on how such case management differs from that of older children.

Conclusion

In India, early growth failure in its various forms is most prevalent among infants under six months of age and is associated with higher risks of morbidity and mortality. Early identification and intervention is therefore critical. Most cases can be treated at outpatient/community level. Experiences from three states in India reflect both progress and the potential to apply the MAMI Care Pathway approach to the Indian context by strengthening and connecting existing community and facility-based programmes, as well as by implementing the recommendations made during the consultation. India is on a pathway towards a scalable approach to continuity of care.

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Merankebandi participant and her children. Burundi, 2021

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Field Article

National social assistance programmes to improve child nutrition: Lessons from Burundi, Ethiopia and Tanzania

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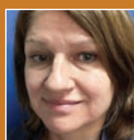

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We acknowledge the support and contributions of Annalies Borrel and Tomoo Okubo from the UNICEF Global Technical Team on Social Protection and Nutrition and the Social Policy and Nutrition Teams of the UNICEF Country Offices of Burundi, Ethiopia and Tanzania in the development of the country case studies on which this article is based.

KEY MESSAGES

- Significant progress is being made by governments in Eastern and Southern Africa (ESA) to implement large-scale social assistance programmes that target financial assistance to the most vulnerable members of society.
- Examples from Burundi, Ethiopia and Tanzania show that combining cash transfers with 'plus' elements – such as social and behaviour change (SBC), livelihoods support and links to services – can help address the underlying determinants of child undernutrition, leading to nutrition impact.
- National social assistance programmes can go further in preventing undernutrition by including scale-up mechanisms in response to shocks, and by linking with food systems interventions to improve access to nutrient-dense foods at all times.

Background

National social protection systems are rapidly evolving in ESA to address poverty and vulnerability among the most fragile populations. Evidence suggests that social assistance, usually in the form of large-scale cash or food transfers and public works programmes, can reduce levels of extreme poverty and improve household food security and diet diversity (Owusu-Addo, 2018). A recent systematic review and meta-analysis has shown that cash transfer programmes have significant, but heterogeneous and modest, positive impacts on child stunting, child wasting, consumption of animal source foods, diet diversity and incidence of diarrhoea (Manley et al, 2022). Nutrition impacts may be enhanced when cash transfers are delivered alongside complementary interventions, or 'plus' elements, such as SBC, livelihoods support and links to primary healthcare and other services (Manley et al, 2022; Little et al, 2021).

UNICEF is supporting national governments in ESA to design and pilot 'cash plus' programmes that target nutritionally vulnerable households with cash and additional services to help prevent maternal and child undernutrition. These programmes aim to address multiple underlying causes of undernutrition by increasing household resources, as well as access to nutritious *foods*, uptake of positive nutrition *practices* and access to nutrition and other *services*. This is a key contribution to UNICEF's Global Nutrition Strategy 2020–2030 (UNICEF, 2020), which positions the social protection system as one of five key systems to prevent all forms of malnutrition by 2025. The following article builds on the experiences of combining cash transfers with nutrition counselling in Kenya that were shared in Issue 68 of Field Exchange (Angood et al, 2022)[1], and illustrates further examples of 'cash plus' programming in Burundi, Ethiopia and Tanzania. The examples and lessons learnt are drawn from country case studies documented by UNICEF ESARO and the UNICEF Global Technical Team on Social Protection and Nutrition, in collaboration with UNICEF country teams. The full set of case studies is available at the following **link**.

Examples of national 'cash plus' interventions

The Merankabandi programme in Burundi

The Merankabandi model provides cash transfers to chronically poor households alongside community-based nutrition SBC and livelihoods support.

Merankabandi is the Government of Burundi's national social safety net programme. It began as a pilot scheme (2018–2022) funded by the World Bank, implemented with technical support from UNICEF and partners. The pilot targeted 56,090 extremely poor and vulnerable households in four provinces (Gitega, Karuzi, Kirundo and Ruyigi) with cash transfers and additional support to build resilience to shocks and prevent undernutrition. Eligible households were those with children aged under 12 years, to reach younger children at high risk of stunting and support older children's attendance at primary school.

The cash component involved unconditional electronic payments of USD24 to households every two months for 30 months, equating to 60% of *per capita* income for the average household. The 'plus' component involved delivery of community-based SBC to caregivers to support uptake of optimal care and nutrition practices. Tented group spaces called 'Hinduringendo' ('let's change our behaviour') were established in each village (215 in total) with a meeting space, handwashing device, kitchen garden, cooking area, playground for children and latrine. Community Agents used these spaces to demonstrate cooking, kitchen gardening and hygiene practices and provide group awareness-raising sessions focused on relevant, actionable skills using locally available resources and foods.

Partway through the pilot, additional funding was received to set up 'solidarity groups' in target areas as an exit strategy for Merankabandi members. Members of solidarity groups met weekly to receive financial education and contribute savings from which income generation activities and unexpected costs could be supported. Ongoing support for kitchen gardens was also given and SBC messages were reinforced. A key implementation challenge was weak integration between different programme components, with the cash, SBC and solidarity group elements often neither being delivered to the same households, nor at the same time. The Community Agent model was also expensive and time-consuming, given the need for recruitment and training.

Results of real-time monitoring have shown positive changes in intervention households along the nutrition impact pathway, including improved access to healthcare, exclusive breastfeeding rates, availability of food for children, handwashing with soap and sanitation, as well as increased joint household decision-making, household savings and birth registration. Survey data collected in March 2021 revealed that the prevalence of stunting for children under the age of five among participating households was 52.8%, compared to 69.8% in non-participating households in the same areas. The greatest difference was seen in the under-two age group. This suggests that, despite the short duration of the project (three years), the delivery of cash plus complementary activities contributed to improved child nutrition outcomes.

Based on these findings, World Bank funding has been allocated to extend the project to 250,000 households in the poorest communes in 18 provinces over five years. In line with inflation and to support greater impact, recipient households are receiving USD54 every three months for 24 months, alongside the same SBC activities and support for job creation. Refugees and host communities are also being targeted. Rather than using Community Agents, mothers enrolled in Merankabandi who engage in positive nutrition practices are being recruited and trained to provide peer support. This aims to improve linkages between the cash and complementary components and improve project sustainability.

The Productive Safety Net Programme (PSNP) in Ethiopia

In Ethiopia, a new cadre of social workers provides individual integrated case management to cash transfer clients, linking them to multiple nutrition, health and agricultural services.

Efforts to link social protection and nutrition in Ethiopia primarily focus on the Rural PSNP. This is Ethiopia's largest social assistance programme, currently targeting eight million extremely poor rural households that are vulnerable to shocks and food insecurity with cash or food assistance, either in exchange for public works or unconditionally where the household has limited labour capacity ('direct support').

Evaluation findings of the PSNP III (2010–2014) revealed that, despite improving household food security, the programme did not improve nutrition outcomes for children (IFPRI, 2013). In response, and in the context of a strengthened nutrition policy landscape in Ethiopia, the PSNP IV (2015–2020) included explicit nutrition-related indicators and embedded nutrition provisions within its design to support improved access to a diverse diet, nutrition and care practices, and health and nutrition services to all participants (Box 1).

Box 1 Nutrition provisions of PSNP IV in Ethiopia

1. Introduction of 'temporary direct support' to excuse pregnant women, as well as caregivers of children under 12 months/children with wasting, from public works to support optimal nutrition and care practices.
2. Introduction of 'co-responsibilities' for temporary direct support clients, including attendance at health facilities and SBC sessions delivered by Health Extension Workers.
3. Increase in the nutritional value of food transfers (by including pulses in addition to cereals and oil) and in cash transfer values to enable the purchase of pulses.
4. Women enabled to receive distributions as joint household heads to enhance their control over household resources.
5. Introduction of a mechanism to scale up transfers in response to shocks using contingency budgets, thereby increasing the shock-responsiveness of the system.
6. Selection of public works projects that have nutrition benefits for the community (e.g., building childcare centres at worksites; water, sanitation and hygiene facilities; kitchen gardens; planting fruit trees).
7. Improvement of work conditions for women (half the workload of men; lighter work; building of childcare centres next to work sites).
8. Delivery of monthly two-hour SBC sessions for public works clients (with six sessions counting as one public workday).
9. Creation of linkages with support for nutrition-sensitive livelihoods for public works clients (e.g., poultry, goat's milk, fruit or vegetable production).
10. Involvement of the health sector in PSNP processes and planning.
11. Embedding of nutrition-related indicators and reporting on nutrition-related outcomes.

[1] https://www.ennonline.net/fex/68/socialprotectionkenya

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Merankebandi participant tending to her kitchen garden. Burundi, 2021

Results of an endline review of the PSNP IV found limited or no change in a range of nutrition outcomes and underlying determinants of nutrition. Food security improved marginally in the lowlands (reducing the food gap by 12 days per year), but not in the highlands. Dietary diversity marginally improved by 0.11 food groups in the highlands but not in the lowlands. Diets for young children (aged 6–23 months) and uptake of health services were no different in PSNP compared to non-PSNP households. Low nutritional impact was largely attributed to poor programme performance on the social transfer side (late and irregular transfers and low transfer value), as well as to the sporadic implementation of nutrition provisions due to budget limitations.

To explore further ways to improve the nutritional impact of the PSNP, the Ministry of Labour and Social Affairs (MoLSA), with technical support from UNICEF, implemented the *Integrated Basic Social Services with Social Cash Transfer (IN-SCT)* programme between 2016 and 2018 in four woredas in the Southern Nations, Nationalities and Peoples and Oromia regions. A case management approach was used to link direct support PSNP clients with an integrated package of services, including SBC, health and nutrition services, and agricultural extension and livelihoods support. PSNP clients continued to receive the regular PSNP transfer of 3 kg of cereals per day or a cash equivalent, depending on the context. An endline evaluation revealed successful linkages between clients and services by social workers, but little impact on child nutrition outcomes. In areas receiving additional nutrition-sensitive interventions (agricultural extension and livelihoods support) some improvements occurred in indicators along the nutrition impact pathway, including household dietary diversity, food security and breastfeeding practices.

Building on lessons learnt, a five-year *Integrated Safety Net Pilot (ISNP)* was launched in 2019 in four woredas in Amhara region and Addis Ababa by MoLSA with UNICEF technical support. The programme tests a similar case management approach to the IN-SCT pilot, with additional elements to strengthen linkages with health, nutrition, education and protection services. A new cadre of social work staff (Community Service Workers) has been recruited to provide more consistent individual case management, supported by a new digital information management system and improved enrolment and referral systems.

Building on lessons learnt from the PSNP IV, further nutrition-sensitive design provisions have been integrated into the wider PSNP V with World Bank support. These include the selection of nutrition-sensitive assets for public works projects; embedded case management and referrals to health and nutrition services; enhanced nutrition SBC for PSNP clients; the transference of women from public works to 'direct support' during pregnancy until their child's first birthday; the mobilisation of female 'nutrition champions'; and the provision of childcare at public works sites. The PSNP V also has an improved shock-responsive component to allow the scale-up of transfers, both horizontally (reaching more participants) and vertically (achieving higher transfer values), in response to crises. Future evaluations of the PSNP will rigorously assess the impact of these provisions.

The Stawisha Maisha programme in Tanzania

Stawisha Maisha targets SBC at participants of the government's cash transfer programme to support the uptake of positive infant and young child feeding (IYCF) practices among chronically poor households.

The Productive Social Safety Net (PSSN) II programme (2020–2023) is the Government of Tanzania's social assistance programme, which targets 1.2 million participants in chronically poor households (identified by a common targeting system). Households with no labour capacity receive unconditional cash transfers ('direct support'), and those with labour capacity participate in public works for cash during the lean season. All participating households with children under the age of 18 also receive a variable cash transfer conditional on the uptake of health, nutrition and education services. PSSN II households receive bi-monthly cash transfers to the value of USD5.30 and USD24.10 per day, depending on the eligibility criteria.

UNICEF worked with the government between 2018 and 2019 to pilot the ***Stawisha Maisha Cash Plus programme*** in two districts. Stawisha Maisha tested the efficacy of delivering additional SBC sessions to PSSN II households to enhance IYCF practices alongside PSSN II cash transfers to increase access to nutritious foods. Peer-led SBC sessions were delivered to caregivers and other household members at PSSN payment sites on the six payment days throughout the year.

A total of 10,837 caregivers were reached with SBC sessions at 127 payment sites, and 85% of participants attended all six sessions. Weaknesses in evaluation methodology meant that definitive conclusions could not be drawn on programme impact. However, an endline review showed acceptance of the approach by participants, integration of activities into the social protection workforce and increased participant knowledge regarding IYCF. A key limitation was the use of written materials among a largely illiterate audience. On the cash side, programme performance was poor during 2019, with several missed payments due to funding shortages. Low coverage of health and nutrition services in some target areas meant that linking PSSN with services was impossible.

UNICEF and the Tanzania Social Action Fund (TASAF) worked together to design a second iteration of the Stawisha Maisha programme, which is now being implemented in Lake Zone. Design changes made in response to Phase One learnings include increased frequency of group meetings (now weekly); meetings within communities rather than at payment

sites; targeting of mothers and direct caregivers; and the use of radio as the main communication channel. Sessions will be supported through the distribution of wind-up radios, improved SBC materials and ongoing supervision by PSSN workers. A much stronger monitoring and evaluation system is being developed to provide valuable information to inform future integration and scale-up.

Lessons Learned

Evidence from these case studies show that ***cash transfers delivered alongside 'plus' interventions can help address barriers to optimal nutrition*** by addressing financial constraints, access to nutritious foods, uptake of nutrition and other services, and improving care and feeding practices. This is best achieved when social protection and nutrition colleagues work together to design and implement joint programmes.

Cash plus programmes have the greatest potential for impact when ***cash transfers are of adequate value, regular, predictable and paid on time***, and when plus elements are delivered to the same population in tandem. Learning from Burundi shows that the latter requires joint planning, system linkages and regular communication between social protection, nutrition and other workforces.

Delivering ***SBC alongside cash transfers*** can 'nudge' vulnerable populations towards optimal child feeding and care practices. SBC can be delivered by trained community volunteer cadres within the health system (as in Burundi), or by the social welfare system (as in Tanzania). Learnings from Tanzania and Burundi shows that SBC is more likely to be effective when the target population has access to quality nutrition services and diverse foods respectively.

A ***referral system for cash transfer participants to multiple services*** can increase access to, and uptake of, multiple services to support child nutrition and wellbeing, as demonstrated by the ISNP in Ethiopia. This will be most effective when clear referral pathways exist between sector workforces and when information systems are integrated or shared. Integrated case management services provide an effective means to manage referrals, and this can be delivered by trained community volunteers (as in Ethiopia).

Experiences in Burundi demonstrate the potential of ***kitchen gardens and support towards increased household savings, livelihoods and job creation*** to improve household earning for transfer participants and to sustain access to diverse foods for children. Tailoring livelihoods interventions to support the availability of nutrient-dense foods for children, such as by providing seeds and small livestock, can help families put nutrition SBC messages into practice.

Cash plus programmes must be robustly ***monitored and evaluated*** to provide quality evidence. Monitoring frameworks should be designed to show impact across the nutrition impact pathways, including indicators to measure short-term change (such as dietary diversity, changes in practices and access to services) and longer-term nutrition outcomes. Findings can be fed into the design of each programme iteration, as in Ethiopia, to ensure that learning leads to programme improvement and increased impact over time. Robust information will also support advocacy for investments as part of future scale-up.

Conclusions

Increasing domestic and external resources are being invested in the development of large-scale government social assistance programmes in the ESA region to target financial assistance to the most vulnerable members of society. These programmes provide a valuable opportunity to address poverty as a key underlying cause of child undernutrition. The country examples provided here show that, by intentionally including nutrition provisions within their design and adding nutrition-responsive 'plus' elements, social assistance programmes have the potential to address multiple barriers to optimal child nutrition (beyond financial barriers) to achieve positive change along the nutrition impact pathway. Scale-up of programmes in many of the countries is of course critical for contributing to national poverty reduction and nutrition goals. Engagement of multiple sectors (including nutrition) in social policy efforts, as well as in the design and evaluation of social assistance programmes, is critical to making this a reality.

One future opportunity in the ESA region involves the integration of shock-response mechanisms within national social assistance programmes to allow scale-up of cash or food assistance in response to crises. This will help prevent malnutrition in the face of increased climate-related shocks in the region as part of wider malnutrition prevention and nutrition resilience strategies. Opportunities also exist to improve the nutrition-responsiveness of wider social protection systems to support sustained change. This might include improved employment rights for women to support optimal IYCF practices, as well as health insurance schemes to support universal health coverage, including universal access to nutrition services such as treatment of wasting, micronutrient supplementation and counselling. Food systems transformation efforts are also critical for improved and consistent availability of nutritious foods, especially protein sources, to ensure that social assistance translates into improved diets for young children.

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Participants in a development programme to increase resilience to climate change and improve food security and nutrition in Burundi

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