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Planning for Productive Migration in Niger: A Pilot Program

PLANNING FOR PRODUCTIVE MIGRATION IN NIGER

**A PILOT PROGRAM TO TEST THE CONTENT,
IMPLEMENTATION AND RESEARCH DESIGN OF THE
PLANNING FOR PRODUCTIVE MIGRATION PROGRAM**

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DISCLAIMER

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ACRONYMS

DIV	Development Innovation Ventures
EAC	External Advisory Committee
ECOWAS	Economic Community of West African States
IPL	Immigration Policy Lab at Stanford University
PPM	Planning for Productive Migration
RCT	Randomized control trial
USAID	U.S. Agency for International Development

ABSTRACT

In 2022, Mercy Corps and the Immigration Policy Lab at Stanford University piloted the Planning for Productive Migration (PPM) program in the Tahoua region of Niger. PPM is a novel program designed to provide comprehensive job search support and facilitate safe, productive cross-border migration as a livelihoods strategy within the Economic Community of West African States (ECOWAS). The pilot objectives were to test the PPM program content and implementation and key elements of the overall research design including measurement and migrant tracking. This report describes key learnings from this pilot which will be used to adapt the program content, implementation, and research design for a full-scale future randomized control trial to be implemented in the fall of 2023.

EXECUTIVE SUMMARY

Following four years of preliminary qualitative and quantitative research (including a pre-baseline survey of 1,200 households in rural Niger), program design, and community consultations, Mercy Corps and the Immigration Policy Lab carried out a pilot program to test the implementation of the Planning for Productive Migration (PPM) program and our measurement strategy for capturing short-term outcomes. The pilot activities were carried out from September 2021 – March 2022, with endline data collection completed in October 2022. This document outlines the early results of the pilot activities and lessons learned that will inform programmatic adaptations in advance of the implementation of a large-scale randomized controlled trial (RCT) in 2023. The main goals for the PPM pilot were to:

1. Test the relevance of all elements of the PPM program: training, transit subsidy delivery, support to secure legal documentation, vaccine delivery;
2. Test the quality of the training part of the PPM program in order to fine tune the curriculum and increase subject comprehension
3. Test risk-mitigation protocols (e.g., hotline and External Advisory Committee) and identify additional contingencies prior to scaling.
4. Assess our ability to remain in contact with participants using phone calls, WhatsApp, and in-person surveys;
5. Measure short-term outcomes, including rates of migration, employment, and measurements of safety, physical and psychological wellbeing

To achieve these objectives, Mercy Corps and IPL designed and implemented a pilot program with 210 households in four villages and two towns, with random assignment of 110 households to the PPM treatment group and 100 households to the control group. The treatment group received the full PPM package including: seven days of migration preparation training, two facilitated household planning dialogues, support to obtain a national ID card and vaccine, and, if all the former steps were completed, access to a roundtrip bus ticket to an eligible ECOWAS destination. Households in both the treatment and control group completed surveys throughout the pilot to measure outcomes such as economic and psychosocial wellbeing for the individual migrant and their household.

Key lessons from the pilot include:

- Participants and trainers consistently reported that the PPM content was relevant and novel, though there is an opportunity to improve the WhatsApp training as smartphone usage is not widespread among participants.
- The dialogues helped household members improve coordination and communication ahead of a potential period of migration.
- ID card and vaccination delivery took longer than expected during the pilot, so the PPM program delivery should be started earlier in the year to ensure it is fully implemented ahead of the common migration season.
- Our strategies for informing participants of potential risks and mechanisms for providing help to participants functioned well.

- Phone surveys were more challenging than anticipated, given poor network quality and low knowledge of how to use WhatsApp. Testing new data collection strategies, such as combining phone and in-person outreach helped to improve response rates, particularly among participants who have traveled abroad.

Drawing on these key learnings for the pilot, we will adapt and refine plans for the full-scale randomized control trial of PPM to be implemented next year in a broader geographic area with approximately 3,000 households.

BACKGROUND

Mercy Corps is a leading humanitarian and development organization working to build secure, productive and just communities in more than 40 countries around the world. Mercy Corps has operated in Niger since 2005, implementing projects to respond to humanitarian crises, provide youth employment, improve food security, empower adolescent girls, and increase individual, household, and community resilience. Mercy Corps has a long track record with youth employment and entrepreneurship programming, having previously implemented such projects in Agadez, Maradi, Tahoua, Tillabéri, and Zinder regions.

The Immigration Policy Lab at Stanford University (IPL) addresses pressing policy questions through rigorous data-driven evaluation and innovation. The lab's unique team of faculty, professional staff, and students brings together a mix of experience in program design, implementation, and evaluation to develop solutions to today's migration challenges. The Lab specializes in data science and causal inference. The quality of the lab's work is reflected in recent publications in high-profile venues, including Science and Proceedings of the National Academy of Sciences, as well as the financial support from the Ford Foundation, Robin Hood Foundation, Rockefeller Foundation, and Schmidt Sciences.

This project originated from two collaborative scoping trips by IPL and Mercy Corps' Research & Learning team. Subsequent to those visits, Mercy Corps and IPL worked together to conceptualize the program and measurement strategy.

This project is governed by a tripartite Internal Advisory Board that includes Jeremy Weinstein (IPL Faculty Director), Siaka Millogo (Mercy Corps Niger Country Director), and Jon Kurtz (Mercy Corps Senior Director for Research and Learning). All major programmatic and research decisions are discussed and approved by this group so that the country office, HQ team, and IPL can contribute to and learn from these discussions.

The pilot program implementation was funded by a Stage I award from USAID's Development Innovation Ventures (DIV). Research costs were funded by the J-PAL Jobs and Opportunities Initiative (JOI) and internal funding from Stanford University.

PROGRAM DESIGN & IMPLEMENTATION

The Planning for Productive Migration program has three primary objectives:

1. To improve the economic well-being of young people and their families by increasing their access to diverse and productive livelihoods opportunities in destinations across the Economic Community of West African States (ECOWAS);
2. To improve the psychological and social well-being of young people and their families by facilitating activities that encourage broader inclusion in household decision-making, strengthen

social ties, promote proactive planning of migratory journeys, and facilitate long-distance connections between migrants and their families;

3. To generate evidence on program impact and the role of productive migration in shaping individual and household wellbeing, to inform program design and policy debates on successful strategies to address youth unemployment.

The pilot program funded by USAID DIV and implemented in 2022 was designed to inform program design, targeting strategies, and outcome measurement for a full-scale RCT in 2023. The main goals for the pilot were to:

1. Test the relevance of all elements of the PPM program: training, transit subsidy delivery, support to secure legal documentation, vaccine delivery (specifically Yellow Fever and Meningitis, which are required for travel within ECOWAS¹);
2. Test the quality of the training part of the PPM program in order to fine tune the curriculum and increase subject comprehension
3. Test risk-mitigation protocols (e.g., hotline and External Advisory Committee) and identify additional contingencies prior to scaling.
4. Assess our ability to remain in contact with participants using phone calls, WhatsApp, and in-person surveys;
5. Measure short-term outcomes, including rates of migration, employment, and measurements of safety, physical and psychological wellbeing

Importantly, the pilot was not designed to provide a valid estimate of the impact of the PPM program for two reasons. First, the pilot was implemented at a small scale in two intentionally selected locations; it was thus not powered to detect treatment effects (or measure spillovers) and the pilot sites are not representative of a broader population. Second, owing to funding and implementation delays, the pilot did not launch until three months after the migration season began. As a result, the individuals who participated in the training and other activities were among the least likely individuals to pursue migration opportunities (though they expressed interest in migrating as a condition of eligibility). Thus the value of the pilot should be assessed against the goals enumerated above and the realized outcomes that we report should be seen as illustrative and interpreted with caution.

PILOT PROGRAM RECRUITMENT, CONTENT & IMPLEMENTATION

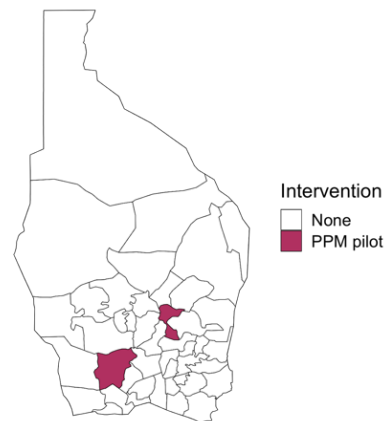
The first goal of the pilot was to test the relevance of all elements of the PPM program including the training, support to secure legal documentation, vaccine delivery, and transit subsidy.

During the pilot, we began by engaging local government authorities and local leaders to explain the project objectives and activities, as is critical in this context. This included signing a Memorandum of Understanding with the Tahoua regional government. PPM program staff also consulted with key leaders in the Ministry of Health, the police, and the local administrative and cultural leaders. In each village selected for the pilot, program staff met with the village or neighborhood chief multiple times, both ahead of the launch and throughout the program.

¹ Note: the vaccines were not funded by the DIV award, but by another funding source.

The pilot was implemented in the communes of Illela and Keita. We identified 210 eligible households in four villages and two towns. Eligible households were those with a young man between 18 and 35 who expressed an interest in migration (unless that man has a high school education or more and at least one member of the household is currently abroad).² The eligibility criteria were designed to focus the program on those households facing the most significant impediments to pursuing their migration aspirations, based on pre-baseline survey data.

Figure 1: Pilot communes in Tahoua region

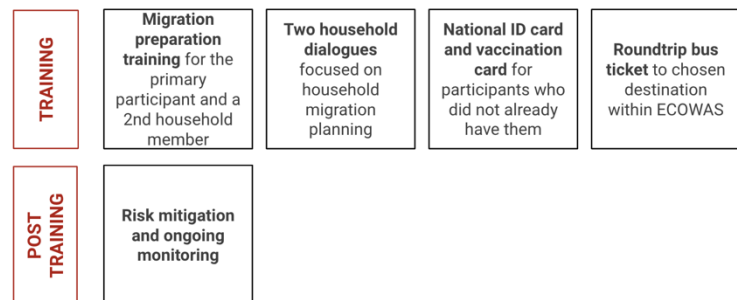


Households were randomly assigned to one of two groups – PPM treatment (110 households) and control (100 households). For the program activities, each selected household had a primary participant (a young man between 18-35) and a second household member (head of household or first wife of the primary participant, depending on household structure). The participants had the following characteristics:

- Demographics: 30% of primary participants are head of household and 33% are married. 64% of secondary participants are head of household.
- Past migration: 45% percent of primary participants have migrated within Niger within the past 3 years. 13% have migrated outside of Niger during that time.³
- Intended migration: Côte d’Ivoire was the most popular intended destination among primary participants; 60% of primary participants expressed an interest in migrating there for work.

For households in the treatment group, the PPM training program was implemented in February – March 2022. The core components of the pilot program for the treatment group are summarized in Figure 2. Led by eight trainers, the training program assisted participants in assessing the costs and benefits of migrating to seek employment, explained how to engage in safe and legal migration within ECOWAS, reviewed

Figure 2: Components of PPM Pilot Program



potential risks, educated participants about remittance processes, and helped prospective migrants think through whether they wanted to pursue migration and how they would make the journey. To encourage joint household decision-making, the program included two facilitated household dialogues. Trainers supported households to work together to build a migration plan, which included discussing participants’ destination choice, plans for remittances, and intention to communicate with family at home. To facilitate legal migration, Mercy Corps helped participants acquire key travel documents required to travel within ECOWAS: a national ID card and a vaccination card. Participants who completed the program (e.g. training, ID cards, vaccinations, and household dialogue) were then eligible

² These criteria, high school education (or more) AND one member of household abroad were intended to screen out individuals who would not migrate even if given access to the program; it is based on analysis of our pre-baseline survey data.

³ Migration is measured as spending more than one month away from home.

to receive a round-trip travel subsidy for bus travel to any ECOWAS country.⁴ In the control group, the primary participants received a smartphone to be used for ongoing data collection purposes.

A key goal of the pilot was to assess both the relevance and quality of the pilot program content and implementation. Key elements of the program were successfully administered with valuable lessons learned along the way:

- **Overall program completion:** Of 110 treatment households, 83 primary participants completed the entire training, participated in the household dialogues, and obtained the required documentation materials to be eligible for a bus ticket subsidy. The program lost ten treatment households immediately after the baseline survey, as primary participants chose to migrate immediately rather than wait for the training, documentation, and transit subsidy. This may have been because it was a particularly difficult agricultural harvest and there was a lot of pressure for young men to seek work outside of Tahoua.
- **ID delivery:** For treatment households, the PPM program team was able to assist 62 people in obtaining their ID card who did not have this document at the start of the training. 20 people first received support obtaining a birth certificate, which is a mandatory document to get an ID card.
- **Vaccination delivery:** For treatment households, the PPM program team was able to assist 77 people who did not previously have a vaccination card to obtain their yellow fever and meningitis vaccines and vaccination card.
- **Bus ticket subsidies:** The team was successfully able to deliver outbound bus tickets to eligible participants wishing to migrate. 20 treatment participants requested and received an outbound bus ticket to an eligible ECOWAS destination. Twelve participants requested and received return tickets from Abidjan, Côte d'Ivoire.

Participants completed pre- and post-training tests to assess their satisfaction and learning on key topics. In the post-test survey, 83% of respondents reported that the whole training was useful and an additional 15% indicated that parts of the training were useful. 100% of respondents correctly answered that ID documents are required for cross-border migration and 95% correctly answered that a vaccination card is required.

We also worked with two Nigerien researchers who observed the training sessions and led interviews with ten different households to evaluate people's experiences with the training and to identify possible changes to the PPM approach. This helped us to incorporate more qualitative perspectives on the program and to identify opportunities to improve the content to ensure it meets program objectives and participants' learning goals.

⁴ At the time of the pilot program, many countries borders were closed due to the COVID-19 pandemic. The program only supported travel to countries without such border restrictions.

Key Takeaways

Training content: Participants and trainers consistently reported the content was relevant and novel. Our story-based approach to training (building on interviews we completed with prior migrants) was well received and helped to encourage critical thinking. Some second household members who participated even expressed that they wished this training had existed when they were younger. We learned that expanding the training on how to use a smartphones, and more specifically using WhatsApp, would be beneficial for the RCT.

Migration preparation: Participants expressed an improved understanding of steps they can take before migrating to facilitate a safe, legal, and productive migration experience, such as reaching out to contacts in the destination city, and making plans with other household members for household activities and income during the migration period. The involvement of family members in the training and the household dialogues appears to have had an important impact on how participants understand the impact of migration decisions on the household more broadly.

Identity documents: The provision of identity documents was extremely well received as administrative processes can be burdensome, too expensive for some households, and opaque.

Household dialogues: The dialogues helped household members to improve coordination and communication by emphasizing the importance of establishing collective goals and positioning the migration decision as a tool to achieve these goals. Several household members expressed that this is the first example of a project that includes household members as key voices in migration planning for their children (who were primary participants).

PILOT PROGRAM RISK MITIGATION STRATEGIES

Another goal of the pilot was to test our risk mitigation protocols and identify any necessary changes prior to scaling the program. Mercy Corps Niger and IPL worked collaboratively to develop a robust risk mitigation strategy for participants in the PPM program including:

- A risk mitigation training for program participants with information about how to access services in potential destination cities;
- A Mercy Corps-run hotline for participants who need urgent assistance;
- A referral system to connect migrants to key contacts in destination cities;
- A mechanism for facilitating return migration when the migrant wishes to end his journey;
- An emergency cash fund to support a family member's travel to help a participant return home in instances when a participant is unable to return home independently;
- A strategy to monitor potential severe adverse events and assess any required program adaptations should there be changes in the overall programmatic risk profile.

In practice, the hotline was used primarily for requesting outbound bus tickets and for participants who had questions about specific programmatic benefits or the monthly surveys. During the course of the pilot program, 71 inbound requests were logged:

- 34 calls were in reference to an outbound ticket request
- 12 calls were in reference to a return ticket request
- 11 calls were about the Mercy Corps program
- 15 calls were a different question or unrelated comment

During the pilot program, we were not notified of any emergency situations that required use of the emergency cash fund.

External Advisory Committee

In addition to the risk mitigation Standard Operation Procedure, we established an External Advisory Committee (EAC) with five members (including Africa-based scholars of migration, experts in research design, and humanitarian practitioners) that reviewed monthly risk reports, assessed any severe adverse event experienced by a participant, and offered additional guidance to the project team. The Charter for the EAC and descriptions of their specific responsibilities is attached.

The EAC met monthly for five months throughout the pilot program. Each meeting began with an opportunity for the EAC to ask questions of Mercy Corps and IPL about the written report, and then continued with discussion in a closed session with EAC members only. In addition to regular reporting on program targets (e.g. people trained, people surveyed, etc.), tracking survey results, and trends in political instability and violence in the region, we identified four types of severe adverse events to report on to the EAC:

- Death of a participant, or grievous bodily harm
- Death of a participant's spouse or child
- Wife/family loses home or land
- Participant experiences severe human rights abuses in destination (trafficking, torture, etc.)

In the course of the pilot program, one severe adverse event was reported. On Sunday, September 18th, the PPM team was informed of the death of an individual (hereafter, Participant A) assigned to the treatment group. Two calls were made to the hotline to share the news directly with program staff. The calls included the following details:

- Participant A passed away on Thursday, September 15th in Abidjan, Côte d'Ivoire.
- Participant A was sick with malaria and was only sick for a short time.
- Participant A accessed treatment at a hospital before he passed away.

In response to this severe adverse event, the PPM Program Manager visited Participant A's village and family to share condolences. We used our surveys to date to gather the information we knew about Participant A and called a meeting with the External Advisory Committee. We also examined data from the Round 4 tracking survey on health outcomes disaggregated by treatment and control group. The goal was to understand whether health outcomes appear to be systematically different for those who received the PPM program, and we did not see any systematic variation between groups.

Given the nature of Participant A's passing, the EAC's consensus was that this was a tragic event, but the death did not occur on account of the program and no programmatic adaptations were necessary. The EAC invited the PPM program team to reevaluate the risk mitigation protocols and ensure that there is a standard procedure in place for how Mercy Corps will respond when severe adverse events occur.

Key Takeaways

Risk mitigation: We have a comprehensive register of potential risks to participants, which we are updating marginally post-pilot. Our strategies for informing participants of risks and providing opportunities for participants to get help are functioning well. Our approach with a formal External Advisory Committee and the tracking of severe adverse events does ensure we focus attention on risks on a regular basis, and gather systematic data on risk exposure.

EVALUATION DESIGN

Through the pilot, we also sought to assess our ability to remain in contact with participants using phone calls, WhatsApp, and in-person surveys. Staying in contact is essential for tracking outcomes for both the participants and their families. Knowing that attrition would be a significant challenge for mobile populations, we approached the pilot with the goal of trying out different strategies in successive survey rounds so that we could optimize the measurement strategy for the full RCT.

For the pilot program, our data collection included surveys of the primary participant, a second household member, and a female household member. In each case, we sought information about additional contacts we might reach out to if we were unable to contact the surveyed individual. We designed three survey instruments:

1. A baseline survey which included a robust household roster, migration history, income measures, assets, a consumption schedule, and measures of psychosocial well-being. This was conducted in-person.
2. Shorter, periodic tracking surveys every month for both primary participants and household members. These were mostly carried out by phone, with one exception where we added an in-person component.
3. A comprehensive endline survey which repeated most of the questions in the baseline and asked for very specific details on recent migration experiences for both primary participants and others in the household. This was carried out in-person.

We assess our ability to stay in touch with participants by the response rate for our surveys. Figure 1 summarizes the response rates for each survey round. Response rates are reported separately for the treatment and the control groups. Figure 1 also reports whether surveys were completed in-person, by phone, or both. Note that round five focused on a small sub-sample of individuals who we had reached only once since the baseline in an effort to test whether a larger financial incentive would increase response rates.

The headline is that we were able to stay in contact with 95% of the households between the baseline and the endline. Although individuals may move, households generally did not, and households generally have very good information about the location and status of the participant in the program. We learned that face-to-face contact with households through in-person surveys will need to be a critical part of data collection for the full-scale RCT.

Staying in direct contact via phone was more challenging, especially with program participants, many of whom were on the move. We saw a significant drop in response rates between the baseline and round 1 of the survey which we attributed to two primary causes: (1) poor mobile network coverage in parts of Niger from which we recruited (2) participants who move internationally change their WhatsApp phone number.

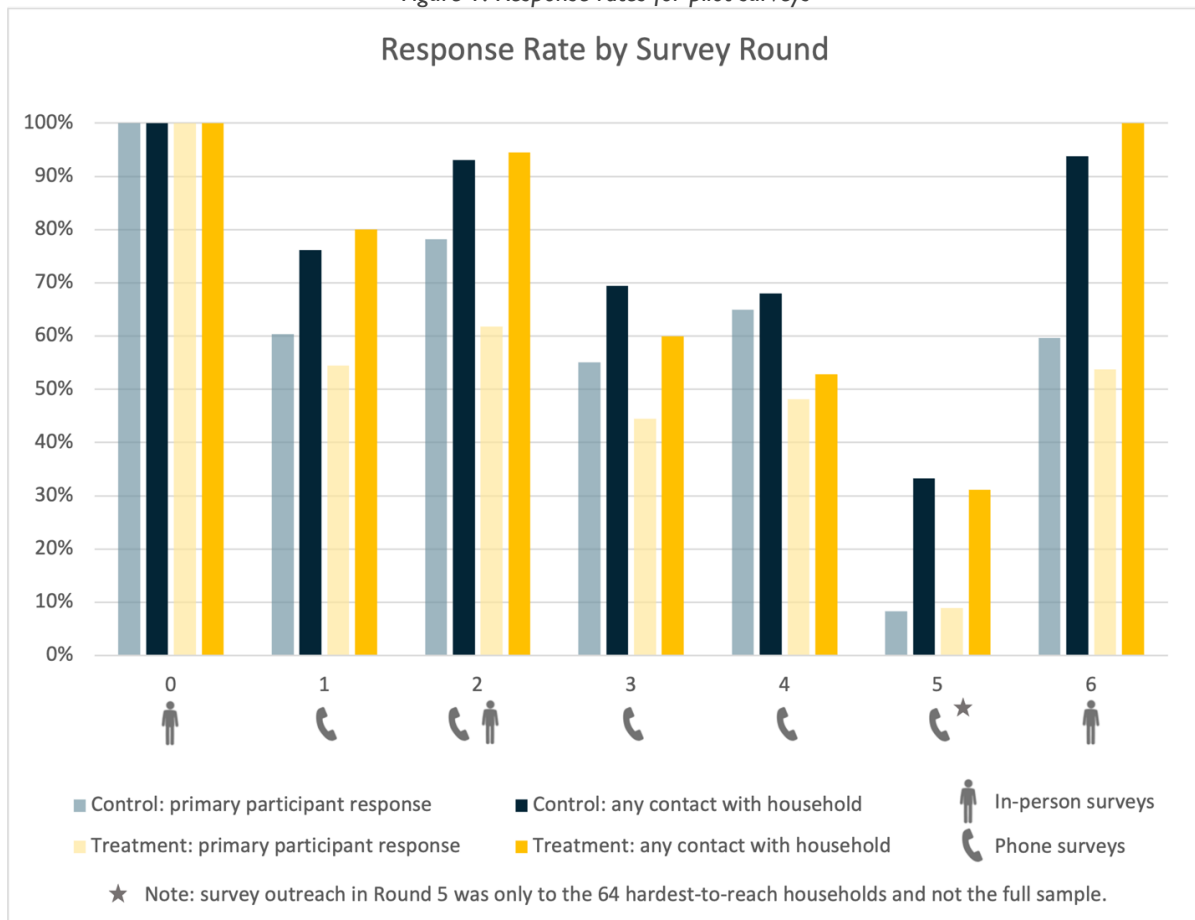
In subsequent tracking surveys, we tested different strategies for reducing attrition and we collected information about the primary participant's location from secondary contacts. To assess whether attrition was due to poor phone connectivity, we supplemented phone outreach with in-person surveys in round 2. To determine whether respondents were not answering because they had turned off WhatsApp, we implemented additional outreach in round 3 by sending WhatsApp messages to participants that did not answer the initial call. In round 4, we ensured that enumerators systematically varied the time of day of each attempt to contact participants. Finally, in round 5 we targeted participants that had been difficult to reach and tested whether increasing the incentive payment for

survey completion, and informing them ahead of time of the incentive, could increase our response rate among these hard-to-reach participants.

We learned that cell network connectivity was a major driver of attrition for households and participants who remained at home in Niger. This reinforces the need for face-to-face surveys, despite their expense. It has also informed decisions about sampling strategy for the full RCT. We plan to only include villages in the RCT sample with reliable mobile network coverage.

With the non-response among primary participants in the tracking surveys, it is difficult to know how much this is related to being outside of Niger. We do see significantly lower response rates among individuals who have traveled abroad (either self-reported in a prior round or reported by another household member). In some rounds, the response rate for those abroad is about half that of those in Niger, with us reaching approximately 60% of participants in Niger and 30% of those outside of the country. Face-to-face surveys in round 2 helped to decrease attrition by providing updated contact information for participants. The tests we conducted in rounds 3, 4, and 5 suggest that was not a function of enumerators calling at inconvenient times or when phones were turned off. We also know that there were issues with the quality of the phones provided to participants and more time was needed for WhatsApp training. This suggests that for the RCT, it will be important to invest more resources in training, better quality phones will be needed, and we will need to invest heavily in in-person surveys to complement phone calls. We have updated our protocols and training accordingly. We are also looking into the possibility of conducting in-person surveys in destination cities when we are unable to reach participants via phone.

Figure 1: Response rates for pilot surveys



Key Takeaways

Data collection: Phone surveys have proven more challenging than anticipated, given poor network quality and low knowledge of how to use WhatsApp. Testing new data collection strategies, such as combining phone and in-person outreach has helped to improve response rates, particularly among participants who have traveled abroad. We are focused on improving the quality of training, distributing higher quality phones, improving our protocols for updating contacts, and carrying out more in-person surveys to reduce attrition. We will also only include villages with cellphone connectivity for the large-scale RCT and ensure that surveys of the household collect as much information as possible on program participants so that we can learn about their welfare even if they are unreachable.

PILOT PROGRAM OUTCOMES

Finally, we used the pilot as an opportunity to test our strategy for measuring key outcomes. As an important reminder, the pilot was expressly not designed to measure the impact of the program, both due to the small sample size and the delayed implementation of the pilot in the middle of the 2022 migration season. We developed survey measures to capture key outcomes including rates of migration, employment, income, assets, consumption, as well as safety, physical, and psychological wellbeing. We offer some summary statistics below for context around our learning goals of the pilot, but they should not be interpreted as an estimate of treatment effects as the pilot study was not powered nor designed for that purpose. Moreover, we only completed the endline survey in mid-October, so these outcomes are illustrative and not comprehensive representations of what we measured.

Table 3 reports one key outcome: the rate at which participants and other members of their family migrated during the pilot period. We are able to gather this measure nearly the complete sample, drawing on responses from household members.

Table 3: Migration rates as reported at endline by household members*

	Control	Control N	Treatment	Treatment N
Percent of participants who migrated internationally for at least one month during the pilot	27.8%	89	36.1%	103
Percent of households in which another household member migrated internationally for at least one month during pilot	28.9%	103	28.7%	103

*Note: The rate is calculated using the total number of households in the treatment group as the denominator: N=97 for control and N=108 for treatment because a few households opted out of follow-up surveys.

Figure 2 maps the migration destinations of participants in both the treatment and control groups. Côte d'Ivoire was the preferred destination of most migrants. This was also true in the baseline survey where individuals reported on their migration aspirations. Importantly, the program did not offer outbound bus ticket subsidies to Côte d'Ivoire as the land border was closed until early September 2022. Nonetheless, a number of participants chose to migrate there using their own resources, after first visiting Accra or another regional destination.

Participants traveled to the following destinations:

- Algeria: 1 treatment group participant
- Burkina Faso: 1 treatment group participant
- Cameroon: 3 treatment group participants; 1 control group participant
- Central African Republic: 1 treatment group participant; 2 control group participants
- Chad: 2 treatment group participants
- Côte d'Ivoire: 28 treatment group participants; 16 control group participants
- Libya: 2 treatment group participants; 5 control group participants
- Nigeria: 1 treatment group participant; 3 control group participants

Figure 2: Destinations for pilot participants in treatment and control groups

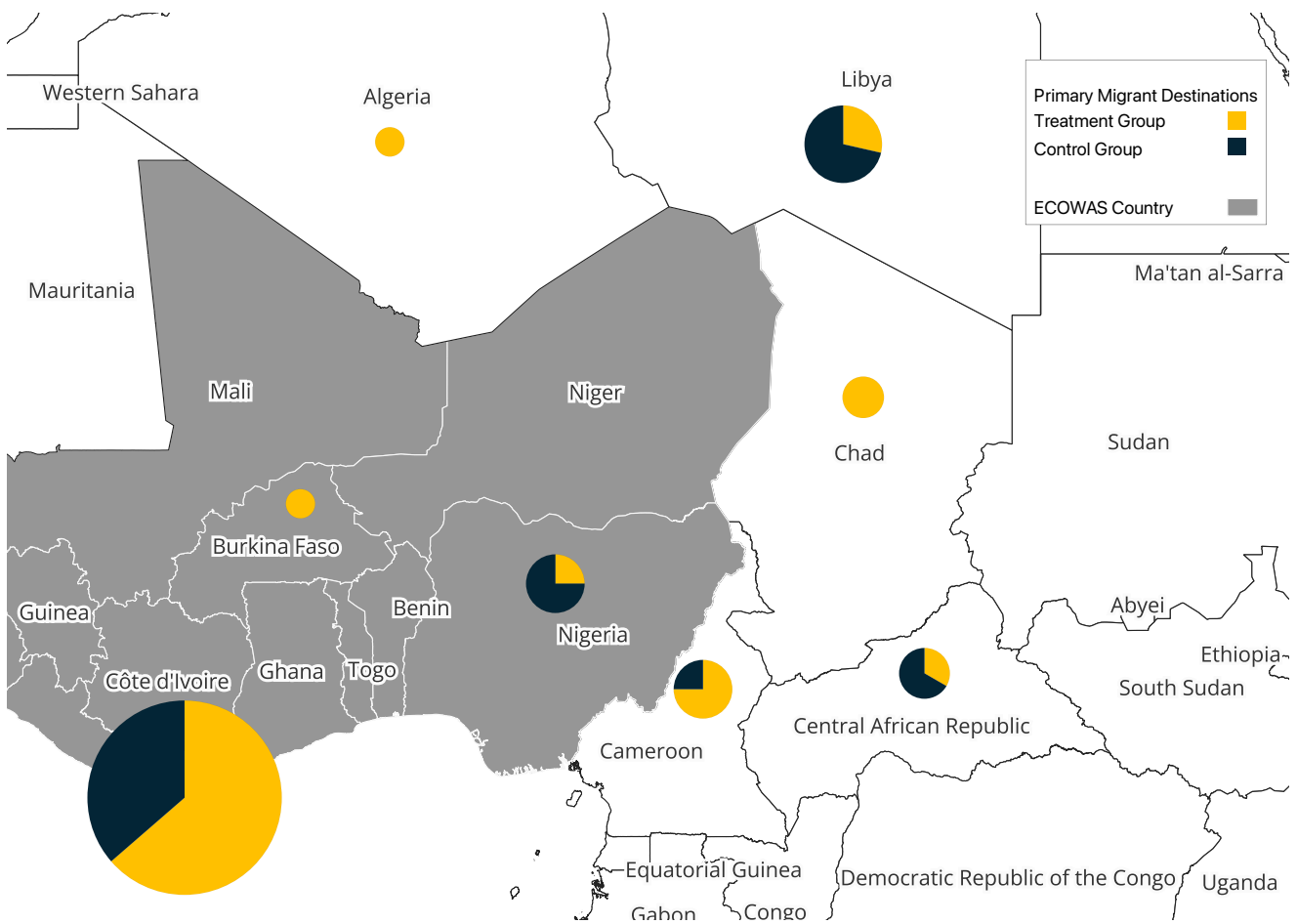


Table 4 reports a broader range of short-term outcomes at the household level using the near universal coverage of households through the endline survey. We report on food security, household income, remittances, assets, mental health, and physical health.

Table 4: Key short-term household outcomes measured at endline

	Control	Control N	Treatment	Treatment N
Food Insecurity (Adult) Percent of households in which adults skipped meals or reduced the size of meals in the past month	35.2%	91	26%	104
Food insecurity (Children) Percent of households in which children skipped meals or reduced the size of meals in the past month	17.6%	91	7.7%	104
Household income Average total income from income-generating activities for all individuals currently residing in the household over the past two months	20075 CFA	80	26293 CFA	100
Remittances Percent of households that received remittances from any household member who traveled outside of Tahoua region since the beginning of the year	37.5%	80	56%	100
Remittances value Average total remittances received from people living outside the household since the beginning of the year	35744 CFA	80	39915 CFA	100
Index of assets Standard index of asset ownership drawn from nineteen asset categories	0.717	80	1.02	100
Mental health (household head) Mean score on depression symptom index (0-1)	0.285	80	0.289	100
Mean value of physical health (1-5 scale) for household member identified to attend training	3.89	89	3.83	98

Finally, in Table 5 we report a set of short-term outcomes for primary participants in the treatment group and the control group. As described in the prior section, we have data on between 50 and 60% of participants at the endline as reported in direct surveys versus via household members.

Table 5: Key short-term outcomes for primary participants measured endline

	Control N=58	Treatment N=59
Food Insecurity Percent of primary participants who skipped meals or reduced the size of meals in the past month	19%	15%
Mental health Mean score on depression symptom index (0-1)	0.372	0.359
Income Income from all income generating activities since Tabaski	65939 CFA	90215 CFA

At this stage, we are still working through a comprehensive set of outcome data. Early indications suggest, unsurprisingly, that income and psychological well-being are challenging to measure, especially via phone surveys. Our early analysis of tracking survey data revealed inconsistent reporting of income. We asked participants how often they were paid and how much they earned in each payment. Because responses were inconsistent, we altered our approach to measuring income in the endline survey. We shifted to an approach focused on asking participants to estimate their total earnings for each income generating activity for each of four reference periods. We chose reference periods that would be salient to participants: 1) from our first survey to the beginning of Ramadan 2) from the beginning of Ramadan to the end of Ramadan 3) from the end of Ramadan to Tabaski, 4) From Tabaski to the current survey. Our enumerators also flagged for us that the validated psychological question batteries we used to measure mental health were not very relevant to the local context, and people had difficulty understanding or identifying with the questions. We shortened and updated these batteries for the endline and plan to revise them further in advance of the RCT. We expect to do a systematic refining of the measurement strategy based on a deeper analysis of the survey data, which is ongoing.

CHANGES TO PROGRAM PLANS AND RESEARCH DESIGN FOR THE FULL SCALE RCT

Beyond the takeaways highlighted above, we made two additional changes to the RCT model based on the pilot:

Increase sample size and geographic spread: We decided to increase the sample size from 2,250 to 3,000 households to strengthen our overall research design. We have done this to improve our ability to detect treatment effects, given what we are learning through the pilot about baseline rates of migration, take-up, and within- and across-village spillovers. The larger sample size will enable us to increase the size of the treatment groups (the RCT includes both PPM and an unconditional cash transfer) and the control group. We will also include an additional pure control group: roughly 60 randomly selected communities (~400 households) where no households will participate in either of the treatment arms. During the pilot we concentrated recruitment in three towns, generating relatively high levels of saturation. We found that our control group quickly acquired information about the PPM program: 68% of individuals in the control group had discussed the program with others in the first month of the pilot. If control households are “partially treated,” in that they might benefit from the information provided to the treatment group, then they won’t provide a good counterfactual. We risk

underestimating the impacts of PPM by using “partially treated” households as our comparison. By comparing households in these pure control communities to untreated households in communities with programming, we can more precisely estimate spillovers from the program. In order to maximize statistical power to detect these effects, the current plan also involves recruiting participants from just over 140 villages across eight communes in Tahoua. The PPM team will also hire two additional Program Officers and up to six Field Agents to ensure sufficient staffing over a larger geographic area and sample size.

Extend program period to target the 2023 migration season: After a weeklong pilot review workshop with both Mercy Corps and IPL in May 2022, we determined that extending the program timeline by one year, to target the migration season beginning in fall 2023, would ensure that we could learn from the pilot and fully deliver the highest quality implementation and evaluation. The extended timeline allows us to:

- Incorporate learnings from the pilot to update the PPM training curriculum, risk mitigation strategy, and data collection infrastructure.
- Pursue community engagement with local authorities and plan for expansion into new communities, complete recruitment and on-boarding of a larger project team, and engage with partners for the delivery of the unconditional cash transfer, vaccines, and identification cards.
- Start the PPM program delivery earlier in the year as the ID card and vaccination delivery took longer than expected during the pilot.
- Allow additional time for Côte d’Ivoire to formally reopen its land borders (which has now happened). This is the preferred destination for potential migrants based on our surveys during the pilot.

FEEDBACK FOR USAID

Working with USAID DIV on the PPM pilot has been a great experience, overall. We have benefited greatly from DIV’s support for the project, and in particular, the desire to connect our work in this project to broader shifts within the U.S. Government on how to conceptualize and work on migration, and the needs of mobile populations. In this regard, we commend DIV’s help with organizing or inviting our project team to participate in events where we have been able to share the work we have been doing. We also appreciate DIV’s open communication with us throughout the grant period, including in response to questions about grant milestones and other expectations. The ability to connect quickly and easily with our grant focal point has greatly helped our team manage the project effectively.

In terms of suggestions for future engagement, we would like to recommend that Stage 1 grantees would greatly benefit from more engagement with DIV in considering how their work could be scaled, including support for navigating the process for moving towards Stage 2 funding. While we recognize that the recommendation for scaling will come out of the final results of the pilot, it would be useful to begin some earlier conversations with partners when all signs indicate that the pilot has been a success and there would be value in moving forward to a test-to-scale stage.

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