculture and health sectors. There is lack of clear and simplified linkage guides for DAs, HEWs and woreda steering committee on implementation of the linkages.’

(Regional key Informant 1)

‘The DAs and HEWs are expected to monitor the TDS clients to ensure they fulfil the obligation even though without any sanction, and the record is kept at the kebele level. We don’t include the report on compliance with co-responsibilities in our report at the regional level, but we have noticed that there is poor documentation at woreda and kebele level about the TDS record of compliance.’

(Regional Key Informant 1)

‘Except participating in meetings occasionally there is no intersectoral collaboration between PSNP coordinating unit in the Agriculture office and regional/ woreda health offices, there is no regular monthly, or quarterly coordination platform to discuss PSNP performance at regionally.’

(Regional key Informant 3)

‘There is no adequate knowledge about the program, many people think that PSNP is a project owned by agriculture bureau only.’

(Regional Key Informant 4)

‘The understanding of the project as we know is that PSNP is a multi-sectoral project involving different offices, but it is only people in agriculture office who get the training and other benefits of the project. It is necessary the health workers also benefit from the project like the development agents.’

(Woreda Health Office Key Informant 1)

‘It seems there is no enough awareness and understanding or complete information about the project among the stakeholders and the beneficiaries especially about the role expected by each person for effective linkage of the PSNP with health services.’

(Woreda Health Office Key Informant 2)

‘Development Agents and health extension workers in each kebeles are responsible for the monitoring and following up of the beneficiaries after being transferred to TDS category but this doesn’t usually happen because the HEWs are always busy.’

(Development Agent Key Informant 1)

‘Sometimes the health teams do not participate in our meeting and so not aware of many things we do and can’t get report from them about the TDS clients they see in the clinic.’

(Development Agent Key Informant 2)

‘Some of the pregnant women or malnourished children are from kebeles or sub kebele where there are no health facilities and have to travel a lot distance which sometime make them not to come to the nearest health facilities and difficult to follow them up.’

(Health Extension Worker Key Informant 1)

‘We don’t have regular meeting with the PSNP team to discuss about the issues of the health services we provide for the beneficiaries which would have been a good opportunity for better working relationship and understanding of the problem we face.’

(Health Extension Worker Key Informant 2)

‘We don’t have fund to move around in the budget to follow up the TDS clients if they don’t come and no good communication with the PSNP team. We have

not been trained on the project unlike the DAs and no reporting format to be used for recording our activities.’

(Health Extension Worker Key Informant 3)

#### **4. Discussion**

The transition of the eligible pregnant and lactating women and caregivers of children with malnutrition from public work to temporary direct support category and implementation of the co-responsibilities (soft conditions) are key components of the linkage between productive safety net program (PSNP) and health services.

The study observed that the stakeholders have adequate knowledge and understand their roles in the linkages between PSNP and the health services through the temporary direct support clients. In addition, the beneficiaries are also aware of their rights and the process for transitioning. However the major barriers to effective linkages are the poor coordination especially at the kebele level among the implementing actors, poor monitoring and reporting of compliance with the co-responsibilities by the development agents and health extension workers and poor adherence to co-responsibilities by the TDSs clients. The adherence to the co-responsibilities is the crux of project aimed at improving demand and utilization of services for better maternal, newborn and child health and nutrition outcomes.

The study shows that the selection of the beneficiaries into the TDS category was adequately and transparently done, and none of the beneficiaries complained about the process this is unlike in a study on safety net program in some countries in Latin America and the Caribbean [16]. The study reviewed

linkage between conditional cash transfer program and health services and reported poor selection and identification of appropriate beneficiaries as one of the major problems in the project [16].

Our study found weak coordination among the key actors at all level in terms of planning, joint monitoring, report sharing and participation in coordination meetings. This seems to be a major problem in many interventions that requires multisectoral collaboration. The finding in our study is similar to findings from other studies in interventions that involved multisectoral collaboration that also observed poor coordination among the implementers especially at the community level even though they reported better coordination at the central level [16-17]. A study in Malawi that looked at integration of intervention to improve nutrition outcomes found strong multidisciplinary interaction exists at central levels but not at the community level [17]. This is similar to a study on improved linkages between conditional cash transfers and reproductive health programs in Latin America and the Caribbean that reported limited integration at the sub- district level among the various actors and suggested increase supervision by regional team needed to ensure effective linkages [16]. A landscape analysis done in 19 countries that assessed the extent of agricultural investments contribution to nutrition outcome noted that strong collaboration observed at the higher policy level, national coordination and district coordination levels does not extend to the community level in most of the countries studied and provided practical guidance on how to initiate and manage multi-sectoral approaches and improve coordination and collaboration across a range of stakeholders [18].

The focus of the PSNP in linkage can only be achieved if the co-responsibilities are adhered to. This is aimed at ensuring pregnant and lactating women and children with malnutrition have access to regular health services. This will help to improve maternal, newborn and child health and nutrition outcomes. It will also reduce defaulter among children seeking nutrition and immunization services especially in a region like Somali with poor health and nutrition indices. However, our study found out that knowledge of the stakeholders and TDS beneficiaries about the co-responsibilities (soft conditions) is poor. In addition, there is no established follow up or monitoring, or reporting mechanism to monitor compliance. Some of the factors mentioned to be responsible for this included work overload by HEWs, limited or no budget/operational/logistic support for the HEWs for follow up and monitoring.

As found in this study, the health workers, the development agents and the TDS clients did not appear to have more precise knowledge of co-responsibilities in terms of the specifics apart from the general advice for health seeking behaviour. This is similar to finding from earlier studies in Ethiopia which reported that woreda and kebele staffs and beneficiaries did not have adequate knowledge on co-responsibilities especially on the specific obligations of the beneficiaries [15, 19]. A similar review study on conditional cash transfer and linkage with reproductive health reported that in many of the countries evaluated, a large proportion of program beneficiaries were not aware of, or did not know about, all or even some of the conditions for to be fulfilled in receiving payments [16]. However, an intervention study in Ethiopia where social workers were engaged to follow up and monitor compliance

to co-responsibilities of beneficiaries, found that the knowledge and compliance to co-responsibilities was higher among those in intervention area compared to the control group with no active follow up or monitoring of compliance [20].

The study found out that there is no or limited monitoring of compliance to co-responsibilities by the TDS clients with associated risk of not being able to achieve the objective of exemption from public work which aimed at improving maternal, newborn and child health and nutrition outcomes. A study on conditional cash transfer shows that only if the conditionalities are monitored and compliance enforced will it have an effect and found that similar to our study in some conditional cash transfer programs, compliance was not necessarily being monitored [21]. The study noted that in conditional cash transfer programs where there was effective monitoring, compliance was found to be extremely high by up to 94 percent of households and reported that in cases without monitoring the evidence of the impact of the program was mixed [21]. A study in Honduras found no effects in the conditional cash transfer program where conditionality was not enforced and reported that unless adequate measures are put in place to monitor compliance the program beneficiaries will not comply with program conditions [22]. The study suggested joint review of adherence to the co-responsibilities by all stakeholders to be part of the activities in the project cycle [22].

One of the major barriers to monitoring of the compliance to co-responsibilities and poor intersectoral collaboration at the kebele level by the HEWs is the workload. This is more especially in health posts where only one health extension worker

is assigned as result of increase demand and responsibilities expected from HEWs (monitor co-responsibilities, provide services for the PSNP client, follow up ) in addition to the routine activities in the clinics. A previous study in Ethiopia also identified human resource shortage with too few staff with heavy workloads as factors that constrained the program implementation by reducing the ability of the Health extension workers to conduct home visits and monitor compliance to the co-responsibilities [19]. This is similar to findings in previous studies which found that community health workers performance is affected by workload, number of tasks, the size of the catchment area, and organization of tasks [23-24]. The studies proposed that community health workers should have manageable workload in terms of a realistic number of tasks and clients, an organized manner of carrying out these tasks and a reasonable geographic distance to cover [23-24].

A study in Malawi on the integration of community health workers from different sectors reported the integration was affected/limited by workload and suggested a need to have a liaison officer who should track integration of the activities [17].

The use of social workers to track and monitor implementation of integration was found to be effective in as previous study in Ethiopia which showed improved multisectoral collaboration among social workers and local development agents and health extension workers [20]. The study reported improved client fulfilment of co-responsibilities in health compared to where social workers were not engaged [20].

Access to health services by the temporary direct support beneficiaries especially those who live in kebeles/sub kebeles where there are no health facilities or those who live far from the nearest health facilities and requiring travelling from a long period of time was reported to be another barrier to compliance with co-responsibilities. This is similar to a study on conditional cash transfer program which identified access to health services by beneficiaries as a major challenge in effective linkage between the program and health services and implemented various strategy including use of mobile team and use of NGOs to provide services to the population including home visits and follow up which improved access to services and ensure better results [17].

A study in Ethiopia reported that temporary direct support beneficiaries who were aware and able to fulfil their co-responsibilities said that they had been able to do so because their health posts were near their homes and provided good services [20].

Other concern raised by the health extension workers affecting their performance and for effective intersectoral collaboration and follow up, monitoring and reporting compliance to co-responsibilities was lack of funding allocated to the health sector for logistic or operational support including inadequate transportation unlike the agriculture sector. A previous study in Ethiopia also identified inadequate transport support as being responsible for infrequent visits by the HEWs to conduct home visit of monitor compliance especially in remote communities [19].

This is similar to other studies that reviewed the practical implication of linkages between agriculture and health sector which reported funding and budget controls as the core reason why there was little interaction between the two sectors [25-26]. A

similar study in Ethiopia also identified lack of resources within individual sectors as barriers to effective coordination between health and agriculture sectors and these studies recommended development of joint work plan with budget allocated for all activities to be implemented by both sectors for effective integration of intervention [27].

Another barrier to effective linkage and multisectoral collaboration reported in this study is the perceptions by the respondents in health sector about the PSNP being seen as a project that solely belong to the agriculture sector. There are concerns that the success will be attributed to the agriculture sector because this is managed as vertical program and not included as part of the responsibilities of the health workers in the woreda plan. This is similar to finding in a study that assessed the role of agriculture program in improving nutrition outcome which identified sector mandate and priorities as one of the barriers to integration [26]. This is because for the individual civil servant working within the confines of a sector ministry or agency, personal incentives like career advancement tend to revolve around their contribution to that attainment of narrowly sector-specific objectives [26].

Another study in Ethiopia on linkages between health and agriculture sectors also identified presence of competing priorities within individual sectors as barriers to effective coordination between the two sectors and the studies recommended inclusion of the integrated activities in the workplan or deliverables of the staffs in the health and agriculture sectors [27].

## 5. Conclusions

The Productive Safety net program which is the main tool to help forward Ethiopia's Social Protection

Policy and Strategy, has the potential to improve maternal newborn and child health and nutrition outcomes. This can be achieved if more efforts are put to strengthen integration and linkages with the health sector and monitoring of compliance of co-responsibilities by the temporary direct support beneficiaries of the program. Considering the size of the program in the region targeted to the poor, the benefits of improving linking the beneficiaries with health services could be decisive for the government and all stakeholders in the region.

## Recommendations

The focus on linkages between PSNP and the health services should be beyond coordination but deliberate pursue of collaboration among agriculture and health sectors especially at the kebele level. This should involve sharing of resources and enhancing one another's capacity for mutual benefit and to achieve a common purpose in addition to exchanging information and altering/ synchronization of activities. The development and deployment of a management information system to provide timely data about temporary direct support beneficiaries and improved monitoring systems would help strengthen the linkages.

## Limitation of the study

The study couldn't report on the number of temporary direct clients who adhered to co-responsibility and effect on utilization of health services because of no available data at the time of the study. The findings in our study are also subject to response biases since we rely on the information provided by the respondents. The study was done in only two woredas in the region, however this is the first study in the region to have assessed linkage between PSNP and health services and the findings

from the study will help provide guidance to implementers in improving the linkages in the planned fifth phase of the program. We suggest future studies to look at the effect of the safety net program on utilization of health services and cost effectiveness.

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