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GUIDANCE NOTE

Social protection and nutrition

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Abbreviations

CCT	Conditional Cash Transfer
DFAT	Department of Foreign Affairs and Trade
DHS	Demographic & Health Survey
HBS	Household Budget Survey
HIES	Household Income and Expenditure Survey
IFA	Iron and Folic Acid
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
NGO	Non-Government Organization
REACH	Renewed Efforts Against Child Hunger (and Undernutrition)
SMART	Specific, Measurable, Achievable, Relevant and Time-bound
SUN	Scaling Up Nutrition
VfM	Value-for-Money
WASH	Water, Sanitation and Hygiene

1. Introduction

Social protection and nutrition have both risen fast up the development agenda over the past few years. The recent and recurrent global food, fuel and financial crises have pushed many national, regional and international bodies increasingly to consider the use of social protection instruments in poverty alleviation strategies — a push largely motivated by the positive results delivered by conditional cash transfer (CCT) schemes launched in several Latin American countries in the late 1990s.

Greater attention is also increasingly being paid to the issue of malnutrition, which remains a serious brake on development. Within strategies to improve nutrition, social protection has been promoted as a key instrument to reach those most in need and to address underlying causes of malnutrition. Yet, while social protection does present a real potential to help tackle malnutrition, evidence to date on its nutritional impact has been mixed. This calls for a review of past experience to understand better the factors influencing nutritional impact, and to improve the design and implementation of future social protection initiatives for a greater contribution towards achieving nutrition security.

This Guidance Note aims to equip aid administrators and practitioners working on social protection programs and familiar with the policy context¹ to understand the challenges and potential of social protection to improve nutrition. It presents the theoretical case for using social protection in the fight against malnutrition and sets out a series of questions that should be considered, at each stage of the program cycle, to help to maximise the nutritional impact of social protection interventions.

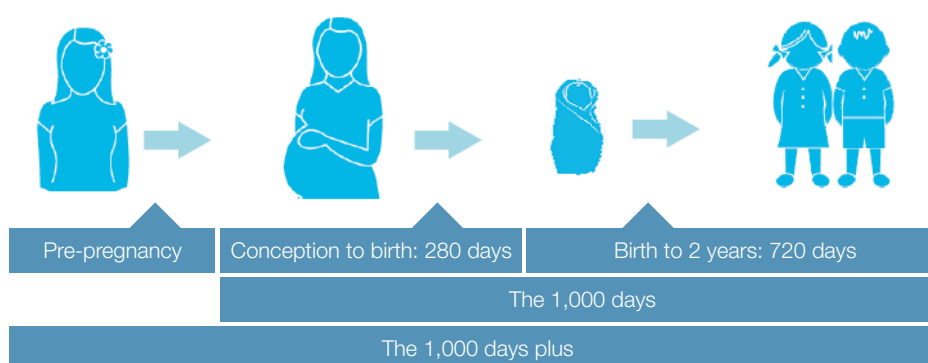
When reading this guidance, staff should use the following structure to assist them:

- > An overview of malnutrition and how social protection can assist (pp. 4–9)
- > How to design and implement a new social protection program investing in nutrition (p.10 onwards)
- > How to improve an existing social protection program so it is more nutrition sensitive (p.13 onwards)

What is malnutrition?

Malnutrition takes a number of very different forms (Box 1) and can affect all ages. The crucial period during which malnutrition has the severest consequences, most of which cannot be reversed, is from conception until the age of two years, often referred to as the first “1000 days”. But the health and nutrition status of adolescent girls prior to conception is also very important, and is further incorporated in the concept of the “1000 days plus” — see Figure 1.

Figure 1 The “1000 days plus”



Adapted from: Menzies School of Health Research (2012)

1 This Guidance Note assumes that readers have a basic level of knowledge and understanding about key social protection concepts and instruments – if that is not the case, please contact the Poverty and Social Transfers Section (Paba Griffin, ext. 6029).

Box 1: Common forms of malnutrition

Malnutrition is a physical condition related to the body's use of macronutrients (fats, carbohydrates and proteins) and micronutrients (minerals, vitamins). Undernutrition and overnutrition are the two categories of malnutrition. Both are associated with increased morbidity and mortality rates.

Undernutrition is the physical outcome of a deficit in the energy, protein and/or micronutrients provided by the diet. The deficit may be caused by poor quality or insufficient quantity of nutrient intake (described as 'hunger'), or excess loss of nutrients consumed or extra needs for nutrients (associated with 'morbidity'). It includes:

- > Undernutrition resulting from deficiencies in several nutrients:
 - Low birth weight, mainly due to intrauterine growth restriction (usually due to low maternal nutrition status or maternal illness before and during pregnancy);
 - Being too short for one's age ('**stunting**', which denotes chronic undernutrition);
 - Being too thin for one's height ('**wasting**', which denotes acute undernutrition);
- > Undernutrition resulting from a deficiency of specific micronutrients (referred to as 'hidden hunger'): these '**micronutrient deficiencies**' affect growth, immunity and intellectual development. Some cause specific clinical conditions such as anaemia (iron deficiency), hypothyroidism (iodine deficiency) or xerophthalmia (vitamin A deficiency).

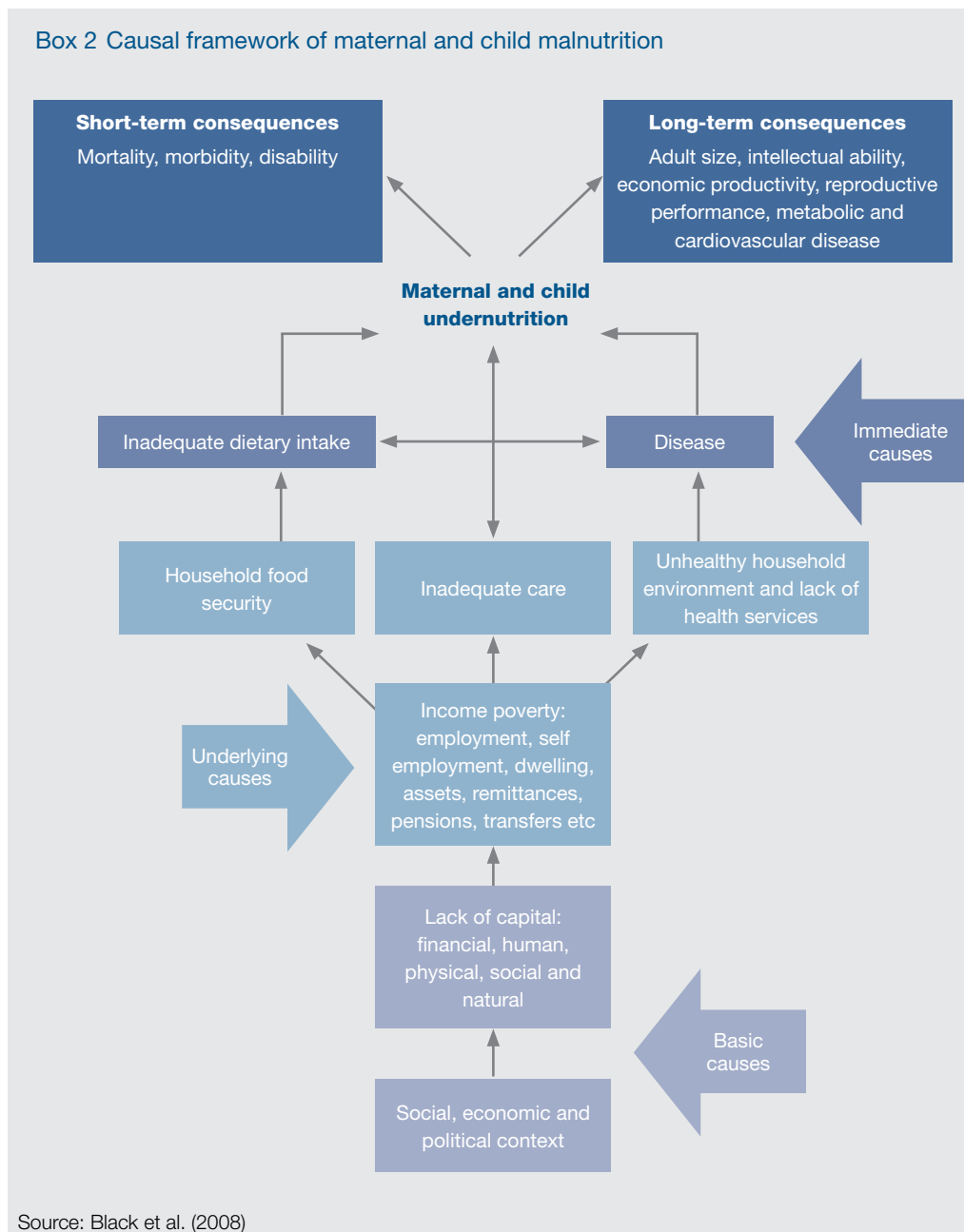
Overnutrition mainly results from an overconsumption of nutrients over time and lack of physical activity. The most common form relates to excess intake of calories notably coming from sugar and fats, which leads to **obesity**. Obese people are more prone to diabetes, cardiovascular irregularities and hypertension, often referred to as 'lifestyle' or 'non-communicable' diseases, and to other forms of disability in later life.

Undernutrition kills more than three million children every year: about one every ten seconds. For those who survive, it can have irreversible consequences on their physical growth and mental development. This in turn undermines virtually every aspect of economic and human development. Undernutrition reduces a nation's economic advancement by at least 8 per cent because of direct productivity losses, losses via poorer cognition, and losses via reduced schooling. Developing countries are those predominantly faced with undernutrition, with South-Central Asia and Sub-Saharan Africa being the most affected regions. While Asia showed a dramatic decrease in childhood stunting prevalence (from 49 per cent in 1990 to 28 per cent in 2010, nearly halving the number of stunted children), Africa has stagnated since 1990 at about 40 per cent. Today, stunting affects about 167 million children aged 0-5 years (29.2 per cent) in developing countries. Wasting is estimated to affect about 52 million children aged 0-5 years (8 per cent) in the developing world, and its prevalence has not showed any major improvement since 1990 — with the Africa region even showing an upward trend. Micronutrient deficiencies, although less visible (often called 'hidden hunger') are no less widespread or severe. Iron deficiency alone affects about a quarter of the world's population, especially young children and women.

If undernutrition remains the most frequent form of malnutrition in developing countries, overweight has now become common in a number of them. Roughly half of the 1.46 billion overweight adults, including 500 million obese people, actually live in developing countries. More threatening, overweight and obesity were estimated to affect 6.7 per cent of children aged 0-5 years in the developing world in 2010, and are expected to affect 9.1 per cent by 2020. This rising prevalence of overweight and obesity is pushing an increasing number of countries explicitly to engage in the combat against the double burden of malnutrition.

How can malnutrition be tackled?

The causes of malnutrition are multiple, deep and complex. The conceptual framework developed by UNICEF in the late 1980s, further endorsed by the International Conference on Nutrition, is widely accepted internationally (Box 2). According to this framework, malnutrition occurs when dietary intake is inadequate and/or health is unsatisfactory. Meals may be low in quantity, nutrient density or variety, or eaten infrequently. Infants may get insufficient breast milk. Infectious diseases, such as diarrheal diseases and acute respiratory diseases, are responsible for most nutrition-related health problems in the developing world. HIV/AIDS, measles and gut parasites are other important causes of malnutrition.



This framework is useful to draw attention to the deep and multiple roots of malnutrition. While the **immediate** causes relate to individuals, the **underlying** causes relate to households, and the **basic** causes to the community and the nation state. Malnutrition can therefore only be tackled effectively if action is taken in all relevant sectors to address those causes that they can influence.

This recognition leads to a distinction between “nutrition-specific” interventions that directly tackle nutrition, and “nutrition-sensitive” interventions that address nutrition indirectly through other sectoral policies...including social protection. The former include a set of ten interventions through the lifecourse — prioritised, modelled and costed by the Lancet series of 2013 — to address undernutrition and micronutrient deficiencies in women of reproductive age, pregnant women, neonates, infants, and children. These are:

- > periconceptual folic acid supplementation
- > maternal balanced energy protein supplementation
- > maternal calcium supplementation
- > multiple micronutrient supplementation in pregnancy
- > promotion of breastfeeding
- > appropriate complementary feeding
- > vitamin A administration in children aged 6-59 months
- > preventive zinc supplementation in children aged 6-59 months
- > management of severe acute malnutrition
- > management of moderate acute malnutrition.

The cost of scaling up this package of ten essential nutrition-specific interventions to 90 per cent coverage in 34 high nutrition-burden countries (where 90 per cent of the world's stunted children live) is US\$9.6 billion per year. However, even this package would reduce the incidence of stunting only by 20 per cent, and of severe wasting by 60 per cent. This would reduce the number of children with stunted growth and development by 33 million, and save an estimated 900,000 lives. But millions more would still die, or remain stunted, malnourished or underweight. This is why the focus is turning towards indirect nutrition-sensitive interventions, which aim to influence the way other sectors function so that nutrition outcomes are improved. Social protection is a key sector in this context.



Health clinic in the Gambia. Photo Credit: Philippa Freeland.

How can social protection help to tackle nutrition?

There is a wide diversity of definitions of social protection. Some are broad to the point of being unhelpful, encompassing everything that might be considered as social development. DFAT recognises this, and has itself adopted a fairly narrow definition of social protection as “publicly funded initiatives that provide regular and predictable cash or in-kind transfers to individuals, families and households to reduce poverty and vulnerability and foster resilience and empowerment”. This definition encompasses a range of different types of transfer, which may be categorised both by their objectives and by the form they take, as shown in Figure 2. As also indicated in Figure 2, social protection can impact nutrition through different pathways, which operate at progressively different causal levels.

Figure 2: Types of social transfer and their impact pathways on nutrition

Objective	Form		
	In-kind transfers	Near-cash transfers (*)	Cash transfers
Immediate causes	School meals Take-home rations Food transfers Food-for-work (**)	Food vouchers	Cash transfers
Underlying causes	Agric input distribution Livestock transfers	Asset/input vouchers	Cash-for-work (**) Lump sum grants
Basic causes	[School meals]	Health fee waivers Educational stipends	Cash transfers

Note: Supplementary feeding, in the form of micronutrient supplementation, is not considered here as a social transfer.

(*) These refer to the provision of in-kind commodities through the market, allowing beneficiaries to redeem vouchers for instance at a local retailer to retrieve their food entitlement or at a seed fair to access agricultural inputs.

(**) These types of social transfers may aim to immediately provide food or income, but another important objective (sometimes primary) is to support livelihood in the medium term through the creation of productive assets, acquisition of new skills through training, etc.

The theory of change behind the use of social protection to tackle malnutrition is straightforward. Some social transfers — like school meals and food supplements — act directly on individual dietary intake to improve quantity and/or quality, thus tackling the **immediate causes** of malnutrition, those of inadequate diet and disease.

But it is primarily the **underlying causes** of malnutrition that social protection has the potential to address — in particular those of household food insecurity and income poverty. Social transfers can enhance household food access by providing food directly (through traditional food distributions or using vouchers redeemable at a local retailer) or by helping households increase their food crop/livestock production (through agricultural inputs/livestock transfers) or by increasing household purchasing power, either directly (through cash transfers) or indirectly (through lump sum grants to support livelihoods). Regular social protection also helps recipients to smooth consumption, and enhances their ability to afford healthcare without having to sell assets or take on debts.



Health clinic in the Gambia. Photo Credit: Philippa Freeland.

Depending on context, social protection may address some of the **basic causes** of malnutrition, specifically those related to the acquisition of financial, human and social capital. Social protection has considerable potential to break the intergenerational transmission of poverty, hunger and malnutrition. There is well-established evidence that educated mothers have better nourished children, and school bursaries and educational stipends can effectively support girls' access to education, in the same way that health-fee waivers can generate improved health outcomes. In general, social transfers invested in infants and women of reproductive age (nutrition, health and education) can yield high returns over the long term by triggering a virtuous dynamic: better nourished children have improved cognitive development and educational outcomes; educated farmers produce higher yields; better nourished girls have a greater chance to later give birth to healthy babies; educated adults earning more money are in a better position to have healthy, well-nourished children themselves.

Cash transfers can boost local markets and increase economic opportunities. They can also generate an increased demand for health care, which may, under certain circumstances, encourage health system actors to provide higher-quality services. Social transfers supporting food production may help increase the availability and affordability of nutritious food on the market. At an even deeper level, social protection can contribute to improving the national social and political environment by transforming relationships within society, and between citizens and the state.

Finally, social protection programs can offer an excellent opportunity to provide greater awareness and education on important nutritional issues. Traditionally, this has often been achieved through the convening power of delivering food or cash transfers at a fixed location and time, where beneficiaries are “pulled” together and can be targeted with key health and nutrition messages. With a move towards “push” mechanisms of delivery (e.g. paying transfers through bank accounts or mobile phones), this physical congregation of beneficiaries has been replaced by an ability to use more innovative communications technologies to relay information, messaging and advice.

2. Program identification

Maximising the nutritional impact of social protection programs therefore requires careful and deliberate attention at all stages of the program cycle. This is presented in the sections that follow under the headings program identification (this section), program design and redesign (section 3), program implementation and review (section 4) and program monitoring and evaluation (section 5). Each section is structured around a set of key questions that needs to be asked at that stage of the program cycle, with guidance under each key question on what are the essential data-sources, analyses and considerations that need to be taken into account in order to answer the question.

Has a nutrition situation analysis been conducted?

A situation analysis needs to consider whether nutrition is a priority national concern; and — if not — whether it should be. Nutrition data should be sought and extracted from any national nutrition surveys (e.g. Demographic Health Survey), or nutritional modules of other household surveys (e.g. Household Income and Expenditure Survey, Household Budget Survey). Analysis should include not just the incidence and prevalence of key nutritional indicators (e.g. stunting, wasting, underweight, overweight, obese), but also their disaggregation by sex and age. It should further analyse their distribution both geographically — to see if some regions are worse affected than others — and across the wealth distribution — to understand whether poor nutrition is closely correlated with poverty.

Is social protection an appropriate response?

The situation analysis should review the local nutritional context, its evolution over time, and the likely causes and drivers of malnutrition, in order to ensure that this informs the program identification. It is likely that social protection will be a potentially powerful response to malnutrition where one of two conditions is met. The first is where social protection is directly aimed at improved nutritional outcomes — for example a child grant that targets pregnant mothers and infants under the age of two — in which case the social transfer component can provide the platform for other complementary nutrition interventions, such as micronutrient supplements or nutrition education. The second is where malnutrition is substantially the product of demand-side constraints (i.e. as opposed to being the result of a lack of knowledge, cultural impediments or supply-side deficiencies), in which case the injection of additional income into households — in the form of social transfers or fee-waivers — will in itself overcome some of the constraints to better nutrition, by allowing people to travel to health centres or obtain access to nutrition professionals.

What is the nutrition policy context?

This needs to consider whether the program aligns with government nutrition policies. For example, the government may have a set of nutritional targets, either of its own formulation or based on (or adapted from) the targets for 2025 established by the World Health Assembly; namely (i) a 40 per cent reduction in the number of children under five who are stunted; (ii) a 50 per cent reduction of anaemia in women of reproductive age; (iii) a 30 per cent reduction in low birth-weight; (iv) no increase in childhood overweight; (v) a 50 per cent increase in the rate of exclusive breastfeeding in the first 6 months; and (vi) a reduction of childhood wasting to less than 5 per cent. These targets would often be spelt out in a National Nutrition Policy, Strategy or Action Plan. It is important to consider the extent to which the program will contribute to meeting any such targets. Such a document may also identify clear roles and responsibilities for the nutrition sector, and the existence (or not) of multi-sectoral nutrition analysis, programming and nutrition monitoring systems, which might provide the basis for collaboration over program implementation.

What is the institutional context?

Here there is a need to consider whether there are existing mechanisms for inter-sectoral nutrition coordination at government level and amongst stakeholders. The government may have signed up to the Scaling Up Nutrition² (SUN) movement; or UN agencies may have agreed to collaborate through a Renewed Efforts Against Child Hunger³ (REACH) initiative. As a result, there may be existing coordinating committees or platforms, with common, shared analysis of the problem and good formal coordination between government and donors, providing opportunities for joint programming. Considerations about the institutional context should include that expectations of available capacity are realistic, both in terms of government and of the DFAT Post; that potential partners have proven skills and experience in nutrition; and that existing opportunities and constraints are properly recognised.



Beneficiary of the Pantawid Pamilyang Pilipino Program, Philippines. Photo Credit: Ben Pederick

- 2 Scaling Up Nutrition, or SUN, is a movement founded in 2010 on the principle that all people have a right to food and good nutrition. It unites people—from governments, civil society, the United Nations, donors, businesses and researchers—in a collective effort to improve nutrition. Within the SUN movement, countries are putting nutrition policies in place, collaborating with partners to implement programmes with shared nutrition goals, and mobilising resources to effectively scale up nutrition, with a core focus on empowering women. As of August 2014, 53 countries have signed up to SUN.
- 3 REACH is a UN partnership established in 2008 between FAO, UNICEF, WFP, WHO and IFAD, with an objective to assist governments of countries with a high burden of child and maternal undernutrition to accelerate the scale-up of food and nutrition actions. As of August 2014, it is active in 12 such countries.

What are the expected nutritional impacts?

It is important that clear and specific nutritional objectives are established for the program (see Box 3 for the example of the 4Ps program in the Philippines). This would include a detailed assessment of the underlying theory of change, and of whether it is realistic in the context of the country. Normally, there should be a significant focus on the critical window of the “1000 days” or “1000 days plus”. And it is important that expected impacts are aligned with the intended design, for example, to ensure that the value of any social transfer reflects the local cost of a healthy diet. Finally, any potential negative impacts on nutrition (such as, for example, the labour requirement on public works programs) should be explicitly recognised, and mitigating measures properly formulated to eliminate (or at least minimise) these. Paying attention to these crucial aspects permits appropriate adjustments to be made to the social transfer component itself, considering nutrition-focused complementary measures, and integrating the program into a broader food and and nutrition security strategy.

Box 3: Pantawid Pamilyang Pilipino Program (4Ps) in the Philippines

DFAT has supported the Pantawid Pamilyang Pilipino Program (4Ps) in the Philippines since 2009. The program provides cash transfers to the poorest households, conditional upon investments in education and health, such as monthly Family Development Sessions for pregnant women and in-school deworming for children, both of which affect nutritional status and subsequent progress in education and health. A second wave impact evaluation of the program (conducted in November 2014), found that beneficiaries (children and mothers) of the program:

- > Had greater access to basic health services such as vitamin and mineral supplementation and immunisation compared with non-beneficiaries: 86% of beneficiaries between the ages of six months and six years received Vitamin A supplementation compared with 74% of non-beneficiaries, and 35% of beneficiaries received iron supplementation compared with 23% of non-beneficiaries.
- > Utilised preventive services in public health facilities more than non-beneficiaries: 19% of beneficiaries aged 0-2 years visited health centres on a monthly basis (for weight monitoring) compared with only 12% of non-beneficiaries; and, among beneficiaries aged 2-5 years, 49% visited health centres for bi-monthly weight monitoring compared with only 25% of non-beneficiaries.
- > Gave birth in health facilities more commonly than non-beneficiaries: 7 in 10 live births in the past five years by beneficiaries were delivered in a health facility, compared with 5.5 in 10 live births among non-beneficiary mothers.

3. Program design and redesign

Listed below are questions that, while critical to the design and implementation of new programs, are equally relevant for staff reviewing existing programs in order to make sure they are nutritionally sensitive.

What are the nutritional objectives?

It is essential that clear nutritional objectives and outcomes should be integrated in the program design and reflected in its logical framework. They should be directly associated with nutrition indicators that are SMART (specific, measurable, achievable, relevant and time-bound); and ideally these should capture impacts on both maternal and child nutrition (disaggregated by sex and age for the latter). Furthermore, if the program includes any lesson-learning objectives (e.g. in the case of a pilot), these should be clearly stated, and should correspond with the envisaged methods of monitoring and evaluation. For existing programs, the review process (e.g. annual review, mid-term review) may offer opportunities to modify logical frameworks, adjust objectives, or introduce new indicators that will better reflect a greater emphasis on improved nutrition (see Box 4 for an example of how this was achieved on the DFAT-supported Chars Livelihood Programme in Bangladesh).

Box 4: Chars Livelihoods Programme (CLP) in Bangladesh

DFAT has supported the Chars Livelihoods Programme (CLP) in Bangladesh since 2009. CLP has always had indirect components aimed at improving the health and nutrition of its beneficiaries. This has included access to improved water and adequate sanitation; providing training on nutrition, water, sanitation and hygiene; and promoting homestead gardening as a way to increase nutritional status. But impact studies on CLP showed mixed results in terms of nutritional outcomes. So, in 2013, CLP introduced a range of direct nutrition interventions, specifically targeting the improvement of the nutritional status of core participant households, especially for pregnant women, breastfeeding women, children under two, and adolescent girls. Activities include one-on-one counselling on Infant and Young Child Feeding (IYCF) and hygiene promotion, providing iron and folic acid tablets to pregnant and lactating mothers and adolescent girls and providing deworming tablets for all family members. At the same time, the Programme modified its logical framework to introduce explicit nutrition targets, as follows:

- > % of targeted lactating mothers of infants 0 - 6 months exclusively breastfeeding (as per WHO definition)
- > % of targeted lactating mothers of children 7-23 practicing appropriate complementary feeding (as per WHO definition)
- > % of targeted children (7-24m) consuming micronutrient powders
- > % of targeted mothers and adolescent girls consuming iron and folic acid (IFA)
- > % of targeted members consuming anthelmintics.

Who will be eligible?

It is important that the targeting strategy of the proposed program represents the best way to help the groups which are most vulnerable to food and nutrition insecurity. This might in some cases imply an exclusive focus on the “1000 days plus”, or an explicit target group of children, women and adolescent girls. And it might involve targeting only the poorest households. But the political economy of targeting, and the profile of malnutrition in the country also need to be carefully considered. In some countries malnutrition is high across the wealth distribution, so targeting the poorest in such cases makes little sense from a nutrition perspective: here



Chars Livelihoods Program, Bangladesh. Photo Credit: Philippa Freeland.

a better solution might be nutritional education campaigns linked to more universal social transfers. And it is generally recognised that more universal programs have greater social acceptability and political appeal, which is why many nutritionally-oriented programs adopt a more inclusive targeting approach. An interesting illustration would be South Africa, where the near-universal old age pension had significant impacts on the nutrition of children in beneficiary households, with girls in particular being 3.5 cm taller than in non-recipient households. Finally, there needs to be an appropriate balance between the costs of targeting to the program implementer, the costs of targeting to the target groups (travel expenses, opportunity costs, social stigma, etc.) and the effectiveness of the targeting. Again these are aspects of existing programs that need to be critically assessed, and if necessary adjusted, at regular stages in the ongoing review process.

Is the government appropriately engaged?

The government should be closely involved in program design, and the design should fully recognise government constraints. This would argue for keeping the design of the program as simple as possible, with a burden of proof — founded on convincing evidence — that any added complexities (e.g. conditions, identification requirements, reporting systems) add incremental value overall. In particular, additional demands on often-overstretched health facilities and nutrition staff should be kept to an absolute minimum; and should be offset by capacity building and support at all necessary levels. There should be a clear division of responsibilities between institutions, ensuring that each has the mandate, capacity and comparative advantage to fulfil its respective role. Coordinating mechanisms should be developed (or existing ones used) to ensure links with other government departments relevant to nutrition.

Is the budget realistic?

Careful consideration should be given to whether the budget for the program has been properly calculated. This should include a specific assessment of the costs and benefits of alternate approaches to achieving the selected nutritional objectives. There should also be provision for indexing any transfers to maintain their value over time, otherwise there is a danger that nutritional outcomes will be compromised as the value of the transfer becomes eroded.

4. Program implementation and review

How will nutritional messages be conveyed?

Every opportunity should be exploited to convey important messages about nutrition through the program. The way this is achieved will depend upon program design, and in particular on the payment mechanism selected. For social transfer programs operating on a “pull” payment basis (i.e. where beneficiaries have to come to a particular point at a particular time), there may be opportunities for delivering awareness and training in optimal nutrition practices direct to the assembled groups; whereas for programs operating on a “push” basis (i.e. delivering transfers to bank accounts or by mobile phones), there may be scope for personalised individual messaging, counselling and guidance. In all cases, mechanisms should be in place for maximising synergy and complementarity with other nutrition initiatives (education, safe delivery, training schemes, health centres, nutrition surveillance, early childhood care and development, etc.) thus maximising value-for-money. Finally, there will be the need for a comprehensive publicity campaign (covering program objectives, eligibility criteria, appeals procedures, value of transfers, etc.).

Is any work requirement nutrition-sensitive?

Programs with a work requirement call for particular sensitivity from a nutritional perspective. It is essential that any such work requirements are compatible with the agricultural labour calendar and with the objectives of improved nutrition. At a minimum, this would include measures for adaptation or exemption for certain categories of recipient (e.g. pregnant or lactating women). In addition, community childcare centres should be organised for under-fives whose mothers participate in public works. There is also a risk either that children themselves will participate in the works, or that their domestic workload (at home or in the fields) will increase because a parent is busy on the public work programme, and that their nutrition, health or education might thereby be negatively impacted as a result. And there is a more general risk that the proposed assets created through public works might have negative impacts either on nutrition (by increasing the risk of water or livestock related illnesses, by reducing the quality of care given to children, by impacting on breastfeeding practices, etc.), or on food security (by reducing production diversity, encouraging soil degradation, etc.). If such risks do exist, measures are needed to reduce or eliminate them. An alternative to public works programs that should be considered, and one which may have better impacts on nutrition, is to support own production, by providing input/asset transfers to support home gardening (e.g. to grow orange-flesh sweet potato or legumes) or household animal production (e.g. poultry rearing, fish farming, cattle or goat dairy production).

Are the type and value of the transfer nutrition-sensitive?

The value of the transfer should be sufficient to achieve the stated nutritional objectives (ensuring a nutritious diet, improving dietary diversity, etc.). If the transfer is in cash, mechanisms should be envisioned to adjust its value both to the size of the household, and for inflation, e.g. based on the contents of a nutritionally-adequate food basket per adult equivalent in the household. If it is an in-kind transfer of food, it needs to take account of the specific needs and dietary preferences of individual beneficiaries. Understanding the capacity, potential and limitations of markets (for goods and services) is also crucial to appropriate transfer selection: where markets can supply the required essential goods and services, cash-based transfers would provide beneficiaries with the purchasing power to access basic commodities and hence let them participate as consumers and express their choice in existing markets. And the proposed transfer type (food, cash, inputs, voucher) should be designed to maximise the nutrition potential of the program (e.g. through supporting local markets, supporting local production of nutritious foods). Even where the predominant form of social



Health care center, Philippines. Photo Credit: Ben Pederick

transfer might be cash, there would be a case to consider, for example, complementary food supplements to pregnant and lactating women and under-twos to prevent or treat any prevailing micronutrient deficiencies.

Are delivery mechanisms and frequency nutrition-sensitive?

The delivery mechanism and frequency of the transfer should match the needs (dietary, productive or cash-based) of beneficiaries, while reducing to a minimum the costs borne by beneficiaries in collecting the transfer (opportunity, transport, stigma, etc.). Again, the proposed delivery mechanism should maximise the program's nutrition potential (e.g. through support to local markets, access to financial services, access to agricultural information, greater gender equity, etc.). And, again, all possible opportunities should be exploited to deliver awareness, education and key messages on health and nutrition issues to beneficiaries and non-beneficiaries alike. Nutritional education and deworming are important complementary activities to improve the nutritional impact of social protection. In addition, emotional stimulation of children can be incorporated in the treatment and prevention of malnutrition. There is considerable potential for community-based nutrition delivery platforms to reach poor and remote populations.

Are conditions desirable?

The justification for including any conditions must be based on a thorough analysis of the socio-economic barriers to accessing goods and basic services, and to achieving better nutrition: if the reasons for malnutrition are associated with poor knowledge, then an educational campaign might have more impact; or if they are more due to remoteness, then increasing the accessibility of services might be the better solution. And it is important that the additional costs associated with monitoring and enforcing the conditionality remain lower than the expected incremental gains. There is also a danger that the condition may introduce perverse nutrition incentives (e.g. keeping a child underweight to ensure continued eligibility, or over-feeding the child immediately before a health visit to demonstrate results) or that it may have negative impacts such as overcrowding health services resulting in a lower quality of care, or requiring frequent tiring trips to remote health centres by pregnant women or mothers of young children. So the burden of proof should be to demonstrate that there is genuinely no better way than conditions to raise beneficiaries' awareness of, and access to, health, education and nutrition (e.g. through incentives or nudges, or supply-side interventions).

5. Program monitoring and evaluation

Are nutrition indicators included?

It is important that “SMART” nutrition indicators are included within the M&E framework. These will depend on the objectives and design of the program, but they might include, for example, (a) quantitative indicators, such as duration of breastfeeding, dietary diversity (e.g. using a dietary diversity score), anthropometry (e.g. birthweight, height-for-age, middle upper arm circumference), micronutrient status, and (b) more qualitative indicators such as nutrient intake, nutritional and hygiene practices, intra-household sharing patterns, women’s workload (and time for self-care and child care), caregivers’ basic knowledge, water quality and sanitary conditions, as well as physical, economic and social access to health care (and its quality). It is also important to include indicators that will measure possible negative impacts, and to disaggregate indicators in such a way that it is possible to monitor heterogeneity of impact (for example, are female-headed households or child-headed households impacted differently in any way?). To capture these properly is likely to require a mix of survey approaches.

How will data for monitoring be collected?

Ideally, as much nutritional monitoring data as possible will be derived from the existing management reporting systems of the government or other stakeholders (e.g. health centres, clinics). In this case, mechanisms may be required to ensure that these are reinforced and improved. But it is likely that other data collection will need to be programmed, either through the inclusion of more detailed nutrition modules in existing national health and income/expenditure surveys; or through the implementation of specific questionnaires, focus group discussions and key informant interviews having a nutrition lens.

How will nutrition-related impacts be captured?

There has been a dearth of rigorous evaluations on the impacts of social protection on nutrition. It will be important to capture nutrition-related outcomes and impacts, in line with the objectives and indicators selected for the program. This may involve comparison with a stable and valid control group, against which the impact on beneficiaries will be compared. There may also be a danger that the program has negative impacts on nutrition: in this case it is important that the evaluation is flexible enough to detect these, and independent enough to publicise them in order to correct any such deficiencies. There may also be ethical issues with the evaluation that need to be considered (e.g. excluding the control group from receiving benefits; interviewing children and adolescents; creating intra-household tensions by focussing health and nutrition related questions on the mother). Other under-researched areas include: cost-effectiveness, the value of nutritional education, value chains for nutrition, spillover effects (on women’s empowerment, local markets, food production, local governance, etc.), and sustained, intergenerational impact. Ultimately, evaluation research findings should help policymakers to better adapt social transfer design and implementation arrangements to the local context for greater positive impact on maternal and child nutrition.

6. Conclusion

Social protection has significant, though as yet under-exploited, potential to help to reduce malnutrition. To optimise program effectiveness, it is essential to consider carefully, at each stage of the program cycle, the possible interactions between social transfers and nutrition, both positive and negative. Only by asking, and responding to, the key questions set out above, will it be possible to maximise the beneficial impact of social transfers on nutritional outcomes.



Father with his child, Philippines. Photo Credit: Ben Pederick

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